MEET OUR TALENTED NEW STAFF
BY PATRICIA ROHRS

Emily Hubbard joined the staff March 1, 2011 as social science research assistant in the division of pain management, working in the Stanford Systems Neuroscience and Pain Lab at 780 Welch Rd. She recruits participants for research studies, runs behavioral experiments, and assists with fMRI scans. Previously, Emily was a research assistant in the psychology and neuroscience departments at UC Davis. Emily earned a BA in Sociology and Psychology from UC Davis. In psychology, her emphasis was cognition and development. Emily recently moved to Mountain View from Davis and enjoys exploring the Bay Area, running, and walking with her energetic black Labrador retriever. You can reach Emily by telephone at 736-0311 or by email at ehubbard@stanford.edu.

Kelvin Leung joined the Information Technology (IT) staff March 16, 2011, working at 1201 California Ave. Kelvin’s duties include server administration, special IT projects, and working with the current desktop support IT team. Previously he provided technical support to The Harker School in San Jose, and he was a computing information systems analyst in Stanford’s Computer Resource Center and its Office of Development. Born and raised in Hong Kong, Kelvin graduated from Hong Kong Polytechnic. He loves photography and travel. He is bilingual in Cantonese and English. You can reach Kelvin by telephone at 650-618-5540 or by email at kelvinl@stanford.edu.

Bill Magruder joined the staff December 1, 2010 as research administrator supporting Dr. Rona Giffard and other research faculty in the Grant Building. His responsibilities include grant administration, scheduling, ordering lab supplies, drafting correspondence, editing proposals, and formatting and submitting articles for publication...
Bill enjoyed living in San Francisco, bicycling, visiting parks and beaches, and listening to various styles of music. You can reach Bill by telephone at 650-725-5875 or by email at magruder@stanford.edu.

Denisa Marcisovska joined the Pain Division staff on March 29, 2011 as Division Administrator, reporting to Pain Division Manager, Andrew Morrow and Rebecca McCue, Systems Neuroscience & Pain Lab Manager. She will handle reimbursements, subject recruitment, flyers and brochures, and other administrative duties. Denisa previously worked as a paralegal for a patent attorney. Denisa earned a BS, summa cum laude, in Business Administration from California State University in Chico. Denisa enjoys hiking, baseball, eating, friends, and road trips. You can reach Denisa by telephone at 650-723-1235 or by email at denisa@stanford.edu.

Rosario Ngo joined the staff March 28, 2011 as adult anesthesia scheduler, reporting to Norma Riestra. Her work location is 1501 California Ave. Her job duties include the following:

1. develop the adult OR master schedule,
2. ensure faculty meet clinical commitments and report incentive hours and clinical credits earned,
3. ensure appropriate faculty coverage of daily clinical assignments,
4. coordinate scheduling preferences and vacation requests,
5. work with the chief faculty schedulers to adjust for changing OR needs.

Previously, Rosario worked for the Stanford Hospital at its control desk, and she was an anesthesia tech for both UCSF and Stanford. She is currently pursuing undergraduate studies in anthropology. Rosario enjoys running, snowboarding, and reading. You can reach Rosario by telephone at 725-8633 or by email at rngo@stanford.edu.

Norma Riestra was promoted February 11, 2011 to Scheduling and Credentialing Manager. Norma’s chief responsibilities include supervising the Adult OR Faculty Scheduler, Pediatric Faculty OR Scheduler, and Credentialing Coordinator. She assists the faculty and the schedulers to keep the ORs functioning as effectively as possible. Norma also provides administrative support to Jane Duperrault. Previously, Norma worked for Stanford Hospital and Clinics (SHC) at the OR Control Desk. At SHC she worked with physicians and assistant nurse managers re: perioperative scheduling, mnemonic procedure assignment, and EPIC reports. She previously held positions at Washington Hospital in Fremont, San Leandro Hospital, and Children’s Hospital of Orange County. She earned her AA degree from San Jose City College and expects to...
Norma Reynolds earned a BA in Business from Menlo College in December 2011. She is fully bilingual in English and Spanish. You can reach Norma by telephone at 650-723-7562 or by email at norma1@stanford.edu.

Brenda Robertson joined the staff on March 16, 2011 as administrative associate for Drs. Chu and MacIver. Her duties include the following: grant administration, scheduling, ordering lab supplies, drafting correspondence, editing proposals, and formatting and submitting articles for publication in scholarly journals. She previously performed administrative work at the following institutions: (1) Stanford’s Department of Neurobiology, (2) Howard Hughes Medical Institute at Stanford, (3) Howard Hughes Medical Institute at Columbia University, New York City, NY, (4) J. David Gladstone Institutes in San Francisco, (5) NIH, National Institute of Allergies & Infectious Diseases (NAID) in Bethesda, MD, and (6) Duke University School of Medicine, Durham, NC. Brenda attended the John F. Kennedy University (formerly Phillips Jr. College) in Campbell, CA where she majored in Court Reporting. You can reach Brenda by telephone at 723-6632 or by email at broberts@stanford.edu.

Yuki Shamoto joined the staff in August 2010 as Division Manager of Research, working in the Grant Building. She supports Drs. Angelotti, Angst, Drover, Trudell, and other researchers. She works on grant submissions and Endnote references for journal articles, as well as trouble-shooting various problems. Brenda Robertson, Jan Shriber, Erin Reiland, and Bill Magruder report to Yuki. Previously, Yuki worked in a variety of fields—co-coordinator of Pulmonary Division fellowships at Stanford and trader and fund manager in international banking and finance (New York City, Tokyo, and Vienna). Yuki earned a BA from UCLA in political science and an MA in international economics from Johns Hopkins School for Advanced International Studies. Yuki is mother of three, active, school-age youngsters. She enjoys traveling to Hawaii and scrapbooking. You can reach Yuki by telephone at 723-9896 or by email at yshamoto@stanford.edu.

Jan Shriber joined the staff on March 7, 2010, after temping two months, as an administrative associate supporting Drs. Yeomans, Patterson, and Peltz. She returned to work after an 18-month retirement. She currently works in anesthesia research in the Grant Building. Jan’s prior Stanford assignments (totaling 24 years) were in Central Benefits, Medical Development, and Central Development, where she managed the Alumni/Donor Records database. In Medical Development, she worked with the international fundraiser who cultivated Li KaShing, the donor of the medical school’s new Li Ka Shing Center and the donors for the Stanford Comprehensive Cancer Center and the Richard M. Lucas Center. However, her favorite role was running the Financial Aid program that matched medical school students with their donors, including the dean’s annual dinner at the Faculty Club. Jan attended San Jose State University. Outside of work, Jan’s four children, three grandchildren, and two kitties keep her busy. She enjoys reading, her book club, travel,
her RV camping club, and her Sierra cabin retreat during the spring, summer and fall months. You can reach Jan by telephone at 723-7442 or by email at jshriber@stanford.edu.

Melis Sunay joined the staff December 9, 2010 as a life science research assistant, supporting the research efforts of Drs. Lisa Wise-Faberowski and Bruce MacIver. She is a recent graduate from Trinity College, Hartford, Connecticut, where she studied neuroscience and worked in a biomedical engineering lab for three years, studying the effects of stress on synaptic plasticity in the amygdala. Melis was born and raised in Turkey, but she came to the US at age 14. After university, she and her significant other, Jacek, took an extensive road trip—Newfoundland, Texas, the West, Alaska, and California. They decided to settle in the Golden State. Melis loves her new golden lab puppy, Newfie, and so does everyone else along the Anesthesia research hallway. You can reach Melis (and maybe see the puppy) by telephone at 725 5851 or by email at msunay@stanford.edu.

Yun Tao joined the staff November 1, 2010 as clerkship co-coordinator. She assigns Stanford and visiting medical students to work with a faculty member on a two-week rotation on a general operating room topic. Previously, Yun pursued a variety of careers: project assistant in Beijing, China for the Deutsch Tourenwagen Masters car-racing tour; adjunct faculty in Singapore’s Ngee Ann Polytechnic, teaching Broadcasting in Chinese; and intern financial news reporter for China Central Television Station (Beijing). Yun earned a BA in broadcasting from Communications University of China, Beijing and an MS in Communication from Indiana State University. She also possesses a certificate in Accounting from Evergreen Valley College in San Jose. Yun enjoys reading about exploration and history, traveling, and developing a website for Chinese mothers. Yun herself is mother to one child. Her work location is Department of Anesthesia, H3583. You can reach Yun by telephone at 724-1706 or by email at yuntao@stanford.edu.

Kate Wiley joined the staff April 4, 2011 in the Systems Neuroscience and Pain Lab at 780 Welch Road. She is responsible for functional magnetic resonance imaging (fMRI) data-analysis support in studies relating to managing and alleviating pain. Previously Kate worked as a psychological research assistant, where she collected and analyzed data and recruited participants for various projects—psychotherapy for anorexia, perceptions of working mothers, and memory and emotional attention in aging populations. Kate graduated from Scripps College, Claremont, CA in December 2010 with a BA in Psychology. She grew up in Minnesota and loves to rock-climb, hike, and play the piano. You can reach Kate by telephone at 723-8346 or by email at kwiley@stanford.edu

CONGRATULATIONS, MARIA ROJA

Maria Roja, Human Resources Coordinator for the Department, was recently honored for her outstanding service to the Stanford Asian American Activities Center (SAAAC). As part of
The Filipino-American Community at Stanford (FACS), which is within SAAAC, Maria and her husband, Denny (a Stanford Business School alum and an inductee into the Stanford Multicultural Hall of Fame), raised enough money to help start the Philippine Development Foundation, whose mission is to improve Philippine global competitiveness through education, science, and technology. The foundation has already provided Internet access for students and basic Internet literacy programs to over 3,000 schools and supplies scholarships for deserving high school students.

As secretary and active supporter of FAC, Maria supports the staff by linking them with influential, successful people who can be role models for students and staffers. She is also involved in membership recruitment and raising money to aid the victims of earthquakes, volcanoes, and typhoons in the Philippines. An ardent supporter of Philippine arts, Maria also brings talented dance, music, and film performances to campus.

Maria possesses a BS in Chemical Engineering from the University of Santo Thomas, Manila, Philippines, an MS from the University of Washington, and an MBA from Yale University. During her career, Maria transitioned from research chemist to business owner to HR coordinator at Stanford.

---

**RESEARCH FUNDING: AIM HIGH & SHARPEN COMPETITIVE EDGE BY PATRICIA ROHRS**

**NIH funding rates drop to record lows**—*Nature Medicine*’s recent headline and article (June 2011) gives us all pause.¹ An excerpt states, “Although the US National Institutes of Health (NIH) was largely spared the budgetary ax in the agreement reached last month by Congress, researchers will nevertheless soon feel the sting. Speaking before a Senate appropriations subcommittee last month, NIH director Francis Collins said that agency will probably fund only one in six grants in 2011—the first time that the award rate has dipped below 20%. ‘It’s devastating,’ says Howard Garrison, deputy executive director for policy at the Federation of American Societies for Experimental Biology (FASEB), an organization headquartered in Bethesda, Maryland that represents 23 scientific societies. With the stimulus funding drying up and the NIH budget shrinking slightly, former FASEB president Mark Lively warns that increased competition for a smaller slice of the NIH pie could force principal investigators to lay off lab staff or drive junior scientists out of biomedical research altogether. ‘Discoveries will go unmade, scientific progress will be interrupted and budding careers are going to be cut short.’”

**NIH funding rates may go lower still**—For several years, overall NIH funding of biomedical research projects has been flat. In the last fiscal year, one percent of the total NIH budget was cut. As of April 26, 2011, another 1% of the total NIH budget was cut. These cuts have affected the quantity, dollar amounts, and duration of awards granted. What will happen to funding during the next fiscal year is uncertain, but additional budget cuts are widely expected.

**Stanford Anesthesia aims high**—The Department takes these grim facts and projections very seriously but remains ambitious about competing for a slice of the NIH pie and improving its national ranking among US academic departments of anesthesia. Even though our Department is smaller than many others, we improved our ranking in NIH funding from 16th in 2009 to 12th in 2010. By the end of 2011, we expect our funding to have greatly increased, and we aim to rank in the top ten nationally.

**We celebrate recent and anticipated successes**—The Department is proud of its investigators. Recently, Dr. Gary Peltz was awarded a transformative R01 grant for $6.8 million over five years, Dr. Sean Mackey was awarded a P01 center grant for $9.0 million over five years, and Dr. Larry Chu received his first R01 grant. Additional awards are expected: a K99/R00 career-development grant for Dr. Eric Gross, and a K08 career-development grant for Dr. Kevin Johnson. Other strong proposals are in the pipeline.

But we cannot take anything for granted.

---

We plan to boost the rate of success—To achieve our top-ten goal, Drs. Ron Pearl and Rona Giffard and the Research Executive Committee emphasize their support for applicants’ focus on the following three points:

- “Get it right the first time.” There’s one chance to resubmit an NIH grant before an applicant has to start over with a new idea, there’s no more error-correction window, and the funding environment is more competitive than ever. Applicants must present well-polished applications every time, ensuring that reviewers understand the high impact of their ideas. To succeed requires more preparation than one might think.

- Rigorously engage in an internal, pre-submission review process one month before the sponsor’s deadline (see table below and print it for reference). Dr. Mike Helms states, “from my perspective, using internal review, we have submitted much more polished, complete, error-free applications than in the past, and they are getting better scores. The faculty are reaching out to colleagues outside of the Department and Stanford to seek grant application input, and they actually have the time to incorporate it. This input improves grant applications a great deal.”

- Promote collaborations with Stanford departments and external institutions. For example, the anesthesia faculties of Stanford and UCSF plan a joint meeting on August 13th explicitly to promote collaborations between our departments.

What’s the take-home message?
Be aware of how the NIH funding environment has changed and will continue to change. Prepare your grant proposal with the greatest of care and submit it one month in advance of the sponsor’s deadline to maximize your opportunities to revise and polish it into a high-impact application.

You can make the most of pre-submission time—people and websites to help

<table>
<thead>
<tr>
<th>Who or What</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You</strong></td>
<td>1. See the summary of funding opportunities.</td>
</tr>
<tr>
<td></td>
<td>2. Re: your proposal, answer these checklist questions:</td>
</tr>
<tr>
<td></td>
<td>• Did I effectively emphasize the impact of my project on its field of science?</td>
</tr>
<tr>
<td></td>
<td>• Did I clearly describe how the proposed work is both innovative and significant to public health?</td>
</tr>
<tr>
<td></td>
<td>• Does the text leave room for argument with my conclusions?</td>
</tr>
<tr>
<td></td>
<td>• Would a reviewer believe my team is especially qualified for the work and that my institution is a good place to do the research?</td>
</tr>
<tr>
<td></td>
<td>• Did I check the CSR Study Section Roster Index to determine likely reviewers, evaluate their expertise, and fine-tune the impact and significance of my application accordingly? Will they 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?</td>
</tr>
<tr>
<td></td>
<td>3. Revise the proposal in accordance with all feedback received.</td>
</tr>
<tr>
<td><strong>Your personal network of peers &amp; mentors</strong></td>
<td>1. Ideally, seek as peer and mentor reviewers those who are successful grant writers, those who’ve served on NIH study sections, and those who are not necessarily experts in your field.</td>
</tr>
<tr>
<td></td>
<td>2. Ask them to apply the checklist stated above and to assess science, impact, and presentation.</td>
</tr>
<tr>
<td></td>
<td>3. Ask them to be brutally honest in analyzing the application’s strong and weak points (content and presentation).</td>
</tr>
<tr>
<td></td>
<td>4. Ask them to score your application according to NIH review criteria: (see the Scoring Table for Research Grants and Review Criteria.)</td>
</tr>
<tr>
<td>Who or What</td>
<td>How</td>
</tr>
<tr>
<td>-------------</td>
<td>-----</td>
</tr>
<tr>
<td><strong>Department Resources</strong></td>
<td></td>
</tr>
<tr>
<td>Ron Pearl, MD, PhD, Chair&lt;br&gt;650 723-5024&lt;br&gt;<a href="mailto:rgp@stanford.edu">rgp@stanford.edu</a></td>
<td>1. Ask them for help in identifying and applying for funding opportunities that match your research interests.</td>
</tr>
<tr>
<td>Rona Giffard, MD, PhD, Vice Chair&lt;br&gt;650 725-8482&lt;br&gt;<a href="mailto:rona.giffard@stanford.edu">rona.giffard@stanford.edu</a></td>
<td>2. Ask for assistance on study design, data analysis, statistics, and available graphical presentation tools.</td>
</tr>
<tr>
<td>Mike Helms, PhD, MBA, Director of Strategic Research Development&lt;br&gt;650-721-6119 or <a href="mailto:mkhelms@stanford.edu">mkhelms@stanford.edu</a></td>
<td>3. Ask them to apply the checklist stated above and to assess science, impact, and presentation.</td>
</tr>
<tr>
<td>Frances Davies, PhD, Director of Faculty Development&lt;br&gt;650 493-5000, ext 64854 or <a href="mailto:fdavies@stanford.edu">fdavies@stanford.edu</a></td>
<td>4. Ask them to be brutally honest in analyzing the application’s strong and weak points (content and presentation).</td>
</tr>
<tr>
<td>Patricia Rohrs, BA, Department Editor&lt;br&gt;650 483-7584 or <a href="mailto:rohrs@stanford.edu">rohrs@stanford.edu</a></td>
<td>5. Ask them to score your application according to NIH review criteria: (see the Scoring Table for Research Grants and Review Criteria.)</td>
</tr>
<tr>
<td><strong>Helpful website information</strong></td>
<td>Ask her for editorial review for standard, scientific, English. As a surrogate reader, she improves organization, clarity, and brevity.</td>
</tr>
<tr>
<td>1. For early-stage and new investigators, see NIAID’s valuable portal site on Research Funding.</td>
<td></td>
</tr>
<tr>
<td>2. For application advice, read NIAID’s articles in its New Investigator Series. For example:</td>
<td></td>
</tr>
<tr>
<td>• Create an Appealing, Blemish-Free Application</td>
<td></td>
</tr>
<tr>
<td>• Writing the Research Strategy</td>
<td></td>
</tr>
<tr>
<td>• How Much Detail for Your Shorter Application?</td>
<td></td>
</tr>
<tr>
<td>• The Art of Application</td>
<td></td>
</tr>
<tr>
<td>• How to Pick a Project</td>
<td></td>
</tr>
</tbody>
</table>

Continued, next page
As we finish one academic year and start the next, our department continues to be successful in all its missions. I will briefly review some of these successes and focus on the underlying reasons for them. To balance my remarks, in my next column, planned for publication in the 2011 fall issue of Anesthesia News, I will also discuss the challenges we face to maintaining this success in the coming years.

Academic medical departments have missions of clinical care, education, advancement of knowledge, and development and practice of local and national leadership. Our clinical care activities continue to expand, both within the traditional operating room settings and throughout the hospital and outpatient clinics. By pursuing continuous quality improvement and increasingly emphasizing subspecialization, we have developed evidence-based approaches to provide the highest quality care, improving objective outcomes across a wide range of disciplines.

For medical students, we revised the anesthesia rotation to increase students’ responsibilities, providing them a deeper educational experience. To prepare interns accepted to our residency, we designed Successful Transition to Anesthesia Residency Training (START), a 10-month, online, blended-learning educational and virtual mentorship program, intended to enhance interns’ preparedness for anesthesia residency.

In resident education, we revised our curriculum, adding rotations in perioperative medicine, echocardiography, orthopedics, urology, and abdominal surgery. We are expanding options for residency and fellowship training, including categorical anesthesia positions for those medical students looking for an integrated internship-residency experience, a combined anesthesia-pediatrics residency training program, a combined anesthesia residency-critical care fellowship program and a combined critical care-cardiac anesthesia fellowship program. We have expanded simulation experiences, added a wellness curriculum into the residency program, and included innovative information technology (IT). For example, some residents, fitted with portable iPad devices, can carry and interact with the curriculum from wherever they are working (See News from the Residency Program on pages 11-13 of this newsletter). To make our didactic lectures more accessible, we have pioneered the use of laser-capture technology to create edited podcasts and indexed archives of our weekly presentations. In addition, residents engage in more teaching of medical students, which provides residents further education in how to teach. Finally, the FARM program, our research track in the residency program, is training the next generation of physician scientists in anesthesia.

As the graduating and incoming groups of residents demonstrate, we continue to attract the best medical students in the country into our residency program, and we provide unrivalled training experience. This year, the students who matched at Stanford had an average USMLE score of 245, and 70% of those who attended schools with AOA chapters received that honor.

To advance knowledge, our research programs continue to expand, as evidenced by the numbers of principal investigators, awards, and publications. The department has 18 active NIH grants and over a dozen principal investigators, plus an additional 31 VA and other awards. In 2010 alone, the department submitted 42 proposals totaling almost $100 million. Last year Rona Giffard received a prestigious T32 training
grant, and this year we received two major awards—a transformative R01 to Gary Peltz ($7 million over 5 years) and a large P01 center grant to Sean Mackey ($9 million total over 5 years). The breadth of our research is reflected in our 136 papers published in 2010 on such varied topics as educational research, animal studies of myocardial and neuronal protection, use of large databases for outcomes research, computational genetic mapping, anesthesia for bariatric surgery, regional anesthesia, molecular modeling and ion-channel effects of anesthetic agents, pharmacokinetics in children, new technology, postoperative delirium, obstetrical anesthesia, and new gene-based approaches to pain (e.g., identifying genes associated with chronic pain).

What are the reasons behind our continuing success? Obviously, it is not possible to succeed without adequate resources, and we continue to benefit from the Stanford funds flow system, which provides appropriate compensation for our clinical efforts. This year we will have a record clinical profit, allowing us to fund expansion of our educational and research activities. In addition, our diverse patient population allows educational and research activities in all areas relevant to anesthesia. However, although resources are a necessary ingredient for success, they are not sufficient, and our success has involved additional factors.

Another reason for success is that we have truly superb faculty and have attracted future leaders throughout the past decade; almost no faculty turnover has occurred. Although the beautiful Bay Area weather is an obvious explanation for faculty remaining in place, I believe the major reason for this degree of stability is our departmental culture, which values the contributions of all faculty and allows each individual to excel, whether in clinical care, education, research, or administration. We have invested in faculty development, for example, our nationally recognized Teaching Scholars Program. We have also subsidized faculty to pursue master’s level degree programs in epidemiology, health services research, integrative medicine, and global health and to pursue training in business administration and academic medicine. Our senior faculty have taken seriously the mentoring of our junior faculty, encouraging them to develop their careers and become future role models for the next generation. Finally, because our resident classes are so consistently outstanding, we have benefitted from being able to recruit and hire known quantities—Stanford residents who become superb junior faculty.

In Silicon Valley, where Stanford sits, innovation is expected, and innovation is the engine of success. Our department has developed innovative ways to care for patients, new ways to educate students and residents, and novel ways to acquire and analyze knowledge. A willingness to try new things, to develop better methodologies, and to advance the boundaries is necessary if we are to remain a leader in anesthesia. Such innovations result from our collaborating within and beyond the department, most dramatically in research, where we have benefitted from the incredible talent throughout the Stanford medical school and the university. Because of Stanford’s small size, many critical multidisciplinary interactions are a walk down the hall rather than a drive across town. As anesthesiologists, we are involved in important clinical questions that can be approached through translational research, and our greatest research successes have involved the use of multidisciplinary collaborations to answer questions that will improve patient care.

Despite record success, I foresee major challenges ahead (to be discussed in 2011 Anesthesia News). However, I believe that by continuing to focus on the themes mentioned above, we will remain successful in the coming years.

Finally, I extend my congratulations to the graduating class of 2011, and I invite them to remain part of our extended department throughout their careers.

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

Clinical Case for Discussion: You’re planning a career in private practice anesthesia following your residency. One night during a dream, a wizened man with a long white beard speaks to you and says, “Beware of lateral spread, and the OON model....” He retreats into a swirling fog, and you wake up in a cold sweat. What was he talking about, and why should you care?

Discussion: Whatever model of anesthesia practice you are employed in, your income will depend on two things: how many hours you spend giving anesthetics and how much you are paid per hour. In a sense, operating room anesthesia providers are like taxi cab drivers—the more rides we give, the more fares we collect.

The busier your surgeons are, the busier you will be. If your surgeons operate from 7:30 a.m. until 3:30 p.m., you will be earning money for 8 hours, minus break times between cases. If your surgeons operate from 7:30 a.m. until noon, your income may be halved.

Ideally your anesthesia group will employ \( n \) anesthesiologists, working in \( n \) rooms, for 8 hours in each room. What if the number of operating rooms your group covers each day increases to \( n+5 \), but the total number of surgeries stays constant? This is happening in the surgical/anesthesia world today for several reasons. We call this phenomenon “lateral spread,” and it refers to the same surgical volume spreading out over more operating rooms, all starting at the same 7:30 a.m. time, yet now finishing hours earlier.

Reasons behind lateral spread include: (1) Surgeons prefer to operate at 7:30 a.m. when they are not following another surgeon and therefore will not to be delayed. They can schedule their afternoon as clinic or personal time, instead of waiting to do their first case at an undependable, later time slot; (2) Some busy surgeons like to run their cases concurrently in two operating rooms, so that they can operate in the second room, while the first room is turning over between cases. This enables them to do more cases in less time; and (3) Many surgeons are opening their own operating rooms in freestanding surgery centers or in their offices, which gives them the advantages of controlling their own operating room schedule and environment and the opportunity to make extra income from owning and billing for the operating room.

This last point, the extra income from owning a share in the operating room, has become a significant business issue in the current surgical/anesthetic world outside academia. By owning an operating room and then referring cases to that operating room, it’s possible for a surgical specialist to augment his/her surgical income significantly.

Note: It’s unusual for anesthesiologists to own the surgery center and enjoy this same advantage. Why? Because the surgeon has patients to refer to the surgery center, and most surgeons see no advantage in diluting their income by sharing it with anesthesiologists who do not refer any patients to the surgery center. (An exception to this is an anesthesiologist who is a pain specialist, and who refers his or her patients to the surgery center, thus bringing value and money to the surgery center.) A surgery center may employ an anesthesiologist as a Medical Director and may allow a small ownership share in the surgery center to the anesthesiologist for this role. In full disclosure, I am the Medical Director of Waverley Surgery Center in downtown Palo Alto.

Waverley Surgery Center is contracted with all major insurance plans, but some surgery centers remain out-of-network (OON) with insurers.
Why remain out of network? Let’s look at an example. Let’s say a patient’s health insurance pays 80% of a usual-and-customary rate for contracted physicians and health care facilities and pays only 50% to out-of-network physicians and facilities. But what if the OON facility chooses to charge a markedly inflated charge to out-of-network patients? For example, what if the facility charges $35,000 for a surgical procedure when the in-network, contracted rate is $6,000? What if the insurance company then pays the facility 50% of the $35,000 or $17,500?

What if the OON facility waives the patient’s co-payment, and waives the balance of the bill not paid by the insurance company? The patient is not upset, and the facility receives a larger payment than if it were contracted with the insurance companies. It is not unusual to see out-of-network reimbursement be as much as five times higher than contracted reimbursement rates. Insurance companies have filed litigation against out-of-network ambulatory surgery centers, attempting to recover a substantial portion of the OON fees, basing their claims on a number of theories, including that a) the waiver of the co-pay is fraudulent, and b) the waiver of the co-pay is illegal interference with the contract between the patient and the payor.


In 2009, HealthNet of New Jersey sued Wayne (N.J.) Surgical Center, claiming that the center engaged in fraud when it waived patients’ coinsurance payments so they would use the facility. An Appellate Court rejected HealthNet’s claim, and sided with the surgery center (www.ama-assn.org/amednews/2009/12/07/gvsc1207.htm).

Will insurance companies eventually cease to pay higher levels to OON facilities? Will the government and courts move to outlaw this practice in some way? Perhaps, but for now the playing field includes OON surgery centers making healthy profits. And the increased income from owning surgery centers provides a powerful monetary incentive for surgeons to move as many cases as possible from hospitals into these surgery centers.

Lateral spread to multiple, freestanding locations complicates anesthesia scheduling and manpower. The surgical schedule may require \( n \) anesthesiologists at 7:30 a.m. for certain days, \( n + 3 \) anesthesiologists for other days, and \( n - 3 \) anesthesiologists on still other days. If the group hires \( n + 3 \) full-time anesthesia partners, then on certain days they may have 3 to 6 more anesthesiologists than they have rooms. No cases = no income for the day, which makes people unhappy. If the group hires \( n - 3 \) full-time anesthesia partners, then on some days they may be 3 to 6 anesthesiologists short at 7:30 a.m. How does a group handle this problem? It helps to have flexibility, i.e., individuals whose job description is to be available 5 days a week but guaranteed only to work 3 out of 5 days. It helps to have relationships with other anesthesia groups, so that when your group is short on manpower, the other group(s) may have extra anesthesiologists to lend for a day.

My advice: Be thankful for your free time those days when you’re finished at noon, and be thankful for copious income on the days when you’re working until 7 p.m. You’ll have plenty of both kinds of days.

**NEWS FROM THE RESIDENCY PROGRAM**

**BY PATRICIA ROHRS**

Alex Macario, MD, MBA
Residency Director, amaca@stanford.edu

When *The Gas Pipeline* contacted Dr. Alex Macario recently, we learned about three, newsworthy
Combined Anesthesiology/Pediatrics Residency

We are very pleased to announce innovative, combined residency training in anesthesiology and pediatrics at Stanford and Packard Children’s hospitals. It is a true integrated program which requires the first (PGY-1) year to be all pediatrics, the second year all anesthesia, and each of the three, subsequent years to be evenly divided—six months of pediatrics alternating with six months of anesthesia. This integrated program will require five, not six years, as would be necessary if these two residency programs were completed sequentially. We have matched one person to start this special residency July 2011.

We want to spread the word about this program locally and nationally to recruit great applicants.

- Application to the program requires applications to and interviews with both the anesthesia and pediatrics residency programs.
- Physicians completing this training should be competent pediatricians and anesthesiologists capable of professional activity in either discipline.
- We expect that many graduates will develop careers focused on caring for children with complex medical and surgical conditions, who are hospitalized and/or require perioperative and/or periprocedural management.
- The program director is Dr. Madelyn Kahana, Professor of Pediatrics and Anesthesiology, Division of Pediatric Critical Care Medicine, Pediatrics Residency Program Director, Associate Chair of Pediatrics for Education, Lucile Packard Children’s Hospital, Stanford University, mkahana@stanford.edu
- Dr. Alex Macario is Associate Program Director.
- After completion of the combined residency, the candidate is qualified to take both the ABP and ABA certification examinations.
- For the NRMP match, the program is listed as Stanford Univ Progs-CA: Pediatrics-Anesthesiology C 1820726C0.

Is an iPad based curriculum better than a traditional, binder-based one?

Drs. Pedro P. Tanaka, K. Ashley Hawrylyshyn, and Alex Macario recently conducted a comparative study during an “anesthesia for orthopedics” two-week rotation that focused mainly on hip and knee joint arthroplasty.

Would residents whose curriculum was delivered via an iPad wireless tablet computer rate “overall teaching quality of this rotation” higher than they would if their curriculum was delivered via a traditional binder populated with printed documents?

At the beginning of the two-week rotation, each resident was given an iPad containing the following: a syllabus with daily reading assignments, rotation objectives related to the six ACGME core competencies, and journal articles. Prior to the study, these same materials had been distributed as printed materials in a binder. The iPad also contained links to online textbooks and peer-reviewed Internet sites, but it did not link to the electronic medical record.
At the end of the rotation, each resident anonymously rated several items to evaluate the rotation on an ordinal scale from 1 (unsatisfactory) to 5 (outstanding). The mean global rating for “overall teaching quality of this rotation” increased from 4.09 (SD 0.83) to 4.89 (SD 0.33) p = 0.04.

Residents using the iPad-based curriculum said rotation goals were better defined and achieved than did residents using traditional curriculum. Residents with iPads felt their learning was more self-directed and interactive; they said the device helped them engage with faculty. They used the tablet to store and share resident-generated materials about unique, interesting cases they encountered. Overall, residents said the iPad-based learning experience helped them meet two of the six ACGME core competencies: Practice-based Learning and Improvement and Interpersonal Skills and Communication.

Although residents responded favorably to the iPad-based curriculum and liked the tablet’s touch screen, handwriting recognition, wireless connectivity, and recording capabilities, they identified wished-for iPad features and curriculum improvements. For example, they would like the iPad to be capable of running FLASH applications and allowing learners to annotate their curriculum. To improve the curriculum itself, they recommended adding a question bank, ACLS algorithms, weight-based dosing protocols, and a content rating system.

Drs. Tanaka, Hawrylyshyn, and Macario state that more studies are needed to show whether and how iPad-based learning may enhance all six ACGME core competencies.

Residents of the Month—These residents were selected by faculty:
- February 2011, Dr. Jack Kan
- March 2011, Dr. Bill Ennen
- April, 2011 Dr. Bryan Maxwell
- May 2011, Dr. Ioana Brisc
- June 2011, Dr. Neil Lawande

New Chief Residents—Drs. Jay Jay Desai, Laura Downey, and Javier Lorenzo

MEDICINE AND THE MUSE: AN ARTS, HUMANITIES AND MEDICINE SYMPOSIUM
BY AUDREY SHAFER, MD

Medicine and the Muse celebrated its 10th anniversary with a music-oriented program held in the new Li Ka Shing Center. The event, organized by an enthusiastic medical student committee, included a keynote presentation by psychiatrist-concert pianist Richard Kogan on “The Mind and Music of Beethoven.”

Dr. Ashley Hawrylyshyn presenting the study at IARS meeting, May 2011, Vancouver, BC

Pianist Richard Kogan

Featured as a “Memory” event by Stanford Institute for Creativity and the Arts, Kogan’s playing was noted to be “magnificent” by
attendees, including Dean Pizzo. Kogan received a standing ovation for his rendering of Beethoven’s Piano Sonata No. 23 in F minor Op. 57 (Appassionata) as well as at the end of the program. More information about Kogan’s approach to understanding a composer’s life and work can be found in a review of the program by Dr. Bryan Maxwell, Stanford anesthesia resident, forthcoming in the CSA Bulletin.

Other musical performances circled the globe from belly dancing, to Indian classical song and dance, to a classical violin sonata and a string quartet. Writers from the medical school creative writing class read a group poem entitled, “The Body Electric.” The art exhibit, featuring works by students, staff and faculty, included painting, photography, film, mixed media and glass.

The evening event was the first concert to be held in the new medical school building, and it attracted a large audience of students, housestaff, faculty, staff and community members. Select art from the exhibit will continue to be shown elsewhere in the building.

Further information about the Arts, Humanities and Medicine Program is located at http://bioethics.stanford.edu/arts/; photos and an archive of Medicine and the Muse symposia are at http://bioethics.stanford.edu/arts/events/MedicineandtheMuse.html.

STANFORD SHINES AT WARC 2011
BY JOHN BROCK-UTNE, MD, PHD

La Paloma Resort in Tucson, AZ was the venue for the 2011 Western Anesthesia Resident Conference (WARC), hosted by the University of Arizona’s Department of Anesthesiology, April 29–May 1 (Attendance was higher last year in Disneyland; I guess even at this age Donald Duck attracts). WARC is specially designed for anesthesia residents, medical students, and fellows from the western US’s 19 anesthesia residency programs. WARC’s object is to promote and encourage academic pursuits by future leaders in anesthesia.

This year featured 338 abstracts and oral presentations. Stanford residents’ and fellows’

<table>
<thead>
<tr>
<th>Contributor</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Bain</td>
<td>Prolonged neuromuscular blockade following cardiac surgery in a patient with ESRD after administration of Clindamycin.</td>
</tr>
<tr>
<td>Ioana Bric</td>
<td>A diagnostic dilemma in PACU</td>
</tr>
<tr>
<td>Carlos Brun</td>
<td>Paralyzed by beauty or if chins could kill</td>
</tr>
<tr>
<td>Michael Charles</td>
<td>Rocuronium induced tachycardia</td>
</tr>
<tr>
<td>Jay Jay Desai</td>
<td>Clinical and cultural perspective: establishing an immersive international rotation for anesthesia residents</td>
</tr>
<tr>
<td>Jay Jay Desai</td>
<td>Ultrasound popliteal nerve block in a patient with malignant degeneration of neurofibromatosis</td>
</tr>
<tr>
<td>Laura Downey</td>
<td>Anesthetic management for a patient with anterior horn disease undergoing serial electroconvulsive therapy</td>
</tr>
<tr>
<td>Erin Hennessy</td>
<td>Improving resident education on the post-operative anesthesia care unit rotation</td>
</tr>
<tr>
<td>Christine Jette</td>
<td>The sensitive button: Intraoperative diagnosis of a cardiac paraganglioma</td>
</tr>
<tr>
<td>Matthew Jolley</td>
<td>Optimization of electrode configuration for subcutaneous ICD using finite element modeling (oral presentation)</td>
</tr>
<tr>
<td>Shaun Kunnavatana</td>
<td>The severely agitated ECT patient—an alternative treatment option</td>
</tr>
<tr>
<td>Steven Liu</td>
<td>Cost analysis of fiberscope use for double lumen endotracheal tube placement (oral presentation)</td>
</tr>
<tr>
<td>Vanessa Moll</td>
<td>Three cases of failure to ventilate with the Drager Apollo Anesthesia Workstation</td>
</tr>
<tr>
<td>Andy Neice</td>
<td>A case of serotonin syndrome after methylene blue administration</td>
</tr>
<tr>
<td>Cat Reid</td>
<td>No laughing matter: inadvertent exposure to waste anesthetic gas due to machine failure. Is there a solution?</td>
</tr>
<tr>
<td>Vikas Shah</td>
<td>Pseudohyperkalemia in the setting of chronic lymphocytic leukemia</td>
</tr>
<tr>
<td>Pervez Sultan</td>
<td>A cost analysis for neuroaxial anesthesia to facilitate external cephalic version</td>
</tr>
<tr>
<td>Becky Wong</td>
<td>Thoracic irrigation can produce transient EKG changes that may not be consistent (oral presentation)</td>
</tr>
</tbody>
</table>

Matthew Jolley won first prize for his outstanding, five-minute oral presentation—a tough assignment because assumptions and background
must be omitted. He handled many questions like a far more experienced presenter.

Steven Liu and Pervez Sultan landed in the top 10. The Stanford poster presenters were all in great form and dazzled the judges with their knowledge and enthusiasm, but they missed winning second and third place prizes.

Stanford faculty collaborators were Jon Bradley, John Brock-Utne, Jay Brodsky, Brendan Carvalho, Jeremy Collins, Jenna Hansen, Jonay Hill, Gillian Hilton, Richard Jaffe, Vivek Kulkarni, Jennifer Lee, Alex Macario, Suma Ramzam, Vidya Rao, David Soran, and Pedro Tanaka.

While the WARC judges were judging, the CSA judges were also hard at work to establish a winner for the best CSA Resident presentation. Among CSA’s three awards, Matt Jolley won second place and collected his prize at CSA’s later annual meeting in the Fairmont Hotel in San Jose, CA.

At WARC, USC won first place in quantity of submissions for its 38 posters and one oral presentation. University of Arizona won second place for its 22 posters and two oral presentations. Stanford took third place among 19 competing schools, contributing 16 posters and three oral presentations. Not bad!

Other participants were Loma Linda, UC Davis, UCSF, UCLA, UCSD, UC Irvine, Harbor-UCLA, Cedars Sinai, Mayo Clinic, University of Utah, University of New Mexico, University of Washington, University of Colorado, Virginia Mason Medical Center, Oregon Health Sciences University, and Navy Med.

The after-dinner speaker at the customary Saturday evening dinner was E. Philip Krider, PhD, Professor Emeritus in the Department of Atmospheric Sciences in the Institute of Atmospheric Physics at the University of Arizona. Dr. Krider is known worldwide for his research on lighting and thunderstorm electricity. He is also a noted authority on Benjamin Franklin. Hence interesting talk about lightning and its effects was punctuated with visual and audio effects that had us jumping about in our chairs. Lightning hitting planes was not funny; it’s interesting to note that newer planes are more prone to strikes than older ones.

After dinner the Stanford group, along with two University of Utah residents, gate-crashed a prom (we have pictures to prove it) and some of us got into a wedding. Lovely party!

EXTRAORDINARY RANGE OF RESEARCH: ANNUAL RESEARCH AWARDS BY PATRICIA ROHRS

“I thought I was at a big scientific meeting,” commented guest evaluator Dr. Michael Cousins, after reviewing the variety, quantity, and quality of abstracts and case reports presented at the Department’s May 2, 2011 annual research awards event, held at Palo Alto’s Sheraton Hotel.

Dr. Cousins, a luminary in the Pain field, serves as Foundation Professor and Department Head of Anesthesia and Pain Management at the University of Sydney and as Director at the Pain Management Research Institute at the Royal North Shore Hospital, also in Sydney. Dr. Cousins added, “The range of work I saw is extraordinary.” Dr. Cousins’ remarks applied to the 59 poster abstracts and eight resident case reports he had seen and the discussions he had had with the researchers who prepared them.

Drs. Michael Cousins and Sean Mackey

“A resident case report is what got me into research,” said Dr. Michael Cousins, who has published over 200 original papers.

Before dinner, members of the Department sipped wine and nibbled on hors d’oeuvres, while engaging with researchers and their poster...
abstracts and case reports. After a lovely buffet dinner, Rona Giffard, MD, PhD, vice chair of research, opened the after-dinner program by noting that faculty had been awarded two RO1 grants—one transformative RO1 award to Dr. Gary Peltz and a first RO1 award to Dr. Larry Chu. Industry grants were given to Drs. Yeomans, Lemmens, and Hammer. Dr. Sean Mackey is likely to win a PO1 grant (the score was high), and career development awards in the pipeline for Dr. Eric Gross (K99) and Dr. Kevin Johnson (K23). In addition, Dr. Matt Jolley won first prize at the Western Anesthesia Residents Conference (WARC) for his work Optimization of Electrode Configuration for Subcutaneous ICD using Finite Element Modeling. Four, new CA-1 FARM fellows began July 2010 and three more are expected, beginning July 2011. Finally, Dr. Giffard announced a new award category—best resident case report—given to Dr. J.J. Desai.

Next, Dr. Giffard introduced speakers for each award-winning abstract, each of whom described intricate, seminal work.

The first speaker, CCM fellow Dr. Josh Douglas, co-authored his abstract with Drs. Rani Agrawal, James A. Russell, and Andrew Patterson A. Robo1 binding receptor is upregulated by vasopressin during septic shock leading to decreased sepsis induced cardiac dysfunction in a murine LPS sepsis model. The researchers found that “in a murine model of septic shock, vasopressin induced upregulation of Robo1, the co-receptor for Robo4, increases catenin expression leading to improved cardiac compliance and diastolic dysfunction. Vasopressin therefore may function to inhibit cardiac permeability improving sepsis induced cardiac dysfunction.”

The second speaker, Dr. Eric Gross, co-authored his abstract with Ms. Anna Hsu, Dr. Garrett Gross, and Dr. Daria Mochly-Rosen: Acute capsaicin treatment reduces myocardial infarct size in rats via the transient receptor potential vallinoid 1 (TRPV1) channel.

The third speaker, Dr. Jenna Hansen, co-authored her abstract with Drs. Ed Kim, Sesh Mudumbai, and Ed Mariano: Combined ultrasound and neurostimulation guided low-dose lumbar plexus block versus intrathecal morphine for total hip arthroplasty within an established analgesic clinical pathway. On the basis of their small retrospective study, these researchers found that “spinal analgesia with intrathecal morphine may provide superior pain relief in the first 24 hours after surgery compared to single-injection, low-dose lumbar plexus block.”

The fourth speaker, Dr. Anthony Doufas, coauthored his abstract with Drs. Pericles Panousis, Kevin Padrez, Puntarica Suwanprathes, James Cardell, Holden Maecker, Yael Rosenberg-Hasson, and Steven Shafer: Experimental pain and analgesia responses in male volunteers suffering from sleep-disordered breathing. “This preliminary study supports the evidence that nocturnal desaturation

---

2 From abstract’s “Conclusion.”

3 From abstract’s “Conclusion.”

4 From abstract’s “Conclusion.”
and fragmented sleep may enhance sensitivity to pain and opioid analgesia. Systemic inflammation may mediate these effects.  

Having complimented the Department for its vital research culture, Dr. Cousins reminded the audience of the importance of cross-fertilization between Anesthesia and Pain.

He concluded by recommending reading *The Mold in Dr. Florey’s Coat: the Story of the Penicillin Miracle* by Eric Lax. Although Alexander Fleming discovered how penicillin could fight infection, it was a team of Oxford researchers, including Dr. Florey, a Nobel-winning Australian, who extracted penicillin mold’s active component and made penicillin available to Allied troops during World War II. Worried that the lab could be destroyed by Nazi bombs or a Nazi invasion, the research team planned to destroy their lab and burn their research papers, if invaded. They smeared penicillin mold into the coats of Dr. Florey and his four colleagues, where it could be covertsly carried if they had to flee the country.

In concluding the evening’s events, Dr. Giffard thanked the administrative staff who helped put on a very successful evening: Yuki Shamoto, Bill Magruder, and Jan Shriber of the research division, and Alan Winkleman and Jill Wilson. She also thanked the participants and congratulated them again on the great research occurring in the Department.

---

**GLOBAL HEALTH IN ANESTHESIA**

*BY ANA M. CRAWFORD, MD*

**What is global health?** Global Health has become an increasingly popular topic and pursuit recently. Every year there are increasing numbers of resident and fellow applicants who inquire about the opportunities for international rotations and exposure while in training. And, training programs are on the move to address this growing demand. Awareness of global health disparities is definitely on the rise. When asked, “What is global health?” respondents’ answers vary widely. Global health can include disaster response, maternal and child health, tropical and other infectious diseases, immunizations, drug availability, and water sanitation programs, just to name a few. Global health in surgery and anesthesia has largely revolved around obstetrics and gynecology, cleft lip and palate repair, ophthalmology and trauma and general surgery. The major impact of surgical and anesthetic services has resulted from the good will of countless volunteers making a difference in individual patient lives.

**How did I get involved?** I first became interested in global health issues when offered a sponsored trip to Africa as an intern in internal medicine. Our group organized a four-day health clinic in a small town in Kenya and managed to see close to 2000 patients! I was amazed to see the lack of basic components of health such as immunizations programs; clean water systems; and availability of basic medications, medical care clinics and medical training programs. I was angered to see the high incidence of AIDS-defining illnesses contrasted with the complete lack of appropriate treatments that are so readily available in our country. We definitely made a difference to a handful of patients out of the two thousand. However, I quickly realized how small an impact we really had on the basic health care of that community. I became determined to narrow the gap in these basic human rights, a determination I gratefully share with many of my Anesthesia colleagues here at Stanford.

**Why is our Department involved?** Global Health is a multidisciplinary problem with many challenging facets: health care resources, education systems, economic and political factors, environmental issues, disaster readiness and infectious diseases. Our department has recently increased focus on the importance of our responsibility to the global community. In response, we have created a Global Health division of the Anesthesia department, composed of interested residents, fellows and faculty. Our goal is to build the capacity of developing communities to provide safe and effective health
care and anesthesia services to all citizens through service, volunteerism, education, research, and awareness.

The goals of our division are outlined on our new website: http://globalanesthesia.stanford.edu

**How is our Department involved?** We are organizing the volunteer trips available to residents. Also, for each mission, residents are now writing trip reports posted on our blog (see my recent report in the next article), so others can share in their experience and know what to expect if they attend the same trip at a different time. On the website is additional information regarding travel warnings, vaccinations, visas and insurance necessary prior to travel. More long-term solutions are focused on the creation of education programs in Anesthesia and peri-operative care for anesthesia physicians and non-physician providers in developing communities.

We are pleased to announce the creation of a new resident rotation in collaboration with the Canadian Anesthesiologists’ Society International Education Fund (CASIEF) and the World Federations of Societies of Anaesthesiologists (WFSA) starting in 2012 in Kigali, Rwanda. The residents will have the opportunity to teach and work with local anesthesia residents in the Rwandan training program. Further, we are developing a Global Anesthesia fellowship that will begin in 2012, again focusing on Anesthesia education programs for applicants interested in making global health part of their career. We have numerous enthusiastic faculty members, fellows, residents and students in our department working toward alleviating the global health burden. We are hopeful that through the force of collaboration we can work together to improve the lives of all our fellow global citizens.

**KIGALI, RWANDA TRIP REPORT**
**BY DR. ANA CRAWFORD**

**General Information and Logistics**

*Type of trip:* Volunteer medical mission  
*Dates:* March 2 – March 13, 2011  
*Site/Location:* Gitwe, Rwanda  
*Trip leader/team:* Andrew Patterson (ANES)/Jagdish Dhingra (ENT)  
*Affiliated organization:* Medical Missions for Children (MMFC)

*Money and Associated Costs:* $1000 for trip plus $500 for gorillas excursion plus spending and some food and some lodging costs. Overall, about $2500.

*Travel:* SFO to AMS to EBB to KGL, then vans to selected destinations (gorillas excursion and Gitwe)

*Safety:* Overall, we felt relatively safe, despite a recent grenade attack in Kigali prior to our arrival. We practiced routine travel vigilance, e.g., not showing money and keeping passports in secure locations at all times. There were no adverse events in our group related to theft or personal injury or danger.

*Work Hours:* We were typically in the OR by 7am and finished up by 8pm.

**Anesthesia**

*Cases:* From Monday to Friday, we performed 24 adult thyroidectomies for goiters and one thyroglossal duct cyst resection. Most were subtotal although some were total thyroidectomies. About 50% were substernal goiters. Most were female. There were two males, one for thyroidectomy and one for thyroglossal duct cyst resection. Ages ranged from 24 to 75 years old. One female patient also had a finger lipoma removed in addition to her thyroidectomy. Two patients also underwent dental extractions under anesthesia.

---

7 The full report is posted on https://www.stanford.edu/group/globalanesthesia/cgi-bin/blog/2011/03/14/gitwe-rwanda-2/
Preop: Patients were recruited through local advertisement and word of mouth. Patients were screened for significant co-morbidities by both the surgeons and anesthesiologists. Factors excluding patients from surgery were significant co-morbid conditions and/or advanced age. Because there were a limited number of surgical slots, the largest most symptomatic goiters were chosen. Each patient underwent a thorough history and focused physical exam. One scheduled case was subsequently cancelled upon further questioning that revealed classic angina. On admission to pre-operative holding, a 16-gauge peripheral IV was started, or a 20-gauge IV if 16-gauge was not possible. Those with 20-gauge IVs would then receive a 16-gauge intraoperatively. The large IV access was deemed necessary in anticipation of either thyroid storm and/or need for fluid resuscitation for bleeding. Once the patients had an IV, they all received transthoracic echocardiograms to assess fluid status and to evaluate for any significant cardiac lesions. For patients who were volume replete and with stable vital signs, Metoprolol 2-6mg IV was given for a goal HR of 60-80. Patients walked into the OR and positioned themselves onto the OR table.

Intraop:

• OR: Prior to our arrival, the OR consisted of one OR table with non-functioning manual controls for changing table position, three large wooden tables and two overhead OR lights, only one of which worked, although dimly. The floors were clean and tiled. There were power strips on the walls with some outlets converted to 110 volts from the standard 220. We had several voltage converters and outlet adapters on hand. Electricity was lost several times per day with minutes time delay prior to back-up generator power. The windows in the OR were open to the outside, without screens to prevent insects, etc.

• Machines/Monitors: The anesthesia machine was a DRE, which provided a sevofluorane vaporizer, CO2 absorption, oxygen fresh gas flow, airway pressure, and a circle circuit with a ventilation bag, but no ventilator. A Propaq monitor provided NIBP, EKG, SPO2 and RR. A NICO monitor allowed measurement of ETCO2 with respiratory pressure waveforms, RR, heart rate, SpO2, and VCO2. There were no measurements of temperature, FiO2, or end-tidal Sevofluorane. There was a suction machine present, and electrocautery/Bovie/Bipolar and an autoclave were brought from MMFC. Surgical instruments were washed in a sink with Cidex prior to sterilization. Surgical instruments were donated by MMFC. Surgical supplies were gathered by the staff on this trip. Anesthesia supplies were gathered by the staff on this trip. There were some supplies from previous trips that were in boxes on site. We also had the pleasure of working with an Anesthesia resident from Kigali and the local Gitwe nurse anesthetist.

• Airway, emergency equipment and special equipment: There were two more Propaqs used in the PACU for patient monitoring. We also had two defibrillation units although we lacked the proper cord connections to make them useful. We had plenty of ETT and stylets. We did have several LMAs of various sizes although we only used one for teaching purposes. A glide scope was present and used three times mostly for teaching purposes.

Dr. Crawford supervises Mugemanshuro Alfred during glide scope endotracheal intubation

There were no airway emergencies despite the large-sized goiters and their substernal components. We did wash and re-use several
oral airways, stylets, Yankauers, and masks. Ventilator circuits were re-used unless visibly contaminated with blood or other secretions. Other equipment brought by the staff included intubating LMAs, suction catheters, nasal airways, several laryngoscopes with various sized blades, lots of batteries of different sizes, and ventilator circuits.

- **Drugs:** Most of the medications used were brought by the staff. The one exception was Morphine. Typical inductions medications included: Metoprolol, Morphine, Cefazolin, Propofol, and Succinylcholine. Phenylephrine was used occasionally. Maintenance was with Sevofluorane and spontaneous ventilation. Each patient received ondansetron 4mg.

- **Neuraxial and regional anesthesia:** Regional techniques were not utilized on this trip.

**Post-op:** After the surgeries were complete and the patients stable and extubated, they were transported across the hall to the PACU without oxygen. An oxygen concentrator was then available, and patients were monitored with a Propaq and two, excellent, ICU-trained RNs. There were inpatient ward beds available for all patients. It is typical for patients’ family members to stay with them while they are hospitalized, and typical hospitalization time can be days to weeks. There is no pressure to discharge patients before they are fully recovered and able to walk home and fully function in their roles at home and work. It is typical for patients’ family members to stay with them while they are hospitalized, and typical hospitalization time can be days to weeks. There is no pressure to discharge patients before they are fully recovered and able to walk home and fully function in their roles at home and work. There was no ICU available, although one was simulated during our trip (see Anaphylaxis below). The hospital typically supplies nursing care, lodging, and meals.

**Educational/Cultural Content**

There were several things I learned during this week in Gitwe.

*Emergence Delirium*—Although common in children I had not seen very much in adults outside of the occasional young male patient. I also had never given Sevofluorane without a pre-operative benzodiazepine. We had a few patients early on the first day that suffered from dysphoria and delirium upon awakening. We quickly learned that this could be solved by turning the Sevofluorane off early and titrating in small doses of Propofol at the end of the case. The rest of the week we had much smoother wake-ups.

*Anaphylaxis*—Around noon on Thursday, I had done the induction and intubation of an otherwise healthy 43 yo female for thyroidectomy and dental extraction. Dr. Patterson then relieved me for lunch since the surgery had started and the patient was stable. Unfortunately, upon my return (I took about 45 minutes for lunch), I learned that as soon as I had left, the patient had rapidly deteriorating hemodynamics with bradycardia and hypotension that briefly required chest compressions and ultimately required an epinephrine infusion. Other empiric therapies included decadron, hydrocortisone, sodium bicarbonate, and calcium. We started a left femoral CVC (central lines are not typical of available equipment) for the epinephrine infusion that ran through a calibrated buretrol/micro-drip tubing. Her airway was secure but with obvious swelling and edema of her tongue and lips. Our differential diagnosis put anaphylaxis at the top, but we could not rule out sepsis as a possibility with her recent dental infection. We took shifts (mostly Dr. Steve Hall and Dr. Patterson) monitoring and caring for her overnight and cancelled the rest of the day’s cases. We continued to titrate down her epinephrine drip and did serial TTEs to evaluate our resuscitative efforts and monitor her cardiac function. Her echocardiograms were key in helping us identify new wall motion abnormalities consistent with a Takasubo’s cardiomyopathy. We used the echo data to adjust our intravenous fluids and our epinephrine infusion. She was extubated and off epinephrine around 2am but required about another hour of jaw thrust and airway support despite visible improvement in her facial swelling. Of note, she did have a positive leak test around a 6.0 ETT. She was awake, alert, and stable by 7am the next morning, and walked home the following day! Overall, most of us agreed that this was most likely an anaphylactic reaction even though it did not occur suddenly after induction. We assumed the most likely agent was the Cefazolin. However, the next day the patient did report diffuse itching whenever she eats eggs. Could Propofol have been the culprit?
Pre-operative assessments—Be careful and explicit in assessing patients pre-operatively. Most patients are reluctant to share complete medical information for fear that they will not be able to have surgery. Similarly, make sure your translator understands the importance of the questions you ask and translates them completely.

The culture and people—The culture of the Rwandan people was incredibly beautiful. Most faces are filled with curiosity and then covered in smiles when you say, “Hello.” They are incredibly grateful and friendly. Everywhere you look you see hard-working people. Rwanda is lush and green with the most amazing views of mountain peaks and hills. We had the opportunity to visit the genocide memorial in Kigali, which was an extremely powerful experience. It is hard to imagine such hate and so much death in such a beautiful country and among such beautiful and happy people.

The landscape and gorillas—The Saturday after our arrival, we hiked about two hours out on a guided tour to see mountain gorillas. The landscape was filled with breathtaking views of the mountain peaks and a surreal interaction with gorillas in their natural habitat.

CRITICAL PRIMARY CARE!
BY IQBAL MIRZA, MD

We checked in about three hours prior to our departure from Ahmedabad for our journey home. I thought there was very little chance of it happening but figured there was no harm in asking for a complimentary upgrade. Perhaps it was the fact that my brother-in-law is a very high ranking police officer or perhaps it was my charming nature, we were pleasantly surprised when the Emirates airline hostess gave us our new seat assignments in business class. Sweet!

Obviously there is no such thing as critical primary care but there is a critical need for primary care in places like India. This was my first medical mission, and I was not sure what to expect. I have been a long-time supporter of a non-profit organization, whose objective is to help the minorities of India, whether that is establishing a vocational program for orphan girls, creating fresh water wells, providing much needed food throughout the year, establishing a new university in Jahangirabad or providing free health care to anyone who arrived at the clinic.

I met John Rosenberg, a retired Kaiser ER physician upon my arrival late on a Tuesday night. I was so moved by his warmth and sincere compassion that I very quickly forgot that it took me almost seven hours to travel from Ahmedabad to Jahangirabad—a 1.5-hour flight from Ahmedabad to New Delhi, 2-hour layover, 1-hour flight from Delhi to Lucknow (both flights on prop jets) and then a 1.5-hour drive through narrow, crowded roads to reach Jahangirabad Institute of Technology (JIT). John in his smiling kind manner just said, “You have arrived.” The full impact of this simple statement didn’t hit me until the next morning when I could appreciate the wonder of JIT.

JIT sits on 48 acres of what was once a palace for the rajah of Uttar Pradesh. The peacocks, owls, wild monkeys and the beautiful foliage are just some of the natural wonders. Before the palace was rehabilitated to become JIT (the process took five years), the beautiful architecture of the old buildings was obscured in ivy, trees grew on rooftops with their roots creating their own impressions, and the building was just plain neglected.
from overhearing usually one-sided telephone dialogue of my questions and answers to colleagues, nurses and housestaff. Our assistants were all locals, who did their best at crowd control, and directing patients to the pharmacy, x-ray and the ancillary lab.

The morning of the opening ceremony held outside under a large tent, was quite cold. After the introductions, it was time to go to work. Patients were lined up outside the little clinic building, and I was sitting at my desk pretending that I was Marcus Welby, MD. My office did not have an examination table or any diagnostic equipment. I had brought my stethoscope. Fortunately, I still remembered a fair amount of Hindi/Urdu and could understand all but the most technical words. After obtaining the history, I would examine the patients as they sat in their chairs, certainly not ideal, but short of having the patients lie down on the cold hard floor, it was the best that I could do.

I would certainly have preferred to be in the operating room, delivering an anesthetic or in the ICU resuscitating a septic patient, but instead I struggled through the first morning. The typed list of available free meds was over four pages long. Unfortunately, the list consisted of an antihypertensive, followed by an anti-helminthic, using brand names, thus adding to my frustration. I quickly went through the list, found Dr. Rosenberg, identified 2-3 available antibiotics used to treat bronchitis, 2-3 anti-tussives, etc. and decided that I was going to organize this list by the next morning. After about three hours and an endless stream of patients, we broke for lunch.

The staff of volunteers returned to the guest house that once served as the summer retreat for the guests of the rajah. I suspect that the rajah did very little entertaining in January. The guest house had high ceilings, marble floors and beautiful archways, carved in the Old-World style. There was no heating system other than two fireplaces. The meals were prepared by 3-4 of the local helpers and usually consisted of roti, yogurt, dal and some other locally grown vegetable. Tea is like soda, so after every meal, hot tea, made with milk and water, was usually served.

I noticed that a lot of the patients were students at JIT. They were busy studying for finals, and they were so stressed out that they presented to the clinic complaining of trouble with sleeping, concentrating, eating, bowel movements, headaches, and reports of suicides at some of the leading universities in India. Their complaints led me to address this issue, and I felt that an evening seminar regarding stress management might help. So the following night, we held a panel discussion led by Dr. Rosenberg; Asif, principal of JIT; Mansour, president of Indian Muslim Relief Charities (IMRC); and me. About 150 students attended, and our presentation was extremely well-received. The next day many of the students came to the clinic and said they were very appreciative of the evening seminar.

In three days, we treated over 1500 patients. Fortunately many did not have any serious, life-threatening diseases, but the diversity of illnesses was amazing. I think that 60% of the patients had either bronchitis or the flu, 20% had either acid reflux or constipation and the rest had chronic fatigue, headaches or backaches. Indians have a very high regard for anything American, including American-trained doctors. Thus people would travel long distances to be evaluated and treated.

After returning to Ahmedabad, we took a day to recover before starting to work at the second of four camps. For the next three days we travelled by private car about 50 kms to Anand. Anand came into the spotlight after the Gujarat ethnic riots, as many citizens of Ahmedabad fled to this city. As a result, during our daily commute, I saw huge numbers of people living in shantytowns, conditions far worse than those on the cattle ranch outside of Modesto, CA. Despite the large numbers of patients, our staff consisted of only three physicians. There was much greater diversity of illnesses in Anand compared to JIT.

I saw kids with otitis, a middle-aged woman with what appeared to be an extremely aggressive squamous cancer of the tongue, and a man with golf ball size nodes up and down his neck! We each saw about 50 patients per day. At times, the crowd would get a bit impatient and would crowd into my office, leaving me very little room to examine the next patient.
Overall, most of the patients were very appreciative and felt a sense of relief that they had a treatable problem.

In summary, these were the most rewarding two weeks of my life! I would encourage you to take time out of your busy schedule and travel to a third-world country and give back to humanity. Thanks for reading.

LOVELY PARTIES!
THE 9TH ANNUAL GOLF TOURNAMENT
BY JOHN BROCK-UTNE, MD, PhD

On Sunday 19 June 2011 @13:00 a total of 30 people, all associated with the Department of Anesthesia in some way or another, “attacked” the Stanford Golf course with a vengeance. As is usual, the number that finally showed up to play is a bit of a moving target. Four hours before the start, we were oversubscribed. But then a couple cancelled and then we were 30…

The weather was fantastic. The course was in great shape, but you had to stay on the fairway; otherwise you were in a lot of trouble.

The 30 players were assigned as per request, and those who did not request anyone got randomly placed. Six groups had the full complement of players, while two had only three players. The latter groups are disadvantaged. We are working on the rules for next year, so that it will be fairer.

After everyone drives, the best ball is selected. All players hit or putt from that position, until the ball is holed out. In other words, there is very little pressure on the individual player.

This year was a new record. We had four teams that came in with a total score of 63. (That was the same as last year’s winners). Since the par for the course is 70, this meant that the winning teams were all seven shots under par.

The members of the four teams were:
Team 1: Carline Schiffner Jewell, Bob Jewell, Colin Jewell and Jeremy Jewell
Team 2: Michael Chen, Raphael Guzman, Alan Cheng and Arjun Pendharkar
Team 3: Scott Rudy, Mike Wagner, Rick Liniger and Jesse Hill
Team 4: Ric Ronquillo, Steven Liu and Mike Bigelow.

To get a winner, a putting competition was held on the 18th Green. The best putter was selected from each team. All four golfers then attempted to sink an eight-foot putt. But all missed. In an effort to make this easier and not to stay there all night, the putt was decreased to seven feet. Scott Rudy and Colin Jewell sank the putt. The final duel was between these two. Colin was triumphant. This started a great jubilation in the Jewell camp…

The winner of the longest drive was Ric Ronquillo, with a mighty drive of 295 yards on number 12. Scott Rudy won the closest to the pin on number 8.
The dinner after the golf was excellent and we are grateful to the Department of Anesthetics for supporting this venture.

Hopefully I will see you all next year. It will be our 10th anniversary. Thanks again for coming. It was fun.

Yours, John

Fare Thee well, “Flawless” Graduates by Patricia Rohrs

The mood was festive, as 20 third-year residents, their families and friends, faculty, and staff celebrated graduation June 25, 2011 in an elegant indoor-outdoor party at the Stanford Faculty Club. Cocktails and hors d’oeuvres on the flower-filled patio were followed by a lovely, convivial buffet dinner inside the club.

In Dr. Ron Pearl’s after-dinner remarks, he emphasized “no one succeeds alone.” Residency graduation is a time “to celebrate, feel proud, and experience one’s emotions.” When he set aside two minutes for expressing them, I noticed a good measure of hugging, kissing, and shedding of tears.

Dr. Pearl made several awards:

- **Staff Recognition Award**: Jennifer Cappelloni, faculty compensation analyst, and Ana Hammonds, VA administrative associate,
- **G. Brant Walton Resident Teaching Award**: Dr. Justin Wortman for excellence in teaching medical students, and
- **Resident Research Award**: Dr. Eric Gross.

Dr. Pearl also acknowledged those most responsible for the residency program’s success: Drs. Alex Macario and Aileen Adriano and Janine Roberts.

Next, Dr. Alex Macario, Director of the Residency Program, expressed his pride in the graduates and made these additional awards:

- **Frank Sarnquist Award for Leadership**: Dr. Matt Jolley
- **Outstanding Resident Award**: Dr. Carlos Brun

Dr. Macario thanked the outgoing chief residents—Drs. Bill Ennen, Erin Hennessy, and Nate Ponstein—for their outstanding work, and presented the incoming ones—Drs. Laura Downey, JJ Desai, and Javier Lorenzo.

The outgoing chiefs gave the resident-voted *Faculty Excellence in Teaching Award* to Dr. Ethan Jackson, and they thanked Kris Arao and Janine Roberts for being “pleasures to work with.”

Before presenting the graduates, Dr. Adriano addressed them, “You’ll always have a home at Stanford, and we’ll look forward to hearing about your future successes.” Then, as graduates came forward, they acknowledged those who had supported them in their challenging educational journeys.

The party took a turn from seriousness to hilarity. The outgoing chiefs made their own gag awards to fellow residents. For example, Jack Kan won for “resident most likely to be call to the OR for a case that doesn’t exist”, Andrew Neice (a good chef) for “resident who is the best housewife,” Matt Jolley for “resident most likely to never hold a real job,” and Troy Wu (who left residency to become an investment banker) for “most likely to succeed.” Then, there followed humorous, imaginative videos (the moonlighting jobs that faculty pursue to afford their houses) and a slideshow depicting each resident moving from childhood through adulthood.

As is his custom, Dr. Ron Pearl gave a special name to the class of 2011: “Flawless.” He noted that diamonds in the rough look quite ordinary, but, when properly cut and polished, become jewels, the best of which are called “flawless.”

To see what’s next for these newly polished graduates, consult the table below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Med School</th>
<th>What’s Next</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Bain</td>
<td>George Washington University</td>
<td>Critical Care Fellowship, Stanford</td>
</tr>
<tr>
<td>Carlos Brun</td>
<td>Northeastern Ohio University</td>
<td>Attending, Palo Alto VA</td>
</tr>
<tr>
<td>Mike Charles</td>
<td>University of Michigan</td>
<td>Cardiac Anesthesia Fellowship, Stanford</td>
</tr>
<tr>
<td>Name</td>
<td>Med School</td>
<td>What’s Next?</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Katie Ellerbrock</td>
<td>Case Western Reserve University</td>
<td>Pediatric Anesthesia Fellowship, Seattle</td>
</tr>
<tr>
<td>Bill Ennen</td>
<td>University of Chicago</td>
<td>Cardiac Anesthesia Fellowship, Stanford</td>
</tr>
<tr>
<td>Eric Gross</td>
<td>Medical College of Wisconsin</td>
<td>Research &amp; Attending, Stanford</td>
</tr>
<tr>
<td>Erin Hennessey</td>
<td>St. Louis University</td>
<td>Critical Care Fellowship, Stanford</td>
</tr>
<tr>
<td>Jesse Hill</td>
<td>University of Southern California</td>
<td>Private Practice, Pasadena</td>
</tr>
<tr>
<td>Matt Jolley</td>
<td>University of Washington</td>
<td>Pediatric Anesthesia Fellowship, Boston</td>
</tr>
<tr>
<td>Jack Kan</td>
<td>Wayne State University</td>
<td>Pain Fellowship, Stanford</td>
</tr>
<tr>
<td>Shaun Kunnavatana</td>
<td>Stanford University</td>
<td>Private Practice, Santa Rosa</td>
</tr>
<tr>
<td>Neil Lawande</td>
<td>Columbia University</td>
<td>Attending, Stanford</td>
</tr>
<tr>
<td>Andrew Neice</td>
<td>Stanford University</td>
<td>Private Practice, Corvallis, OR</td>
</tr>
<tr>
<td>David Peng</td>
<td>Michigan State University</td>
<td>Pain Fellowship, Stanford</td>
</tr>
<tr>
<td>Nate Ponstein</td>
<td>Michigan State University</td>
<td>Regional Anesthesia Fellowship, Stanford</td>
</tr>
<tr>
<td>Carolyn Schifftner</td>
<td>UC San Diego</td>
<td>Pediatric Anesthesia Fellowship, Seattle</td>
</tr>
<tr>
<td>Evan Serfass</td>
<td>Albert Einstein University</td>
<td>Pediatric Anesthesia Fellowship, Stanford</td>
</tr>
<tr>
<td>Vikas Shah</td>
<td>Vanderbilt University</td>
<td>Pediatric Anesthesia Fellowship, Stanford</td>
</tr>
<tr>
<td>Chris Tirce</td>
<td>New York Medical College</td>
<td>Private Practice, Pasadena</td>
</tr>
<tr>
<td>Romy Yun</td>
<td>Case Western Reserve University</td>
<td>Pediatric Anesthesia Fellowship, Stanford</td>
</tr>
</tbody>
</table>

**Published Articles**


- Carvalho B, Drover D, Atkinson L, Riley ET, Collins J. The ED50 and ED95 of intrathecal bupivacaine in morbidly obese patients undergoing cesarean delivery. *Anesthesiology* 2011;114(3):529-35. (Cited in lead editorial)


• Gaba DM. Head to head: have we gone too far in translating ideas from aviation to patient safety? No. 2011;BMJ:342:c7310.


• Vizcaychipi M, Xu L, Barreto G, Ma D, Maze M, Giffard RG. Heat shock protein 72 overexpression prevents early postoperative cognitive dysfunction following orthopedic surgery under general anesthesia in mice. *Anesthesiology* 2011;114(4). Note: This article was selected as an “Editor’s Choice” in *Science Translational Medicine:* http://stm.sciencemag.org/content/3/78/78ec51.full.


• Goodnough LT, Daniels K, Wong AE, Vicle M, Fontaine MF, Butwick AJ. How we treat: transfusion medicine support of obstetric services. Transfusion 2011 May 4. [Epub ahead of print]


• Kim TE, Mariano ER. Update on billing for regional anesthesia (United States). Int Anesthesiol Clin 2011 Summer;49(3):84-93.

ABSTRACTS AND POSTERS

• Lipman S, Cohen SE, Daniels K, Carvalho B. Perimortem cesarean delivery during simulated maternal cardiac arrest: labor room versus operating room. Best Paper Oral Presentation at SOAP 42nd Annual Meeting, April 2011, Las Vegas, NV.

• Hilton G, Carvalho B, Butwick AJ. Study to assess the performance of continuous non-invasive hemoglobin measurement during cesarean delivery. Oral Presentation at SOAP 42nd Annual Meeting, April 2011, Las Vegas, NV.


• Gutierrez MC, Goodnough LT, Sultan P, Butwick AJ. Retrospective study of massive transfusion protocol activation and usage at a large obstetric center. Poster Presentation at the 2011 Annual Meeting of the Society of Obstetric Anesthesia & Perinatology (SOAP) April 2011, Lake Las Vegas, NV.


• Butwick, AJ. Moderated poster review session II and presented Getting good tone: lessons from the operating room in the session entitled Research update 2011: the oxytocin hour at the Annual Meeting of the Society of Obstetric Anesthesia and Perinatology (SOAP) April 2011, Lake Las Vegas, NV.


• Nash P, Brown J, Mackey S. Central sensitization in the human spinal cord as measured with functional magnetic resonance imaging. American Pain Society 30th Annual Meeting, Austin, TX, May 19-21, 2011.

• Sohlberg E, Kong JT, Schwarz D, Johnson K, Mackey S. A dynamic temporal summation procedure to detect individual changes in nociceptive processing. American Pain Society 30th Annual Meeting, Austin, TX, May 19-21, 2011.


**INVITED TALKS AND GUEST PROFESSORSHIPS**

• Brendan Carvalho, MB chB, FRCA, MDCH, spoke about Strategies to optimize labour analgesia at the Combined Scientific Meeting of the Australia and New Zealand College of Anaesthetists (ANZCA) and Hong Kong College of Anaesthesiology in Hong Kong, SAR, China in May 2011.

• Brendan Carvalho, MB chB, FRCA, MDCH, spoke about Failed epidural for unplanned cesarean: spinal anesthesia (Pro/Con Debate) at the Society for Obstetric Anesthesia and Perinatology (SOAP) Annual Scientific Meeting, Lake Las Vegas, NV, in May, 2011.

• Brendan Carvalho, MB chB, FRCA, MDCH, spoke about two topics, (1) Predicting pain and analgesic requirements before surgery, and (2) Obstetric hemorrhage panel: management of antepartum hemorrhage at the Sol Shnider, MD, Obstetric Anesthesia Meeting in San Francisco, CA, in March 2011.

• Brendan Carvalho, MB chB, FRCA, MDCH, was Visiting Professor, University of British Columbia, Vancouver, Canada, in January 2011, where he spoke about Post-cesarean analgesia and pain prediction.

• Edward Mariano, MD, spoke about Continuous peripheral nerve blocks for acute pain management at the 3rd Annual San Matteo International Meeting on Pain Research, Pavia, Italy, December 3-4, 2010.

• Edward Mariano, MD, spoke about three topics at the 2011 ASEAN Congress of Anesthesiology, in Manila, Philippines, February 24-25, 2011: (1) a workshop about Ultrasound-guided peripheral nerve blocks, (2) a lecture, Pediatric regional anesthesia is safe, and (3) a lecture, Managing the complications of regional anesthesia.

• Edward Mariano, MD, gave three presentations: (1) a lecture about Ultrasound-guided perineural catheters: challenges and keys to success, (2) a workshop talk about Femoral, obturator, and saphenous nerve blocks, and (3) another workshop talk about Lumbar spinal sonography at the 3rd Annual International Symposium of Spinal and Paravertebral Sonography, in Hong Kong, SAR, China, March 18-20, 2011.

• Edward Mariano, MD, gave four lectures at the 2011 CSA Hawaiian Seminar, Maui, Hawai‘i, January 24-28, 2011: (1) What every practitioner should know about ultrasound-guided regional, (2) No more excuses: making continuous peripheral nerve blocks work, (3) Regional anesthesia beyond the plexus: not just for extremities anymore, and (4) Good blocks gone bad: managing the complications of regional anesthesia.

• Martin Angst, MD, spoke about All about opioids: opioid-induced hyperalgesia at the Annual Meeting of the American Academy of Pain Medicine, Washington, DC, March 2011.

• Rona Giffard, MD, PhD, spoke about Selective vulnerability of CA1 astrocytes contributes to neuron loss in forebrain ischemia at Harvard University’s Neuroscience Seminar Series at the Massachusetts General Hospital Neuroscience Center on April 26, 2011, Boston, MA.

• Rona Giffard, MD, PhD, spoke about Molecular chaperones and mitochondrial function after brain ischemia at the BRAIN 2011 Conference (XXVth International Symposium on Cerebral Blood Flow, Metabolism, and Function) May 28, 2011, Barcelona, Spain.

• Dr. Elliot Krane, MD, spoke about Pain is a Disease at TED 2011. See the YouTube video http://www.ted.com/talks/elliot_krane_the_mystery_of_chronic_pain.html

• Sean Mackey, MD, PhD, spoke about The strain in pain lies mainly in the brain at Washington University, St. Louis, MO, January 2011.

• Sean Mackey, MD, PhD, spoke about two topics: (1) When acute pain becomes chronic, and (2) NIH grant writing from a principal investigator’s perspective at the American Academy of Pain Medicine Annual Meeting, Washington DC, March 2011.

• Ian Carroll, MD, spoke about the transition from acute to chronic pain at the American Academy of Pain Medicine Annual Meeting, Washington DC, March 26, 2011.

• Ian Carroll, MD, spoke about Duration of pain & opioid use following surgery at the Pain Division, Department of Anesthesiology, University of California, Davis, CA, February 15, 2011.

• Ian Carroll, MD, spoke about Thoughts on neuropathic pain at the University of California, Davis, CA, February 15, 2011.

• Ian Carroll, MD, spoke about two subjects: (1) Pharmacologic management of neuropathic pain and (2) Scar neuromas and treatment with botulinum toxin at the Annual Meeting of the Association of Extremity Nerve Surgeons (AENS), Napa, CA, February 12, 2011.
APPOINTMENTS, PROMOTIONS, AWARDS, & HONORS

• Dr. Sean Mackey and his collaborators were awarded an NIH NCCAM P01 Program Project Grant for the Stanford CAM Center for Chronic Back Pain. Dr. Mackey will serve as the Program Director.

• Dr. Ian Carroll was awarded a supplement to his NIH NIDA K23 Grant Prescription Opioid Use, Misuse and Pain in Post-Surgical Patients.

• Dr. Stephen Lipman was honored by having his oral presentation Perimortem cesarean delivery during simulated maternal cardiac arrest: labor room vs operating room awarded runner up for the Society of Obstetric Anesthesia & Perinatology (SOAP) 2011 Patient Safety Award. Of 300 entries into the Best Paper competition, his was one of six selected for the final competition.

• Dr. David Gaba was awarded the J.S. Gravenstein Award for Lifetime Achievement in Anesthesia by the Society for Technology, January, 2011.

• Dr. David Gaba received the inaugural Under Secretary for Health Award for Excellence in Clinical Simulation Training, Education and Research from the Department of Veterans Affairs, January, 2011.

• Dr. Robin White, postdoctoral fellow in the Giffard Lab, received the 2011 American Society for Neurochemistry NEURO Award for her abstract presentation at the ASN meeting held March 19-23, 2011 in St. Louis, MO.

• Dr. Kevin Malott has been promoted to Clinical Associate Professor of Anesthesia, effective 2/1/2011.

• At Stanford’s first Medical School Gala in May, “In honor of his enduring contribution to clinical excellence and the art of compassionate care, Stanford Hospital & Clinics recognizes Alvin Hackel, MD, with a Lifetime Honorary Medical Staff Appointment.”

• Dr. Eric Gross, a graduating CA-3, will join the Department as Instructor, effective July 1, 2011.

• Dr. Neil Lawande, a graduating CA-3, will join the Department as Clinical Instructor, effective July 1, 2011.

• Dr. Nate Ponstein, a graduating CA-3, will join the Department as Clinical Instructor, effective July 1, 2011.

• Dr. Jack Kan, a graduating CA-3, will join the Department as Clinical Instructor, effective July 1, 2011.

• Dr. Elliot Krane and other Packard Children’s Hospital pain rehab team members— Jody Thomas (psychologist), Christina Almgren (nursing), Sarah Willhalm (occupational therapist), and Ngayin Ngai (physical therapist)—were awarded the Recognition of Service Excellence (ROSE) award.

POPULAR PRESS

• Back pain is a complicated issue. Los Angeles Times April 4, 2011


• Love as pain relief. Gizmag March 1, 2011

• Healing the Hurt. Time February 24, 2011

• Study: In Pain? Love May Ease Suffering. Live Shots February 14, 2011

• Euphoria of romance can blunt intense pain, researchers find. San Jose Mercury News February 11, 2011

• All you need is love. Express February 8, 2011

• Pain be gone. New Scientist January 22, 2011

• Dr. Elliot Krane, MD, and UC Berkeley’s Diana Bautista, PhD, who is Assistant Professor of Cell and Developmental Biology, were interviewed by NPR’s radio station KQED about understanding and treating chronic regional pain syndrome (CRPS).
HILARY’S NEWS: DEPARTMENT LIBRARY

Hillary Farkas, Anesthesia Medical Librarian, announces these additions, listed by title and call number:

- Kaplan’s *Cardiac Anesthesia: the Echo Era* (includes Expert Consult), 6th Ed. RD 87.3 C37 C36 2011.
- *Cardiac Anesthesia and Transesophageal Echocardiography* (+ DVD) RD 87.3 H43 C34 2011.
- *Case Studies in Neuroanesthesia and Neurocritical Care* RD 87.3 N47 C37 2011.
- Guyton and Hall *Textbook of Medical Physiology*, 12th Edition QP 34.4 G9 2011 (see inside front cover for online access through Student Consult).
- *Anesthesia Outside of the Operating Room* (donated by Dr. Macario) RD 82 U76 2011.
- *Smith’s Anesthesia for Infants and Children*, 8th Edition. RD 139 S62 2011 (see inside front cover for online access through Expert Consult).
- Goodman & Gilman’s *The Pharmacological Basis of Therapeutics*, 12th Ed. RM 300 G64 2011 (includes DVD).
- *Anesthetic Pharmacology*, 2nd edition RD 82 P4 A68 2011. Thank you, Dr. Macario, for this donation.

LIFE’S TRANSITIONS

Babies

Sam and Takae Chen welcomed Yumi Kimberly Chen on April 23, 2011. She weighed in at 6 pounds, 9 ounces and measured 20.5 inches. Everything went smoothly and mom and baby are well. Thanks to everyone for support and well-wishes!

Dr. Michael Helms and his wife, Shinae Kim-Helms, welcomed Mae Haena on May 24, 2011. Mae weighed 7 pounds, 5 ounces and measured 21.5 inches. Mother and baby are fine.

Death

Dr. Ron Pearl reported, “It is with great sadness that I convey the news of Alison Palu’s death. Alison worked in the Department of
Anesthesia for many years as part of the administrative staff. She was a bubbly, energetic optimistic woman, with a passion for cooking and deep love for her family. Although she had been diagnosed with two types of cancer and was in remission, she unexpectedly passed away in April at age 52. She is survived by her two high school daughters, Meghan & Molly, and her husband John.

If you are interested in helping the family during this difficult time, such as a meal on occasion, please visit Meal Train at http://www.mealtrain.com/?id=mdw6ond4jkct

In addition, the family has established college funds for Molly and Meghan. If you would like to make a donation, please send checks to: Michael Palu, trustee, 318 El Paseo, Millbrae, CA 94030.”