When I became chair ten years ago, we were in the middle of the dot-com explosion (not the collapse), and the major concerns for the department were the potential impact of Y2K and the national shortage of anesthesiologists. During the subsequent decade much has changed. We are now at the end of a severe recession, and concerns today focus on the impact of health care reform and expansion of non-physician health care providers. During these ten years, the department has successfully expanded its clinical, educational, and research missions, maintaining its position as one of the top departments in the country. However, rather than basking in success, I want to describe the 2010 strategic planning process.

Strategic planning may seem an unnecessary diversion when there is already so much to do each day. However, as Laurence Peter (creator of the Peter Principle) stated, “If you don’t know where you are going, you will probably end up somewhere else.” Our expansion during the past decade has been successful, but planning how to continue to grow will ensure our future success. Thus during 2010 the clinical divisions and the research, education, and governance committees will develop their respective strategic plans to guide our department’s future growth and continuing success.
addition, many future faculty will train in our residency and fellowship programs, and opportunities such as the FARM program, the master’s degree in clinical epidemiology, and NIH T32 training grants will be important pathways.

**Increased Specialization vs. Broad Education**—Another element of each strategic plan is how to address the conflict between the needs for increased specialization and the goal of maintaining a broad range of clinical skills throughout the faculty. Our general OR group includes many areas of subspecialization (neuro, thoracic, ENT, orthopedics, transplant, regional), and there may be opportunities to redefine the larger group into smaller subspecialties.

**Research Expertise and Contribution**—Our research strategic plan will identify areas where we can make major contributions, areas that require both a critical mass within the department and collaborations beyond it. Our existing programs in areas such as pain, genomics, and biomarkers are excellent examples, and we need to expand our efforts into the area of perioperative outcomes research. Because the concept of the triple-threat faculty member may no longer apply, and we need to consider how we choose faculty for the future.

**Education**—Our education strategic plan will emphasize the use of innovative programs to train anesthesiologists for a specialty that will change throughout their careers. Our education programs will increasingly focus on better ways for trainees to gain competency and on better ways for faculty to assess it. Stanford has been the leader in using simulation in anesthesia training; we will expand our programs and help define the optimal way to exploit simulation as part of anesthesia education. Educating faculty in education theory will be important as we transform our educational programs and create new paradigms. One likely theme running through all strategic plans, from research to clinical to education, is how mentorship can help develop better faculty, fellows, residents, teachers, and researchers.

**Changes in Anesthesiology**—Finally, our strategic planners will consider changes that will inevitably occur, so that we can recruit and train faculty and trainees who represent the future rather than the past. The Greek philosopher Epictetus said, “First say to yourself what you would be; and then do what you have to do.”

**A Huge Loss**—On a very sad note, Brant Walton died on December 17, 2009 after a courageous struggle with colon cancer. Brant was a Stanford resident and faculty member with incredible talent and great potential to impact anesthesia and medicine. An obituary is listed at [http://med.stanford.edu/ism/2009/december/obit-walton.html](http://med.stanford.edu/ism/2009/december/obit-walton.html). Memorial contributions may be made to the Walton Family Trust at [www.brantwalton.org](http://www.brantwalton.org). There will be a memorial service for Brant Tuesday, January 19 at 4:00 pm in Stanford’s Memorial Church. The next Gas Pipeline will include an extensive segment on Brant and his life.

**My New Year’s Wish**—Finally, as the next decade begins, I want to wish everyone in the department a new year full of health, peace, friendship, and love.

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**GRANTSMANSHIP—TAP THE IN-HOUSE EXPERTS**

**BY PATRICIA ROHRS**

Do you consider yourself professional writers?

If you answered, “No,” then you are overlooking how central writing is to your academic medical career success, especially given the increasingly competitive funding environment. “With today’s uncertainties, it’s critical to submit the best application you can on the first try. Of course, everyone aims that high, but to actually succeed requires more preparation than you may think.”

**Why is the first shot so important?**

“First, you get only one resubmission. If that doesn’t work, you’ll have to start over with a new or greatly revised idea. Second, expect very limited feedback from the peer review with today’s shorter summary statements….Your goal should be to get it right the first time,” which includes

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1 **Note:** Many aspect of this article—both quotations and ideas—are derived from this website: National Institute of Allergy and Infectious Diseases (NIAID)


Accessed December 9, 2009.
ensuring your readers understand the high impact of your idea.

**How can I quickly find NIH grant application information?**

To help you find an NIH opportunity, Mike Helms and Patricia Rohrs have placed condensed NIH grant information at [http://med.stanford.edu/anesthesia/research/nih.intro.html](http://med.stanford.edu/anesthesia/research/nih.intro.html)

**Who are the in-house experts?**

Mike Helms, Frances Davies, and Patricia Rohrs—members of the Department’s Research Administration staff—are ready to help you find an appropriate grant opportunity, devise an application strategy, and execute the writing and production of the submitted package.

**Mike Helms, PhD, MBA** joined the department on June 1, 2009 as Director of Strategic Research Development. Mike assists faculty in identifying and applying for new funding opportunities.

His biochemistry PhD, MBA, two postdoctoral fellowships, and 10 years of increasingly responsible experience in the biotechnology industry provide an excellent background. Mike received two R43 grants (SBIRs) from NIH and serves as ad-hoc reviewer on an NIH study section. Most recently, as General Manager of the Sunnyvale Research Center for Complete Genomics, Inc., he managed an R&D facility and a $10 million, five-year, collaborative project to sequence single molecules of DNA, funded by National Institute of Standards and Technology (NIST).

Since joining the Department, Mike has helped several faculty identify and apply for grants. Dr. Drew Patterson, a beneficiary, says, “Mike was sent from heaven. We can’t ever let him leave.” Mike also collaborates with Dr. Pearl and senior faculty to develop the Department’s strategic research plan (See *Strategic Planning*, page 1).

Mike may be reached at 650-721-6119 or mkhelms@stanford.edu

**Frances Davies, PhD**, joined the Department six years ago as Director of Faculty Development. Her mission is to help faculty develop effective research programs, search for and obtain funding, work with investigators on the nuts and bolts of grant preparation (including study design, data analysis, statistics, and graphical representation of data), and disseminate results. She has amassed computer tools—for example, Graphpad Prism, SPSS, Adobe Illustrator and Photoshop—investigators can employ to present their results via posters and manuscripts.

“I can be the most effective on the ground floor of study preparation. Please contact me well before your grant submission date, so we can make sure your project has a sound basis.”

Employing the image of a tailor at work, Frances says, “It’s better to measure twice and cut once.”

**Frances Davies**

Frances’ PhD in pharmacology from McGill University, two postdoctoral fellowships, and experience on multi-investigator, drug-development and basic research projects at SRI International, Molecular Research Institute and Moltech Corporation preceded her work with the Department. After joining the Department, she...
fostered multi-investigator neuroscience and pharmacology research projects and conducted basic research into the mechanism of tolerance of α2 adrenergic agonists, before taking on her present role.

Frances may be reached at 650 493-5000, ext 64854 or fdavies@stanford.edu

**Patricia Rohrs**, medical editor and writer for the Department, says, “The faculty, fellows, and residents are my customers, and I aim to provide them with first-rate service.”

Patricia’s services currently include standard, scientific, English review of manuscripts, grant proposals, and curriculum. Patricia says her editorial aims are to be an advocate for the reader and an ally of the writer. Patricia has already collaborated with numerous faculty, fellows, and residents to improve their writing products.

Patricia Rohrs

Patricia was formerly editorial assistant to Steven Shafer, Editor-in-Chief of *Analgesia & Analgesia*. Before joining the Department of Anesthesia in 2005, Patricia pursued careers as educator (teacher of English composition), Silicon Valley business executive, and free-lance medical writing and editing consultant. She has applied her talents in several environments—secondary and higher education, healthcare, biotechnology, software development, and semiconductors.

Patricia can be reached at 650 483-7584 or rohrs@stanford.edu

Who else can help?

“You, your peers, and your mentors, including your department chair are in a perfect position to assess whether your application stands to make a high impact on its field and whether you have conveyed its impact effectively.”

**Be your own reviewer**—Once you’ve written your application, apply this checklist:

- Since my score is based on overall impact, did I effectively emphasize the impact of my project on its field of science?
- Have I clearly described how the work I propose is both innovative and significant to public health?
- Does the text leave room for argument with my conclusions?
- Would a reviewer believe my team is especially qualified for the work and that my institution is a good place to do the research?
- Did I check the [CSR Study Section Roster Index](#) to determine who’s likely to review my application? Did I evaluate [reviewers’] areas of expertise and use that information to fine-tune the impact and significance of the application? Will this set of reviewers see my topic as high impact? If not, is there another group that would? If this is the best group, is there information I could add to convince them?

Revise accordingly and take the next step.

**Ask your colleagues to be reviewers**—Get feedback before submitting your application. Ideal reviewers include colleagues who have written successful grants and served on NIH study sections and colleagues who are not experts in your field (the latter, especially, can comment on your writing’s clarity and persuasiveness).

Ask your reviewers to be brutally honest as they analyze the strong and weak points of your application’s content and presentation. Ask them to score your application using NIH’s review criteria; see the [Scoring Table for Research Grants](#) from our [NIH Grant Cycle: Application to Renewal](#).

Continued…
What other advice is out there?
Read the following material published here:
http://funding.niaid.nih.gov/ncn/newsletters/2009/1209.htm#a01

- The Art of Application NIAID Funding News November 12, 2009.
- Strategy for Picking a Project in Part 2. Game Plan of NIH Grant Cycle; Application to Renewal
- Last Steps After You Finish Writing from Part 6. Other Application Sections of our NIH Grant Cycle; Application to Renewal

What’s the take-home message?
Plan WAY ahead and ask for help. Remember, the 2010 receipt deadlines for new NIH R awards are February 5, June 5, and October 5.

FROM THE DEPUTY CHIEF
BY RICK NOVAK, MD
ASSOCIATED ANESTHESIOLOGISTS MEDICAL GROUP
rjnov@yahoo.com

Clinical Case for Discussion: One week before you graduate from anesthesia residency, you lose the peripheral nerve stimulator you use to monitor neuromuscular blockade. Should you bother to purchase another one?

Scenario: Fast forward to your first day in post-residency private practice. Your first case is a colectomy on an obese, 5 foot 2 inch, 100-kilogram male with adenocarcinoma of the sigmoid colon. You bring the patient into the operating room, anesthetize him with propofol, and inject 10 mg of vecuronium into his IV. You wait 90 seconds before intubating the trachea. The surgeon enters the room. After the Timeout, the patient is placed in lithotomy position. The surgeon performs a rectal exam and sigmoidoscopy under anesthesia.

“We’ve got a problem,” the surgeon announces. “The tumor has grown since my last exam, and it’s too close to the anus to treat with simple colectomy. He needs a total proctocolectomy, and I didn’t give him informed consent for that. We need to wake him up and come back another day.” He shrugs his shoulders, and walks out of the room. (Seem like a far-fetched scenario? It’s not—this exact incident happened to me at Stanford about 8 years ago.)

You are stunned. “Come back another day?” The circulating nurse shakes her head. She and the scrub tech are looking at you—waiting for you to wake up the patient. It’s only been 12 minutes since you injected the muscle relaxant, and you have no nerve stimulator. Being a resourceful Stanford graduate-to-be, you call an anesthesia attending and ask to borrow her nerve stimulator. After the nerve stimulator has been delivered to you, you discover no twitches at either the patient’s facial or ulnar nerves.

The nurse asks, “Is there a problem?”

You answer, “Not really, but I can’t wake up the patient until the muscle relaxant wears off further.” You decide to wait until one twitch returns before you administer neostigmine/glycopyrrolate reversal. You sit down, the nurse sits down, and the scrub tech scrubs out. The operating room seems absurdly quiet for thirty minutes, while you wait to reverse the muscle relaxant. Forty minutes later, you extubate the trachea and take the patient to the Post Anesthesia Care Unit.

Discussion: After you finish your Stanford residency, you need to be prepared for faster surgeons and shorter operative times. Overdosing patients with muscle relaxants is a common mistake when newly-trained anesthesiologists
leave residency. The operative time for a laparoscopic appendectomy may be as little as fifteen minutes. A pediatric tonsillectomy may last only twelve minutes. An anterior cruciate ligament repair may last only 45 minutes.

In private practice, you will probably use modest doses of vecuronium or rocuronium when paralysis is necessary. If the surgeon finishes earlier than expected, you always want to be able to reverse muscle relaxation and awaken the patient without delay. Whenever appropriate, you will prefer to use an LMA instead of an endotracheal tube, partly because the LMA insertion does not require a muscle relaxant, and partly because it’s easier for the patient to breathe spontaneously with an LMA.

How about the need for a nerve stimulator to monitor neuromuscular blockade? I polled the 33 private anesthesiology attendings at Stanford via email, regarding their practices using nerve stimulators and muscle relaxants. I learned the following: Most practitioners do not administer additional muscle relaxant following intubation unless surgical conditions demand it. Most practitioners do not reverse muscle relaxants if no dose was given in the last hour of a case. Almost every private attending still owns a nerve stimulator. Half of them use a nerve stimulator routinely whenever they administer muscle relaxants, but half use the device occasionally or rarely, relying on clinical criteria and judgment alone in regards to the level of neuromuscular blockade. **Is this practice wise, or not?**

The American Society of Anesthesiologists (ASA) Standards for Basic Anesthesia Monitoring, posted on [www.asahq.org](http://www.asahq.org), does not list the use of a peripheral nerve stimulator as a standard.

However, in Miller’s *Anesthesia*, 2008 Edition, Chapter 47, “Neuromuscular Monitoring”, author Jørgen Viby-Mogensen makes the following statements:

- “Many anesthesiologists do not agree with extensive use of nerve stimulators and argue that they manage quite well without these devices. However, the question is not how little an experienced anesthetist can manage with but rather how to ensure that all patients receive optimal treatment.”

- “It is difficult and often impossible to exclude with certainty clinically significant residual curarization by clinical evaluation of recovery of neuromuscular function.”

The author further states that the following clinical tests of postoperative neuromuscular recovery are **not** reliable:

- Sustained eye opening
- Protrusion of the tongue
- Arm lift to the opposite shoulder
- Normal tidal volume
- Normal or nearly normal vital capacity
- Maximum inspiratory pressure less than 40 to 50 cm H₂O

The author states that the following clinical tests of postoperative neuromuscular recovery are **reliable**:

- Sustained head lift for 5 seconds
- Sustained leg lift for 5 seconds
- Sustained handgrip for 5 seconds
- Maximum inspiratory pressure 40 to 50 cm H₂O or greater

The author concludes that “Adequate recovery of postoperative neuromuscular function cannot be guaranteed without objective neuromuscular monitoring.”

In private practice in Palo Alto, most of us use a MiniStim unit (Model MS-1B Miniature Nerve Stimulator (Life-Tech, Houston, Texas), a simple device with one red button for Tetanus and one green button for Twitch. The MiniStim assessment of tetanus or twitch response is done by visual and tactile evaluation of muscle movement, with no quantitation of blockade. **Is there any good reason to avoid using a nerve stimulator?** The benefit/risk ratio of using the device approaches infinity. If you ever lose it, you can purchase another one on the Internet for a mere $155. I’ve had my current unit for ten...
years, during which time I’ve administered 7000 anesthetics. The cost of my MiniStim so far works out to be about 2 cents per case.

During residency or during the years afterward, a MiniStim and a stethoscope are arguably the only tools of your own you need to carry into an operating room to conduct a 21st-century general anesthetic.

**TWO, NEW PROGRAMS BEING DEVELOPED BY ALEX MACARIO, MD, MBA**
**RESIDENCY DIRECTOR amaca@stanford.edu**

In our continuing efforts to provide state-of-the-art graduate medical education, the Department of Anesthesia is working to launch two, new residency tracks:

- Stanford Anesthesia Critical Care (SACC) Scholar Program,
- Stanford Combined Training in Pediatrics and Anesthesiology

**Stanford Anesthesia Critical Care (SACC) Scholar Program**

The 48-month Stanford Anesthesia Critical Care (SACC) Scholar Program begins after the PGY1 internship and is an innovative curriculum allowing the scholar to complete the ACGME requirements for both anesthesiology and subspecialty training in critical care medicine (CCM).

The goal is to recruit the best and brightest applicants nationally, provide an improved educational experience to create better trained intensivists, and increase the number of anesthesiologists in ICU practice.

The SACC curriculum is a combination of both our core anesthesiology program as well as our critical care fellowship program. The 12 months of current required CCM fellowship training are spread over the final two years of the SACC program (3 months as third year anesthesia resident and 9 months during the final PGY5 year) and include elective rotations in areas of medicine related to critical care.

This track prepares the trainee for ABA certification in CCM and in anesthesiology. By the NRMP Match for 2011, we expect to have available 3 slots/year. Applicants will apply via ERAS.

**Current Stanford CCM fellowship rotations (9 ICU months and 2 research months and 1 elective)**

- 5 months MICU Stanford Hospital
- 1 month Palo Alto VA ICU
- 1 month Santa Clara Valley ICU
- 1 month CT ICU Stanford Hospital
- 1 month SICU Stanford Hospital
- 2 months research
- 1 month elective (echocardiography in ICU, CCU, pulmonary inpatient consult, neuro ICU)

**Sample schedule for the 48-month Stanford Anesthesia Critical Care (SACC) Scholar Program**

**PGY-1**

- Two ICU rotations as intern
- PGY-2 (Person enters SACC)
- Ten months CA-1 anesthesiology resident rotations
- Two ICU rotations as anesthesiology resident:
  - Stanford MICU
  - Palo Alto VA
PGY-3

- Ten months CA-2 anesthesiology resident rotations
- Two ICU rotations as anesthesiology resident rotations
  - Stanford CT ICU
  - SICU

PGY-4

- Five months CA-3 anesthesiology resident rotations
- Three months electives as fellow rotations
- Three ICU rotations as fellow
  - MICU 2 mths
  - Palo Alto VA

PGY-5

- Six ICU rotations as fellow
- Two ICU electives as fellow
- Six months as CA-3 anesthesiology resident rotation

Stanford Combined Training in Pediatrics and Anesthesiology

This integrated program will require five, not six, years as would be necessary if these two residency programs were completed sequentially. The residents in this combined training will be eligible for the examination by the American Board of Pediatrics and the American Board of Anesthesiology.

Stanford and Packard are particularly well-suited to offer this innovative training curriculum, and we expect to develop physicians who are competent pediatricians and anesthesiologists capable of professional activity in either discipline. The strengths of the two residencies complement each other well. We are working closely with Dr. Lynn Kahana, the Pediatrics Residency Program Director at Lucile Packard Children’s, to ensure optimal training design.

Training in the PGY-1 will include 12 months of in pediatrics. During the second year, the resident will spend 12 months in anesthesiology. In each of the remaining 3 years, the resident will have 6 months of training in pediatrics and 6 months of training in anesthesiology. This combined training will include all current curricular components that are required by ACGME. In addition, joint educational conferences involving residents from pediatrics and anesthesiology will be held with participation of all residents in the combined training residency.

We are currently submitting our proposal to both the American Board of Pediatrics and the American Board of Anesthesiology.

Residents of the Month

In addition, I would like to congratulate our residents of the month:

- July: Dr. Zeest Khan
- August: Dr. Shea Aiken
- September: Dr. Rob Becker
- October: Dr. Billy Hightower
- November: Dr. Jenna Hansen
- December: Dr. Katie Ellerbrock

As we look forward to celebrating the 50th anniversary of the Stanford Anesthesia Department with you the weekend of September 24-26, 2010, please note these communications to you:

FROM THE ALUMNI ASSOCIATION PRESIDENTS

Dear Prospective Donor:

The Department of Anesthesia at Stanford has been an extremely important force in all our professional lives, for it was during our formative years in the department that we acquired the knowledge, skill and experience that have enabled us to go out into the world and define, for ourselves, the careers of which we are all so justifiably proud. Although Stanford demanded much from us during our period of residency, those demands were always at least in part for our own educational benefit.
Now, as past and current Presidents of the Department’s Alumni Association, we ask you to do something that will be purely for the department’s benefit. The Stanford University Department of Anesthesia has commenced a fund-raising campaign with the intent of providing the resources to insure the future of our clinical, educational and research activities that identify Stanford as one of the leading academic anesthesia programs in the world. As individuals who have received much from the department, we need to consider our obligation to return the favor, so to speak, by contributing to this campaign. We believe this is the right thing to do.

Many, if not most of us already contribute charitable donations to a variety of educational institutions. Including the Stanford Department of Anesthesia, where we all learned our profession, in that list seems a gracious way of expressing our gratitude to those who helped make possible our rewarding careers.

Please consider making a donation today. Simply [click here](#) to make your tax-free donation online through a secure website. Specify in the Special Instructions how your gift should be used, e.g., (1) research, (2) education, or (3) both education and research.

Thank you very much for your attention.

Michael Champeau, MD
Aubrey Maze, MD
William New, MD
John Ahlering, MD
Kent Garman, MD

FROM THE CHAIRMAN

The past half century has been one of tremendous success for our department. However, in these rapidly changing times, we will not maintain our role as a leader if we do not continue to advance our clinical, educational, and research missions. We are entering challenging times for healthcare, academic medical centers and the specialty of anesthesiology. As Chairman I want to see our department develop new techniques to provide anesthesia, better manage complex patients, provide the best education in the country for residents and fellows, and recruit and develop faculty who advance our understanding of the science that underlies anesthesia and its specialties. We will not succeed in these goals if we rely primarily on profit from clinical revenue.

I am therefore appealing to our alumni to contribute as part of this campaign to celebrate the 2010 semicentennial of Stanford Anesthesia. By contributing, you can make a difference to the department that helped develop your own anesthesia career. I look forward to celebrating the success of this campaign with you in 2010.

Sincerely,

Ron Pearl, MD, PhD, Chairman

WE CELEBRATE FIFTY YEARS OF LEADERSHIP


Ron Pearl, 1999-Present

WE CELEBRATE FIVE DECADES OF INNOVATION & ACCOMPLISHMENTS

- **The 2000’s**—Functional MRI Imaging of Pain
- **The 1990’s**—The Modern Preoperative Clinic
- **The 1980’s**—Continuous Cardiac Output, Pulse Oximetry, Pharmacokinetics, and the Modern Anesthesia Patient Simulator
- **The 1970’s**—Patient-Controlled Analgesia (PCA) and the Multidisciplinary ICU
- **The 1960’s**—Anesthetic Toxicity
- 15 Major Textbooks by Faculty Members
- 500 Resident and Fellow Alumni
Presidents of Anesthesia Subspecialty Societies and AUA

Three Former Directors of the ABA

Former Editor of *Anesthesiology*

Current Editor of *Anesthesia & Analgesia*

Celebrate with us September 24-26, 2010. Details will be mailed to you soon.

**Faculty Corner**

**Abstracts and Posters**

**Published Articles**


**INVITED TALKS AND GUEST PROFESSORSHIPS**

- Dr. Alexander Butwick MBBS, FRCA, spoke about 1) Anesthetic management of pre-eclampsia and 2) Anesthetic management of obstetric hemorrhage at the Annual Meeting of the Society of Anesthesiologists in Ho Chi Minh City, Vietnam, on August 8, 2009.

- Steven Lipman, MD, spoke about The 5-minute rule revisited: where should delivery occur in the event of a maternal arrest? at the ASA/FAER session on simulation in October 2009 in New Orleans, LA.

- Steven Lipman, MD, spoke about Obstetric anesthesia and analgesia to the Department of ObGyn residents Nov. 9, 2009.

- Martin Angst, MD, spoke about Update on opioid safety and tolerability: current concepts to minimize side effects and risk at the Plenary Session of the ASA Annual Meeting, New Orleans, LA, October 2009.

- Martin Angst, MD, spoke about The heritability of opioid effects—preliminary results of a twin study at the ASA Annual Meeting, New Orleans, LA; October 2009.

- Andrew J. Patterson, MD, PhD, spoke about Perioperative beta blockers: the quality/performance measure that caused strokes at Grand Rounds at the Department of Anesthesia at the University of Cincinnati, Cincinnati, OH on November 25, 2009.

- Andrew J. Patterson, MD, PhD, spoke about Basic science of beta receptors and beta blockers at the Critical Care Canada Forum, Toronto, Ontario, Canada on October 24, 2009.

- Brendan Carvalho, MD, spoke about 1) Evidence-based approach to the prevention of spinal hypotension during cesarean delivery, and 2) Optimizing labor analgesia with patient-controlled epidural analgesia at the 15th Annual Conference on Advances in Physiology and Pharmacology in Anesthesia and Critical Care at Wake Forest University School of Medicine, Winston-Salem, NC in November 2009.

- Brendan Carvalho, MD, spoke about 1) Non-obstetric surgery and anesthesia during pregnancy, 2) New options to optimize labor and cesarean delivery analgesia, 3) Prevention and treatment of spinal hypotension during cesarean delivery, and 4) Managing the pregnant patient with cardiac disease at the California Society of Anesthesiologists Fall Seminar, October 2009, in Kauai, Hawaii.

- Brendan Carvalho, MD, spoke about 1) Preventing hypotension during cesarean delivery under spinal anesthesia, and 2) Failed epidural top-up for cesarean delivery in a patient with an existing labor epidural at the 20th Annual UC Davis Anesthesiology Update in Napa, CA, August 2009.

- Sean Mackey, MD, PhD, spoke to the Chinese Association for the Study of Pain as an American Academy of Pain Medicine Delegate in Beijing, China in September 2009.

- Sean Mackey, MD, PhD, spoke about Viewing the brain in pain through neuroimaging; understanding and treating neuropathic pain during the Integrative Pain Medicine Course in San Francisco, CA, July 2009.

- Sean Mackey, MD, PhD, was visiting professor at Grand Rounds, Southwestern Medical Center in Dallas, TX in September 2009.

- Sean Mackey, MD, PhD, spoke about Introduction to pain management at the Annual

- Sean Mackey, MD, PhD, was visiting professor at Grand Rounds, University of California at Irvine, CA in November 2009.
- Sean Mackey, MD, PhD, spoke about *Brain mechanisms of neuropathic pain* at the 12th Annual International Conference on the Mechanisms & Treatment of Neuropathic Pain in San Francisco, CA in November 2009.
- Sean Mackey, MD, PhD, spoke about *Can imaging identify analgesics for chronic pain; opioids: the good, the bad and the ugly* at the American Society of Regional Anesthesia & Pain Medicine 2009 Annual Pain Meeting in San Antonio, TX in November 2009.

### Promotions, Awards, and Honors

- Greg Hammer, MD, was invited to the NIH Nov. 18-19, 2009 to help set priorities within the Best Pharmaceuticals for Children’s Act.
- Greg Hammer, MD, is Project Director for NIH/NCRR/NICHD 3UL1RR025744-02S3 (Greenberg H, PI; Hammer GB, Project Director): Methadone vs. morphine PK/PD in infants and young children after cardiac surgery. Award is $500k.
- Greg Hammer, MD, is PI for NIH 3UL1RR025780-02S6 (Galinkin, PI; Hammer GB, Investigator): Development of a small-volume sampling technique for fentanyl pharmacokinetic, pharmacodynamic and pharmacogenetic analysis in preterm and term neonates with and without cyanotic congenital heart disease. Award is $360.2k.
- Patrick D. Soran, MD, was promoted to Clinical Assistant Professor of Anesthesia (Cardiac Anesthesia), effective October 1, 2009.
- Melissa T. Berhow, MD, was reappointed Clinical Assistant Professor of Anesthesia, effective October 16, 2009.
- Timothy Dawson, MD, was promoted to Clinical Assistant Professor of Anesthesia (Adult Pain), effective September 1, 2009.
- Madelyn Kahana, MD, was appointed Professor (Teaching) of Pediatrics and Anesthesia, effective September 1, 2009.
- Vladimir Nekhendzy, MD, was reappointed Clinical Associate Professor of Anesthesia and of Otolaryngology–Head and Neck Surgery, effective 12/01/09.
- Timothy Dawson, MD, and Ian Carroll, MD, both clinical instructors of anesthesia, are among the first US physicians certified by the American Board of Addiction Medicine (ABAM), a new board that certifies addiction medicine physicians from several specialties, including anesthesiology, emergency medicine, family medicine, internal medicine, obstetrics and gynecology, pediatrics, preventive medicine, psychiatry, neurology and surgery.
- Sean Mackey, MD, PhD, has been selected by The School of Medicine’s Office of Diversity and Leadership as a 2011 School of Medicine Faculty Fellow. Fellows pursue several modes to develop and refine their leadership.

### Popular Press

- **Shooting Pain** Nature (Profile) October 2009
- **Stimulus-funded university research addressing issues from climate change to cancer, creating jobs and training a new generation of scientists** The Science Coalition September 2009
- **Your Brain, The Doctor** Sacramento News & Review September 2009
- **Verbatim** Time July 2009
- **Ban Is Advised on 2 Top Pills for Pain Relief** New York Times July 2009
BOOK CHAPTERS


WHAT LOVELY PARTIES!

BY PATRICIA ROHRS

A CLASS OF DIAMONDS

Scrubbed and polished, instead of scrub-clad, graduating residents gathered June 13, 2009 with their families and friends, faculty and staff for cocktails and hors d’oeuvres in the Faculty Club’s gracious patio, studded with maples and draped with hibiscus vines.

Later, during dinner, Department Chair Ron Pearl set the tone: “We are here to celebrate graduating residents, the faculty who supported them, and the residents’ parents and friends for their moral and financial support. The evening belongs to the residents.” Following tradition, Dr. Pearl also named the class—*The Diamond Class*—because of its brilliance and clarity. Dr. Pearl presented graduation certificates, indicating what is next for each graduate:

- Dr. Dondee Almazan, Pediatric Anesthesia Fellow, Stanford University
- Dr. Rich Cano, Faculty, University of Iowa
- Dr. Ellen Choi, Pediatric Anesthesia Fellow, Stanford University
- Dr. Ben Conrad, Pediatric Anesthesia Fellow, University of California, San Diego
- Dr. Mark Gjolaj, Pain Fellow, Stanford University
- Dr. Jennifer Hab, Pain Fellow, Stanford University

Dr. Pearl presented other awards to the following:

- Dr. Alyssa Hamman, Private Practice, Colorado
- Dr. Jerry Ingrande, Research Fellow, Stanford University
- Dr. Marshall Jones, Pediatric Anesthesia Fellow, Stanford University
- Dr. Nate Kelly, Cardiac Anesthesia Fellow, Stanford University
- Dr. Eddie Kim, Regional Fellow, University of California, San Diego
- Dr. Gary Lau, Private Practice, Southern California
- Dr. Jennifer Lee, Regional Fellow, Stanford University
- Dr. Allegra Lobell, Attending, The Veterans Administration Palo Alto Health Care System (VAPAHCS)
- Dr. Julianne Mendoza, Pediatric Anesthesia Fellow Stanford University
- Dr. John Nguyen, Attending, Stanford University
- Dr. Katie Polhemus, Private Practice, Chico, CA
- Dr. Jodi Sherman, Faculty, Yale University
- Dr. Jennifer Wagner, Pediatric Anesthesia Fellow, Stanford University
- Dr. Jerrin West, Private Practice, O’Connor Hospital, San Jose
- Dr. Karl Zheng, Attending, Stanford University

Andrew Morrow, division manager for the Pain Division, given an Outstanding Staff Member Award who helped bring in over $6 million in grant funding,

Dr. Marshall Jones, recognized for teaching medical students,

Dr. Jerry Ingrande, given the Frank Sarnquist Award for teamwork and commitment to excellence in support of the department’s missions of research, patient care, and teaching, and
Dr. Alex Macario, Residency Director and Vice-Chair of Education, given the Ellis Cohen Achievement Award for the faculty member who made significant departmental contributions.

After Dr. Pearl turned over the microphone to Dr. Macario, the latter congratulated Dr. Pearl on being named Richard K. and Erika N. Richards Professor, the Department of Anesthesia’s first endowed chair. Dr. Macario also complimented the graduating residency class on being the best in the US, announced Dr. Jennifer Wagner as resident of the year, and thanked chief residents, Drs. Marshall Jones, Alyssa Hamman, and Jennifer Wagner who “made me look good!”

Finally, Dr. Marshall Jones announced the residents’ attending-of-the-year, Dr. Pedro Tanaka, and recognized Janine Roberts, Theresa Kramer, and Sangeeta Chand for their superior support.

NEW RESIDENTS WELCOMED

On a perfect, summer evening, late afternoon sunlight burnished the black-bronze sculptures in Stanford’s magnificent Rodin garden, as Stanford Anesthesia faculty and staff welcomed new residents and their guests at a delightful party catered by CoolEatz. Attendees mingled under the oaks for cocktails and hors d’oeuvres, before tucking into BBQ, roasted vegetables, lemonade, and confections.

New residents were asked, “What is your dream vacation?” Answers included, “traveling to the moon,” “sailing the Greek Isles,” “fly fishing in Montana,” and “riding domesticated beasts from around the world.”

The image of residents lined up for a photo shoot in front of Rodin’s spectacular Gates of Hell provided witty commentary on their forthcoming residency experience, a far cry from a dream vacation.

HOLIDAY SOIREE

In December, members and guests of the Department of Anesthesia were greeted with chilled Chenin Blanc and sparkling water, as they entered the festive great room in the beautiful Arrillaga Alumni Center, where a sumptuous seafood bar was laid out. Later, at the beginning of a sit-down dinner, the 25-year-old, 30-person Los Altos High School Main Street singers entertained the group with voices, tambourines, and bells. After dinner, the karaoke DJ cranked up the energy and decibels. The first “performers” were Ron Pearl and the governance committee with The Rolling Stones’ I Don’t Get No Satisfaction, a lament Pearl quipped he often hears in his office. Other groups were CV, peds, CA-2, and CA-3. A group dressed as the Village People (Drs. Becker, Macario, Mihm, Pearl, Rosenthal, and Soran) brought down the house with their heartfelt renditions of YMCA and Macho Man. Solo acts included Susie Ruperto and David Parris.

Dancing continued into the night, while fragrant bouquets of white lilies, orchids, and evergreens perfumed the room.

ALUMNI CORNER: REBIRTH OF BLIND NASAL INTUBATION

BY GORDON TAYLOR, MD

In 1960, when I was a resident at Westminster Hospital in London, England, the prevailing intubation technique for dental surgery was blind nasal intubation, assisted by carbon dioxide gas added to the anesthesia mixture after induction. Failure was rare.

In 1964, Dr. John Bunker recruited me to Stanford—the beginning of a British invasion of the department. Over time, I played numerous departmental roles, but the brewing upheavals between the Medical Center and the University in the late 70’s persuaded me to go into private practice in Carson City, Nevada. I would return to Stanford regularly to work in the Pain Clinic and OR.

In the 90’s in Carson City I was frequently asked to intubate patients in the ICU. After one particular terrible session with a laryngoscope, I
reverted to the blind nasal technique I had practiced as a resident, using cocaine as a topical anesthetic, and I became quite good at the technique.

In 1998 I returned to Stanford in a dual role—teaching and private practice—and explored locations for retirement to commence in three years. A key factor was available health care. I chose Maui, Hawaii, 200 air miles from Honolulu and 2,500 miles from California. Maui’s resident population is 140,000, and its visitor population fluctuates between 20,000 and 40,000. For Maui’s population and its 700 square mile area, there’s one, 400-bed hospital with a decent ICU.

Saturday, October 31, 2009 I returned to Maui from the Big Island where I was teaching at the Community College. Crossing the street in a crosswalk, I was struck by a shuttle bus. I rolled 12 feet, sustaining a concussion; a six-piece, comminuted humerus fracture; one fractured rib; a scalp laceration/flap (the size of a side plate); and lots of road burn.

In the ER I awoke listening to the nurse express frustration at removing grit from my scalp—too close to my brain where I “lived.” Next I heard something scary—the ER personnel said no orthopedic surgeon was available on Maui that weekend. The choices were stay put, fly to Honolulu, or fly to Stanford. The cock-up splint on my left arm and my recollection of my 1955 anatomy studies at King’s led me to diagnose radial nerve damage. I opted to stay put to avoid further damage to the radial nerve.

Late Sunday afternoon, an orthopedic surgeon came to see me, and we joked about good surfing spots. I convinced him that his surgery was secondary to successful intubation and induction of anesthesia. (Many of you will remember a 1986 afternoon in Room 11 when my airway challenged my peers to the utmost. At 72” and 250 lbs, I had a #6 tube placed with difficulty.) By Monday afternoon (48 hours post-accident) I glimpsed my anesthesiologist—tall, blond, and looking like a high-school senior. We agreed upon blind nasal intubation, using Lidocaine 5% grease. As he advanced the tube through the right nostril, I slowed him down a bit. When I could feel the tip of the tube on the cords, I asked to feel the tube and push it through the cords. He agreed. A female voice whispered “He intubated himself.” The next day, my physicians were all smiles because they both may have just dodged a bullet.

Documented difficult intubation is the classic challenge for any anesthesia provider. The key was to establish an airway for the general anesthetic. Any method of intubation with a patient who is breathing is to be preferred. Blind nasal intubation was chosen with fiberoptic intubation the backup. Typically for this surgery, stabilization of the humerus without exploration of the radial nerve is performed primarily.

Maui’s rural community hospital is good, but not deep in numbers of physicians. Sometimes the level of physician skill is pitted against further damage to the patient.

My radial nerve, called Rupert may not be healed until Christmas 2010, but I continue with physical therapy.

Have a truly safe and healthy New Year, one and all.

Gordon Taylor, MD

**WHEELS OF LOVE BICYCLE TREK**

Dr. Elliot Krane was among the myriad cyclists who raised funds, traveled to Israel, rode the five-day Wheels of Love charity bicycle trek, and then donated his money to the ALYN Pediatric and Adolescent Rehabilitation Center (http://www.alyn.org) in Jerusalem. The Center rehabilitates infants, children and adolescents afflicted with a broad range of physical disabilities caused by accidents, terror attacks, congenital conditions, and illness-caused physical limitations.
Dr. Krane recorded his adventure with photos and a blog [http://elliotkrane.blogspot.com/](http://elliotkrane.blogspot.com/). Beginning on the slopes of Mt. Canaan and ending in Jerusalem, he rode in the Hula Valley, Galilee, and Golan Heights. In a heartening ceremony, children at the Center presented medals to each participant. Dr. Krane said he hopes to repeat this inspiring event.

![Al-Aqsa and the Dome of the Rock beyond the western wall of the Second Temple](image)

**LIFE’S TRANSITIONS: BABIES**

Suma D. Ramzan, MD, and her husband Zully welcomed their daughter, Ameera Ria Dutta Ramzan, born June 10, 2009. Like her brother Kabir, Ameera (Arabic for “princess”) is named after a Bhakti saint and poet—Meera bai, a Hindu woman who broke many traditional women’s roles in her life. The give thanks for the excellent care by the superb team of Dr. Sukhdeo, Dr Riley, Dr. West and Nurses Pam and Cindy.

![The Ramzan Family](image)

Marisa Brandt, MD, and her husband, Troy, announced the birth of their son, Cash Jacob Brandt, on August 6th, 2009. He weighed 7 lbs 1 oz. Marissa thanks her OB, nurses, staff, and friends, including Dr. Collins for a fabulous epidural.

![Baby Cash Brandt](image)

Jody Cimbalo Leng, MD and her husband, Ted, announce the birth of their daughter, Daisy Ellen Leng, on Monday November 16, 2009. Although “pretty teeny at 4lb, 11oz” she is doing perfectly well. Jody says, “I feel extremely lucky to be a part of such a supportive department, and I’m certain the baby’s health is a result of everyone’s extra help over the past few months. A very special shout-out to Shea Aiken and Dr. Carvalho, who administered the perfect epidural and made the process of “labor” a very pleasant one!”

![The Leng Family](image)
Natalia and Max Kanevsky announce the birth of their son, Aaron Gil Kanevsky, December 22, 2009.

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