

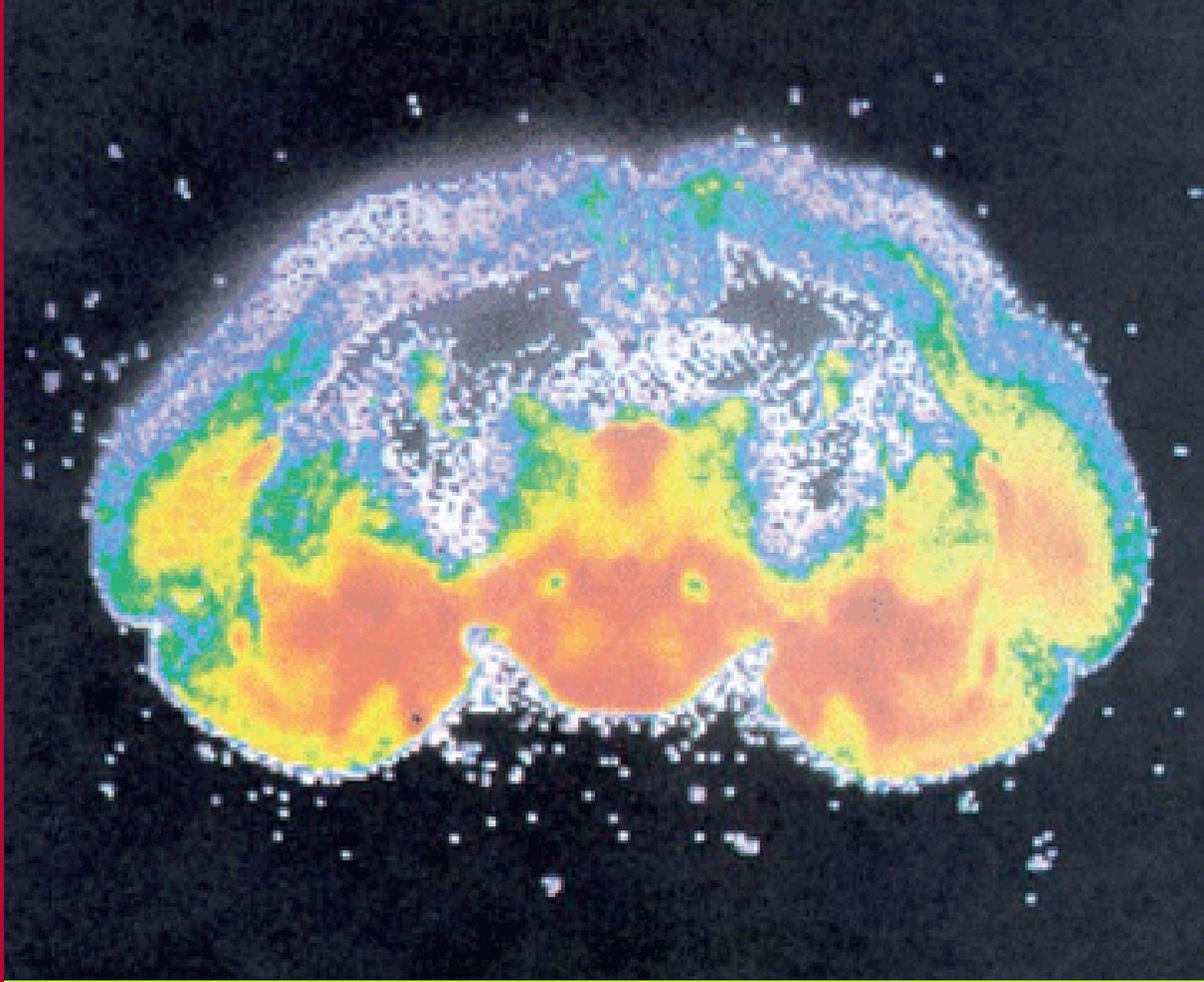
# The Gas Pipeline

from the Department of Anesthesiology, Perioperative and Pain Medicine

March 2014



**Success!**  
**Department Researchers**  
**Closing in on No. 1**  
*see page 2*



# The Gas Pipeline

March 2014

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## Contents

Research Success .....2  
Stanford Anesthesia .....5  
in Afghanistan  
From the Chairman .....6  
From the Deputy Chief .....8  
From the Residency .....10  
Program Director  
Teaching Scholar Program... 13  
Fellowship in Global Health . 14  
Residents vs Attendings .... 15  
Softball Game  
Department Golf ..... 16  
Tournament  
2014 Arts in Anesthesia .... 17  
Soirée  
Division News  
Pain .....18  
VA.....19  
Upcoming Meetings .....20  
Faculty Corner .....21



*The Department of Anesthesiology, Perioperative and Pain Medicine currently ranks No. 2 in NIH funding in the United States, but is less than \$115K behind No. 1.*

◀ Michael Helms, PhD, MBA

# Success!

## Department Researchers Closing in on No. 1

By Michael Helms, PhD, MBA  
Director of Strategic Research Development

The Department of Anesthesiology, Perioperative and Pain Medicine currently ranks No. 2 in NIH funding in the United States, according to recently released 2013 statistics from the Blue Ridge Institute for Medical Research ([www.brimr.org](http://www.brimr.org)). UCSF ranks No. 1, but the gap between us is less than \$115,000 (Table 1). When I joined the department in 2009, we had \$2.5 million in total NIH funding and ranked 16<sup>th</sup>. To rise from 16<sup>th</sup> to 2<sup>nd</sup> place and \$2.5 million to \$7.9 million (a more than 3-fold increase) in total NIH funding in a mere 4 years, during a time when federal funding for research has become more difficult to obtain, is a truly amazing accomplishment and we should all be proud of this achievement.

**Table 1 - NIH funding ranking of anesthesiology departments**

Rank	Name	NIH funding (Total costs, FY2013)
1	UNIVERSITY OF CALIFORNIA SAN FRANCISCO	\$8,000,542
2	STANFORD UNIVERSITY	\$7,887,305
3	WASHINGTON UNIVERSITY	\$6,318,863
4	JOHNS HOPKINS UNIVERSITY	\$5,989,220
5	COLUMBIA UNIVERSITY HEALTH SCIENCES	\$4,680,795
6	UNIVERSITY OF CALIFORNIA LOS ANGELES	\$4,566,024
7	UNIVERSITY OF WASHINGTON	\$4,145,390
8	VANDERBILT UNIVERSITY MED CTR	\$3,928,061
9	UNIVERSITY OF PITTSBURGH AT PITTSBURGH	\$3,816,823
10	DUKE UNIVERSITY	\$3,730,426

How did we accomplish this great success? There are three reasons:

- Department chair Dr. Ron Pearl has strongly championed research efforts for many years.
- We have faculty with great ideas and a passion for research. Three of our members rank in the top 15-funded faculty in anesthesiology in the country—Drs. Sean Mackey and Gary Peltz are the top two anesthesiology researchers in the US, and Dr. Rona Giffard is 13<sup>th</sup> on the list (see Table 2).
- Stanford provides a highly fertile and collaborative environment that encourages and promotes research. We have instituted a review process for grant applications to make them “better” in the sense that they are more likely to win funding. In other words, we have focused on the quality, not the quantity, of grant applications, and the results speak for themselves.

Table 2 - NIH funding ranking of anesthesiology faculty

Rank	Name	NIH funding (Total costs, FY2013)
1	MACKEY, SEAN C	\$2,596,146
2	PELTZ, GARY A	\$2,012,558
3	NIKLASON, LAURA E	\$1,880,409
4	HASHIMOTO, TOMOKI	\$1,836,315
5	ECKENHOFF, RODERIC G	\$1,821,524
6	CAI, HUA LINDA	\$1,756,322
7	GEREAU, ROBERT W	\$1,684,713
8	YAMOAH, EBENEZER N	\$1,544,667
9	WANG, YIBIN	\$1,438,496
10	MARKS, JAMES D.	\$1,401,009
11	ELTZSCHIG, HOLGER K.	\$1,345,578
12	Jl, RU-RONG	\$1,337,728
13	GIFFARD, RONA G	\$1,304,130
14	LUO, ZHIGANG DAVID	\$1,235,921
15	GEBHART, GERALD F	\$1,231,994



◀ Dr. Sean Mackey

▼ Dr. Gary Peltz

What do these rankings include and exclude? They are based on total direct and indirect NIH funds awarded during NIH's fiscal year (from October 1<sup>st</sup> to September 30<sup>th</sup>). Contracts and ARRA awards are excluded. Harvard Anesthesiology is also excluded because their grants are managed by the individual teaching hospitals, i.e., Massachusetts General Hospital, Brigham and Women's Hospital, and Children's Hospital of Boston. Harvard's anesthesiology department is so large, and so much larger than ours, that if their funding were included in the rankings, they would almost certainly be No. 1.

Other non-NIH types of funding are also excluded, such as grants from other federal sponsors like AHRQ, DOD, and the VA, grants from foundations, industry-sponsored clinical trials, and gifts. Faculty affiliated with the Palo Alto VA who have grants, including NIH grants, managed by PAIRE are not counted. Subawards, in which our faculty share a part of the budget from a grant to a faculty member outside of the department, are also not counted. All of these exclusions apply to other departments as well as ours.

What do these rankings mean? They definitely get noticed by some deans and chairs around the country, and total NIH funding is one factor used in ranking medical schools. For example, *US News & World Report* currently ranks the Stanford School of Medicine No. 2 for research in the US (second only to Harvard Medical School), with total NIH funding given a weighting of 0.15.

Despite all the caveats and exclusions that figure into the rankings, and our actual ranks, the increase in our NIH funding dollars from \$2.5 million in 2009 to \$7.9 million in 2013 is an amazing achievement in a short period of time and during such a difficult funding environment.

Awards have been allocated to study a wide range of subjects, including mechanisms of and therapies for addiction, pain, stroke, myocardial infarction, and immunity in surgical patients, to name a few. And much of our total funding went to mid-career and junior faculty, which bodes well for our future.



▲ Dr. Rona Giffard



The following is a highlight of some of the NIH-funded research being conducted by four junior faculty and fellows:

**Dr. Eric Gross:** Eric has a K99/R00 grant from NIH to study the role of the TRPV1 channel in myocardial ischemia-reperfusion injury, suggesting that angina is a mechanism for protection against heart attack injury.

**Dr. Jarred Younger:** Jarred also has a K99/R00 grant from the NIH to study how opioid analgesics impact the central nervous system in humans. His project makes extensive use of human neuroimaging. He is also funded by the Department of Defense to study how immune system dysregulation may drive Gulf War Illness. He is beginning work funded by the Fetzer Foundation to examine oxytocin in humans, and he has funding from non-profit foundations and private sources to test microglia modulators for the treatment of pain and fatigue. Jarred has been recently joined by postdoctoral fellow Luke Parkitny, who is funded by the International Association for the Study of Pain (IASP) to examine new treatments for fibromyalgia.

**Dr. Jennifer Hah:** Jennifer received a K23 career development award from NIDA / NIH. Jennifer received a perfect score on her grant application, on her first try! Her research focuses on the relationships between psychological factors, opioid use, and pain throughout surgery and recovery. She will also evaluate physician-guided opioid weaning through motivational interviewing as a brief non-medication intervention to promote opioid cessation after surgery.

**Dr. Alex Butwick:** Alex has a K23 award from NIH to study ways to reduce postpartum hemorrhage and early postpartum anemia in women who have cesarean deliveries. Alex also received a perfect score on his grant application. This award matches Alex's primary research interests in preventive and therapeutic strategies for the management of obstetric hemorrhage and hematologic-related outcomes-based research in obstetrics.

Currently, Alex is collaborating closely with multidisciplinary investigators, including obstetrical colleagues in the Department of Maternal-Fetal Medicine at Stanford and epidemiologists based at the Perinatal Research Unit at Kaiser Permanente Northern California.



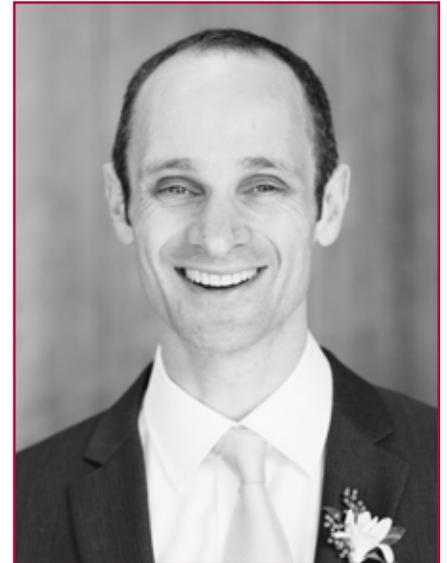
▲ Dr. Eric Gross



▲ Dr. Jarred Younger



▲ Dr. Jennifer Hah



▲ Dr. Alex Butwick



*Please join me in congratulating our entire research faculty on their accomplishments!*

# A Salute to Stanford Anesthesia in Afghanistan

By David Asseff, MD

CDR MC USN

I am a 2013 graduate of the Stanford cardiac anesthesia fellowship. I am currently deployed as an active-duty US Navy anesthesiologist to the NATO hospital in Kandahar, Afghanistan, where I will be until the fall. Also deployed with me is another anesthesiologist, CDR Josh Tobin, MD, a 2006 graduate of Stanford's critical care fellowship. Together, Stanford grads comprise 50% of the Anesthesia Department here in Kandahar, fulfilling our primary mission of providing anesthesia and resuscitative care to critically wounded service members from the US, NATO, and Afghanistan.



▲ Drs. Asseff and Tobin in Kandahar

# From the Chairman

By Ron Pearl, MD, PhD  
Richard K. and Ericka N. Richards Professor



Our anesthesiology department continues to expand, including case volume, faculty numbers, educational activities, and research accomplishments. Although this growth provides significant opportunities, it also requires that we consider changes in faculty roles so that we maintain our culture where every faculty member is equally valued for his or her contributions to the department.

When I finished my training and joined the faculty, the expectation was that faculty could all be quadruple threats, namely experts in clinical care, education, research, and administration. At that time, the faculty size was relatively small, so fulfilling all the departmental missions required that each faculty member excel in all these areas. This expectation of multiple missions paralleled the clinical expectation that most anesthesiologists would practice the full range of clinical anesthesiology, including pediatrics, obstetrics, and neuroanesthesia. During the subsequent years, we have had increasing clinical subspecialization, recognizing that the best anesthesia care for complex patients is provided by anesthesiologists with specific expertise obtained through fellowship training and/or focused clinical practice. The majority of our faculty now belong to one of our subspecialty divisions (pediatrics, critical care, obstetrics, cardiothoracic, and pain management), and our general OR group has become the Multispecialty Division, with areas of clinical focus for the majority of its members. In addition, our subspecialty groups have further developed their own areas of increasing subspecialization, such as pediatric cardiac anesthesia in the pediatric group and pelvic pain in the pain management group. Although many faculty reminisce about the days when an anesthesiologist could do it all, subspecialization has been good not only for patient care, but also for allowing our faculty to develop national prominence in their areas of clinical expertise.

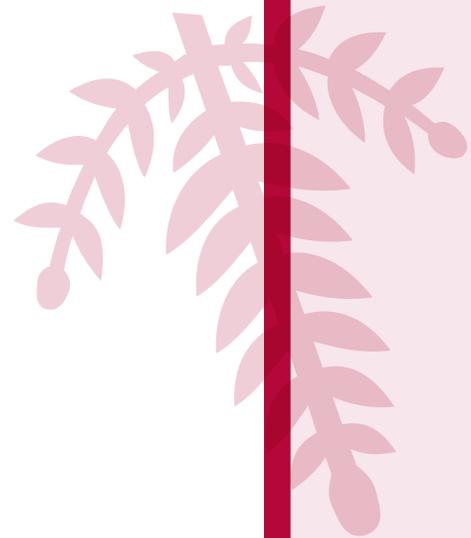
Before the Clinician Educator Line (CEL) was established, the Medical Center Line (MCL) was the predominant faculty line. According to the faculty handbook, the role of the MCL faculty “is defined by engagement in clinical care, teaching, and scholarly activity that advances clinical medicine.” However, the increasing level of scholarly activity expected in the MCL has become difficult to achieve without grant support for research time and increasingly sophisticated and expensive studies. The increased competition for a share of the fixed pot of research dollars and the increased expertise expected in competitive grants has resulted in the expectation that most MCL (and tenure line) faculty will have multiple years of dedicated research training and will spend the majority of their time focusing on scholarship. The paradigm of a combination of adequate training and focused effort in the department has resulted in our research success as documented by our dramatic increase in research funding, number of publications, and national impact.

As a result of the increasing requirement for scholarly activity in the MCL and the rapid growth in clinical volume, the predominant faculty line (now more than two-thirds of our faculty) has become the CEL, which emphasizes clinical care and teaching with or without scholarly activity and administrative contributions. It is imperative for the success of the department that the contributions of the CEL faculty to the department be equally valued as those of the MCL faculty, and that the opportunities for career advancement of the CEL faculty be equal to those of the MCL faculty. A successful research career requires specialized training and a plan for career development to become a leader in the field. Similarly, success in the CEL also requires specialized training and a plan for career development. CEL faculty may become leaders in clinical care, education, and administration. Our best clinicians will generally have specialized fellowship training and

relevant experience (such as pediatric anesthesia and transesophageal echocardiography), participate in national specialty societies, and develop a focused area of clinical practice. Similarly, our best educators will have specialized training (such as a master's-level degree in education), additional experience (such as serving as a rotation or program director), participate in specialty activities at a national level (such as the Society for Education in Anesthesia), and focus on educational activities such as curriculum development and milestone implementation. Finally, our best administrators will also have specialized training and experiences (such as a master's-level degree, six sigma, or Lean training), participate in specialty societies, and focus on administrative activities such as medical direction and quality improvement. Similar to our experience in the MCL, the combination of adequate training plus focused effort has already resulted in unprecedented success in clinical care, education, and administration throughout the department.

As the department continues to grow, we will continue to emphasize our missions of clinical care, education, research, and administration by allowing faculty members to focus their efforts on those areas in which they individually excel rather than expecting each faculty member to be expert in all areas. In this way, we can allow each person to focus on those areas for which he or she has training, experience, skill, and passion. This will result in valuing each faculty member equally and allowing us to celebrate both individual and departmental success.

*The combination of adequate training plus focused effort has already resulted in unprecedented success in clinical care, education, and administration throughout the department.*





# From the Deputy Chief

## 10 Ways Private Practice Anesthesia Differs from Academic Anesthesia

By Rick Novak, MD, Deputy Chief  
Associated Anesthesiologists Medical Group

Stanford is a unique academic hospital, staffed by both academic and private practice physicians. As the deputy chief, I'm an elected officer who leads the private practice/community section of the anesthesia department.

Stanford anesthesia residents frequently question me about how the world of private practice differs from academia. This series of deputy chief columns originated as a forum to educate residents using specific cases and situations I found unique to private practice.

Although many Stanford graduates continue in academic medicine, a large number pursue careers in community or private practice. In 2009, the Anesthesia Quality Institute published "Anesthesia in the United States 2009," a report that summarized data on our profession. There were 41,693 anesthesiologists in America at that time, and the demographics of practice type were: academic/teaching medical center 43%, community hospital 35%, city/county hospital 11%, and ambulatory surgery center 6%. Per this data, the majority of American anesthesiologists practice outside of teaching hospitals.

How does community anesthesia differ from academic anesthesia? I'm uniquely qualified to answer this question. I've worked at Stanford University Hospital for 34 years, including 5 years of residency training and one year as an emergency room faculty member, but my last 25 years at Stanford have been in private practice with the Associated Anesthesiologists Medical Group.

Here's my list of the 10 major adjustments residents face when transitioning from academic anesthesia to private practice/community anesthesia:

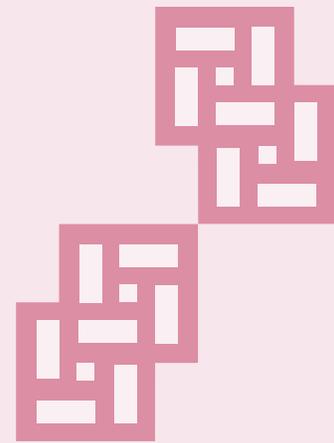
- 1. You'll work alone.** In academic medicine, faculty members supervise residents. In private practice, you're on your own. This is particularly true in the middle of the night or when you are working in a small, freestanding surgery center where you are the only anesthesia professional. In these settings, you have little or no backup if clinical circumstances become dire. An additional example is the performance of pediatric inhalation inductions. During residency training, a faculty member starts the IV while the resident manages the airway. In private practice you'll do both tasks yourself. I'd advise you to adopt a senior member of your new anesthesia group as a mentor, and to question him or her in an ongoing nature regarding the nuances of your new practice. (Note that certain private practices, especially in the Midwest or southeastern US, utilize Anesthesia Care Teams, where anesthesiology attendings supervise nurse anesthetists; this model is less common in California).
- 2. Income.** Your income will be linked to your production. The good news is that you'll earn more money that you did as a resident. Your income will correspond with the number of cases you do. You'll earn more in a 12-hour day than you do in a 4-hour day, so you have an incentive to do extra cases. A job where newly hired physicians have equitable access to workload is desirable.

3. **Income.** Your income will be linked to the insurance coverage of your patients. Privately insured patients pay more than Medicare and Medicaid patients. You may earn more working a 4-hour day for insured patients than you earn working 12 hours for the government plans of Medicare and Medicaid. It's too early to know how much Obamacare and the Affordable Care Act will alter physician salaries. A job with a low percentage of Medicare and Medicaid work is desirable.
4. **Vacations.** You'll have access to more vacation time than you did in academic training. Most jobs allow a flexible amount of weeks away from clinical practice, but you will earn zero money during those weeks. It will be your choice: maximize free time or maximize income.
5. **Recipes.** You'll tend to use consistent anesthesia "recipes," rather than trying to make every anesthetic unique, interesting, or educational, as you may have done in an academic setting. Community practice demands high-quality care with efficient inductions and wake-ups, and rapid turnovers between cases. Once you discover your best method for doing a particular case, you'll stick to that method.
6. **Continuing Medical Education (CME).** In an academic setting, educational conferences are frequent and accessible. After your training is finished, you'll need to find your own CME. In California the requirement is 50 hours of CME every 2 years. Your options will include conventions, weekend meetings, and self-study at-home programs. Many physicians prefer at-home programs because they require less investment in time, travel, and tuition than attending out-of-town lectures do.
7. **Malpractice insurance.** You'll pay your own malpractice insurance. As a result, you'll be intensely interested in avoiding malpractice claims and adverse patient outcomes. You'll become well versed in the standards of care in your anesthesia community.

8. **No teaching.** No one will expect you to teach during community practice. You may choose to lecture nurses or your fellow medical staff, but it's not required.
9. **No writing.** No one will expect you to write or publish scholarly articles. You may choose to do so, but you will be in the minority.
10. **Respect.** You'll experience a higher level of respect from nurses and staff at community hospitals and surgery centers than you receive during residency. Nurses and staff accept that you are fully trained and experienced, and they treat you as such. Free food at lunch and breakfast is common. Some hospitals have comfortable physician lounges where medical staff members gather. Teams of physicians work together at the same community hospitals for decades, and form strong relationships with the nurses, techs, and their fellow medical staff. It feels terrific to collaborate with the same professionals week after week.

Academic training is an essential building block in every physician's career. If and when you choose to venture beyond academia into community anesthesia, this column gives you some idea of what to expect. I recommend that you find a mentor to help you adjust to the challenges of your new practice setting, and I wish you good luck with the transition.

*Rick Novak's collection of deputy chief columns and more can be found on his website [www.theanesthesiaconsultant.com](http://www.theanesthesiaconsultant.com).*



# From the Residency Program Director

## Residency Update

By Alex Macario, MD, MBA



### Residents of the Month

Please join me in congratulating the following residents of the month and the upcoming chief residents:

December: **Tammy Wang**

January: **Joseph Kwok**

February: **Adam Djurdjulov**

**Drs. Christyna Jeter, Jason Johns, and Christopher Press** have been elected as chief residents for the 2014–15 academic year.

The hot topic everyone in residency training is talking about is that beginning in July 2014, all residencies are expected to incorporate formal performance milestones for evaluating residents to confirm that they are fit to practice independently and without supervision following graduation.

Milestones are a component of the Accreditation Council for Graduate Medical Education (ACGME) Next Accreditation System. A national expert panel of anesthesiologists has identified specific milestones for each of the 6 competencies. Housestaff will advance in training by demonstrating they have achieved the required milestones rather than advancing simply because they have completed the required years of training.

What is the action plan for Stanford Anesthesia? Well, milestones is a big project and requires a concerted team effort from all members of the department.

Leading this effort is Associate Program Director Dr. Aileen Adriano. She has recruited attendings for each rotation to lead the milestones for that rotation. These attendings are usually the rotation directors, but not always. These faculty have mapped out the current learning objectives for their rotation to one of the 25 final anesthesiology milestones to see how they match up (Figure 1).

This mapping out process for the 34 rotations in the anesthesia residency has been valuable because the rotations are able to update their learning goals and curriculum. By using a grid with milestones published in rows and columns with existing objectives in rotation, we can prioritize where to create new assessments.

Each rotation is developing a new assessment form with milestones specific to that rotation. This means each rotation will have its own unique evaluation form. The resident can demonstrate milestones at one of 5 levels:

- Level 1: expected of a resident who has completed internship.
- Level 2: expected of a resident before gaining significant experience in the subspecialties of anesthesiology.
- Level 3: expected of a resident after having experience in the subspecialties of anesthesiology.
- Level 4: ready to transition to independent practice. This level is designed as the graduation target.
- Level 5: advanced beyond performance targets defined for residency, demonstrating “aspirational” goals that might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level for selected milestones.

Thus, an evaluation form might look like Figure 2.

Another important resource has been the Stanford GME office, which provides us with best-practice examples from other programs.

We have also prioritized milestone assessment projects in the selection process for this year’s teaching scholars program. Faculty development is crucial with regard to expertise in learning theory and tools because the assessment portion is a challenge, either with clinical, technical, or professional skills, so we need to concentrate efforts in those areas.

**Figure 1. The 25 anesthesiology milestones mapped out to sample rotations**

<b>Anesthesiology Milestones</b>	<b>Rotation 1</b>	<b>Rotation 2</b>
<b>Patient Care</b>		
1: Preanesthetic evaluation, assessment, and preparation	x	x
2: Anesthetic plan and conduct	x	x
3: Periprocedural pain management	x	x
4: Management of perianesthetic complications	x	x
5: Crisis management	x	
6: Triage & management of the critically ill patient in a non-operative setting	x	
7: Acute, chronic, & cancer-related pain consultation and management	x	
8: Technical skills: airway management	x	x
9: Technical skills: use and interpretation of monitoring and equipment	x	x
10: Technical skills: regional anesthesia	x	x
<b>Medical Knowledge</b>		
1: ABA content outline knowledge	x	x
<b>Professionalism</b>		
1: Responsibility to patients, families, and society	x	x
2: Honesty, integrity, and ethical behavior	x	x
3: Commitment to institution, department, and colleagues		x
4: Receiving and giving feedback	x	x
5: Responsibility to maintain personal emotional, physical, & mental health	x	x
<b>Interpersonal and Communications Skills</b>		
1: Communication with patients and families	x	x
2: Communication with other professionals	x	x
3: Team and leadership skills	x	x
<b>Practiced-based Learning and Improvement</b>		
1: Incorporation of QI and patient safety initiatives into personal practice		x
2: Analysis of practice to identify areas in need of improvement	x	x
3: Self-directed learning	x	
4: Education of patient, families, students, residents, & other providers	x	x
<b>Systems-based Practice</b>		
1: Coordination of patient care within the health-care system	x	x
2: Patient safety and quality Improvement	x	x

Another helpful element is automated clinical performance feedback based on EPIC data for residents to help assess some of the system-based practice and practice-based learning and improvement milestones; Dr. Bassam Kadry has worked to formulate a metrics report that can be available to both faculty and residents at their request. The data provided in the report is culled from EPIC entries and can provide feedback on patient outcomes and efficiency. A preliminary draft version of the report may include metrics such as:

- Pre-incision antibiotic administration (Yes/No)
- Intra-op glucose monitoring for diabetic patients for cases > 150 min (Yes/No)
- Post-op pain management: first documented PACU score < 8 (Yes/No)
- Temperature management: first PACU temp > 36 C? (Yes/No)
- PONV management: antiemetic administered pre-emergence? (Yes/No)
- PONV management: antiemetic administered in PACU? (Yes/No)

**Figure 2. Example of evaluation form for one milestone in one rotation**  
**Practice-based learning and improvement 3: Self-directed learning**

Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Completes assigned readings and prescribed learning activities.</p> <p>Uses clinical opportunities to direct self-learning.</p> <p>Develops a learning plan relevant to clinical practice.</p>	<p>Reviews the literature and information relevant to specific clinical assignments.</p> <p>Periodically modifies learning plan based on analysis of multi-source feedback, quality data, examination performance, and self-reflection with program guidance.</p>	<p>Differentiates evidence-based information from non-evidence-based resources to address specific patient management needs.</p> <p>Incorporates experiences from subspecialty rotation to modify learning plan.</p>	<p>Incorporates evidence-based medicine practices into patient management.</p> <p>Integrates past experience, multiple learning activities, and self-reflection to direct lifelong learning independently.</p>	<p>Refines clinical practice based on evolving medical evidence.</p> <p>Continually analyzes personal practice to focus self-directed lifelong learning.</p>

We are also working to collaborate with our residencies to standardize milestone measurements. One example of this is regional anesthesia, which has a dozen centers.

The milestones will also affect the work of the Clinical Competence Committee chaired by Dr. Steve Howard. Starting next year, the CCC will be expected to gather resident performance data from milestone-based tools and report to the residency review committee at the ACGME whether the resident has attained the anesthesiology-specific milestones.

Milestones represent an opportunity to further improve the excellent experience residents have at Stanford. The ACGME has given little feedback to residency programs on how to use the milestones for meaningful evaluation. Although no one knows exactly how milestones measurements will play out, especially for nontechnical behaviors such as communication or professionalism, we do need to make more explicit measurements of residents' abilities.

Finally, Dr. Adriano has put together a milestones assessment/curriculum workgroup to meet regularly and oversee the implementation of the milestones. Committee members include Drs. Kyle Harrison, Andrew Patterson, Steve Howard, Ruth Fanning, Jean-Louis Horn, Julie Williamson, Ed Riley, Nate Kelly, and Sarah Namath. Because there are many moving parts to consider when implementing the milestones, this body of faculty can pool our ideas, decide on which assessments we need, and overall manage the curricular changes as the milestones evolve.

# Teaching Scholar Program

## Now Accepting Applications for 2014

The Teaching Scholars Program is accepting applications from faculty for 2014. The program was launched 6 years ago to further faculty pedagogical training and to improve residency education. To date the program has produced 33 teaching scholars.

Full time faculty (>50% either MCL or CEL) interested in becoming a teaching scholar should email a completed application package to Dr. Pedro Tanaka ([ptanaka@stanford.edu](mailto:ptanaka@stanford.edu)) by April 30, 2014. The application must include your CV, a 1-page essay on your career plan, a description of the education-related project you plan to complete as part of the program, including the resident(s) who will work with you on your project, and the education-themed meeting you plan to attend. Funding is available for travel expenses and tuition up to \$2000.

Pedro Tanaka can provide project ideas for your consideration based on a needs assessment of the residency, but you are encouraged to be innovative if you have a project in mind.

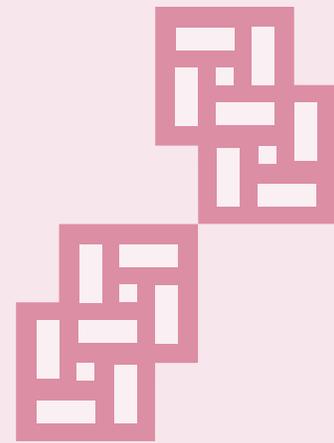
The application should also describe and itemize how you intend to spend up to 12 days (equal to 0.25 clinical commitment reduction for 1 year) of non-clinical time, analogous to a grant application.

The program also includes monthly seminars on topics relevant to each scholar's goals and project. For example, one such topic is curriculum design.

The selection process is competitive. The Teaching Scholar Grant Committee makes the selection based on the applicant's education leadership potential, ability to commit time and interest to the program in relation to their other responsibilities, and the nature of their proposed goals and projects.

Teaching scholar progress will be evaluated at 3 and 6 months to ensure milestones are being met. The teaching scholar title can be added to the faculty's CV as an award.

If you are interested in becoming a teaching scholar, please see Pedro Tanaka for the complete information for this program, including the application and checklist, previous teaching scholars and their projects, and lists of meetings of interest and potential projects for the program.



# Anesthesia Fellowship in Global Health

## Accepting Applications

The Stanford Anesthesia Fellowship in Global Health is accepting applications. This postgraduate fellowship after residency is tailored to the individual physician's background and goals but has several core components:

- Up to 12 weeks working in a medically under-served low- or middle-income country.
- Scholarship project in global health focused on improving infrastructure by improving medical education or by forming and answering an appropriate research question.
- A core curriculum at the crossroads between the multiple disciplines that comprise global health and considerations for delivering peri-operative care in austere environments. Many of the lectures and seminars included in the curriculum throughout the year are available via Stanford's Center for Innovation in Global Health (<http://globalhealth.stanford.edu/>).
- Clinical work as an anesthesiology attending in the Stanford operating room suite one day a week with 1–2 calls per month.
- Attendance at the global health outreach conference in Halifax, Nova Scotia, or Seattle, Washington, addressing the challenges of administering anesthetics in austere environments.

The goals and objectives for the global health fellow include:

- Understanding and promoting global patient advocacy.
- Gaining knowledge of the complexities of the issues contributing to health care disparities on a global scale.
- Recognizing the economic, political, policy, cultural, epidemiological, and infrastructure factors that influence health care delivery in low- and middle-income countries (LICs and MICs).
- Understanding the factors contributing to the surgical component of the global burden of disease and then developing and implementing effective solutions to the problems.
- Developing a knowledge of the differences in assessing patient needs and delivering peri-operative care in settings with limited resources.
- Incorporating the global health knowledge and skill set into a career in anesthesia.

Upon completion of the fellowship, the fellow will become a global patient advocate with the ability to improve peri-operative healthcare delivery in low resource settings. In contrast to service-oriented or volunteer mission trips, the focus of this fellowship is on building capacity by advancing global health research and educational partnerships. Graduates of this 1-year fellowship will be poised for program development, policy work, and research within the burgeoning field of global health.

If interested in applying, please contact Fellowship Director Dr. Ana Crawford at [ana9120@stanford.edu](mailto:ana9120@stanford.edu). Please note that a California medical license is required. More information about Stanford Anesthesia Global Health is also available at [globalanesthesia.stanford.edu](http://globalanesthesia.stanford.edu).



# Play Ball!

## 2<sup>nd</sup> Annual Residents-vs-Attendings Softball Game and BBQ

By Ryan Mountjoy, MD



Although I know we were all shocked and appalled to hear that Punxsutawney Phil saw his shadow and we will have to (occasionally) endure 6 more weeks of sub-70-degree temperatures, the news got me thinking about the allure of casting off that light jacket and instead donning my baseball mitt! With the gracious support of the department, I am happy to announce the 2nd Annual Residents-vs-Attendings Softball Challenge and BBQ. Here's the important stuff:

**When:** Saturday, May 10

4:30 PM – sunset

(another group is on the field until 4 PM and then we have it until dark)

**Where:** Nealon Park, 800 Middle Avenue, Menlo Park

(parking is available near the playground as well as around the back near the softball diamond; I recommend the latter)

**Who:** All anesthesia residents and interns versus any and all attendings willing to rise up to the challenge of facing insurmountable odds and inevitable defeat

**Why:** Self-explanatory. Why would you not want to see Dr. Tanaka take another crack up at the plate, or witness an error-ridden home run by an incredibly fast Dr. Macario once again?

There will be a post-game, catered BBQ similar to last year's event, complete with meat and non-meat options.

Please email me ([ryanmountjoy@gmail.com](mailto:ryanmountjoy@gmail.com)) if you are interested in playing and let me know how many people you will be bringing with you to the BBQ after the game.



# 12th Annual Stanford Anesthesia Department Golf Tournament

## Slated for June

**G**olfers, get ready! Dust off your clubs, get out your finest golf duds, and find that lucky rabbit's foot! The 12th annual department golf tournament will be held on Sunday, June 15, at the Stanford Golf Club. The format will be a scramble, the same as it has always been, so there is no significant pressure on the individual golfer.

The tournament is open to all current department members and alumni, and each participant can bring one partner who may or may not work for the department. This means that each foursome must include two current or former department members. You must have your own golf bag, and you are not permitted to share golf clubs. You can walk or drive. If you choose to drive, the cost for the cart is \$35 for two players.

Residents who are interested in playing should attempt to sign onto Ann Dohn's list for June 2014. If you are on that list you pay only \$20 per round. University faculty pay \$60 per person, and all others pay \$110 per person.

Please contact Dr. John Brock-Utne ([brockutn@stanford.edu](mailto:brockutn@stanford.edu)) if you plan to play, and tell him whether you will be playing alone or bringing a friend. If you wish to team-up with specific people, please tell John and he will honor your request if at all possible.

At the end of the tournament there will be ceremony on the patio overlooking the 18th green. Prizes will be awarded and hors d'oeuvres and drinks will be served.

*Don't forget to mark your calendars—June 15 will be here before you know it!*



# Maintaining Balance

## Display Your Artistic Side at the Third Annual Arts & Anesthesia Soirée

The Arts & Anesthesia Committee invites you to showcase your artistic endeavors at the 3rd Annual Arts & Anesthesia Soirée on Wednesday, May 28, at 5:30 PM in LKSC Berg Hall B/C.

This event is unique in the school of medicine in that it celebrates the nonmedical, artistic talents and interests of department members and their families and partners. Past soirées have displayed original artwork, crafts, print photography, digital images, music, dance, martial arts, original writing and poetry, and video. This year we will also feature Nerd Art. Remember those daisies made from vial caps or the pedi bandage art from last year? Nerd Art is anything made from or resembling the tools and discards of the anesthesia trade.

An assortment of hors d'oeuvres, desserts, beer, wine, and nonalcoholic beverages will be served.

Anyone affiliated with the department can present their work. This includes staff, residents, fellows, faculty, attendings, perioperative staff from all affiliated hospitals, alumni, and family members. You do not have to showcase your talent to attend the event, but please do consider sharing your creative energies with your friends and colleagues.

If you plan to participate, please send an email to Monique Chao Norquist ([chaom@stanford.edu](mailto:chaom@stanford.edu)) by the end of March and briefly describe how you plan to participate. Based on your email, as the time draws closer, we will ask you for more detailed information about your contribution. One month before the event we will ask for your final commitment, including the specific details of your presentation.

Contact Monique Chao Norquist  
([chaom@stanford.edu](mailto:chaom@stanford.edu))  
or Audrey Shafer  
([ashafer@stanford.edu](mailto:ashafer@stanford.edu))  
if you have any questions about  
the soirée. And remember to  
save the date – we look forward  
to seeing you there!



3<sup>rd</sup> Annual  
**ARTS AND ANESTHESIA SOIREE**

May 28, 2014 5:30pm  
LKSC Berg Hall B/C

Anesthesiology, Perioperative and Pain Medicine  
Stanford School of Medicine

Photo: Alex Quick

# Division News



▲ *Dr. Jordan Newmark*

## Pain Management

Dr. Jordan L. Newmark has been appointed associate fellowship director of pain medicine. Jordan is a clinical instructor in anesthesia and pain medicine, and has recently completed a fellowship in pain medicine. He has special interests in adult learning, education, and simulation, and plans to develop pain medicine simulation courses with the help of the simulation group. He will also be investigating other educational programs for the division.

Jordan is also a 2013–2014 scholar in the department's Teaching Scholars Program.

Jordan received his MD from Temple University School of Medicine and completed his residency in anesthesia at Massachusetts General Hospital, Harvard Medical School Department of Anesthesia, Critical Care & Pain Medicine.

Jordan was born in Philadelphia, and belongs to a medical family. His father is currently a professor of psychiatry at Rowan University in NJ. His wife of 3 years, May, is attending OB/GYN at Highland Hospital in Oakland. Jordan and May met while he was an intern and she was fourth-year medical student at Drexel University/Hahnemann University Hospital in Philadelphia. The couple currently lives in Montclair, a suburb of Oakland.

Jordan has several interests outside of medicine. He loves to travel and has recently spent time in Thailand and India. He is also an oenophile, with several winery memberships in Napa and Sonoma, and loves electronic music.



▲ *Nicky Chu*

Nicky Chu has joined the pain division as the T32 grant coordinator and administrative associate. Nicky received his BS in human biology from UC San Diego. During the summers and other school breaks, Nicky provided administrative assistance in anesthesia and, most recently, he was a temporary administrative associate in the pain division.

Nicky will be coordinating the pain division's T32 postdoctoral training grant, and will be providing administrative support to faculty conducting research in the division. He is located at the 1070 Arastradero office and can be reached at [nchu2@pain.stanford.edu](mailto:nchu2@pain.stanford.edu).

*Welcome Nicky!*

# Division News

## VA

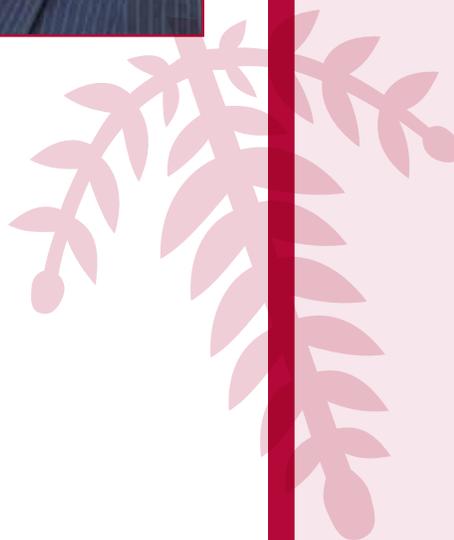
*By Edward Mariano, MD, MAS*

The anesthesiology faculty at the VA Palo Alto has been busy getting ready for the upcoming spring meetings. In particular, we will have a very strong presence at the American Society of Regional Anesthesia and Pain Medicine Spring Annual Meeting in Chicago this April. One of our abstracts has been selected as one of 3 Best of Meeting Abstracts for the second year in a row and will be presented by our research assistant, Toni Ganaway. Another abstract has been selected as one of 3 Best Abstracts by a Resident or Fellow and will be presented by Dr. Mike Rasmussen. Our other two abstract submissions have been accepted for moderated poster discussion.

Drs. Steve Howard and Kyle Harrison and simulation nurse educator Cynthia Shum will be conducting their Crisis Management for the Regional Anesthesiologist Workshop again this year. Drs. Eddie Kim and Ed Mariano will also be representing VA Palo Alto as ASRA meeting faculty.



▲ *Dr. Edward Mariano*



**Workshop**  
*April 24*

**Meeting**  
*April 25–27*

**San Francisco**

# Upcoming Meetings

## California Society of Anesthesiologists Meeting and Workshop

by Dr. John Brock-Utne

The *California Society of Anesthesiologists* is hosting a newly formatted *meeting* (April 25–27, 2014) *and workshop* (April 24, 2014).

The list of topics covers a full array of clinical “pearls” and should not be missed.

Both the meeting and the workshop will be held at the Hyatt Regency San Francisco, located at 5 Embarcadero Center, San Francisco.

Attendees can look forward to intensive educational learning, workshops, and panel discussions.

### Highlights include:

- Learn from 35 leaders in anesthesiology from throughout the US and California.
- Choose from more than 50 sessions, problem-based learning, and panel discussions.
- Earn up to 20 AMA PRA Category 1 credits.
- Earn an additional 8 AMA PRA Category 1 credits by participating in one of the three specialty workshops the day before the meeting (April 24).

For more information visit [www.csahq.org](http://www.csahq.org) or call 650.345.3020. Early bird registration will be available until April 2, 2014.

By supporting this conference you are also supporting CSA. They are working hard on your behalf to promote the medical specialty of anesthesiology in the state of California.

If you have any questions, please contact me at [brockutn@stanford.edu](mailto:brockutn@stanford.edu). I look forward to seeing you there!

## 2014 WARC

by Dr. John Brock-Utne

The 52<sup>nd</sup> Annual *Western Anesthesia Residents' Conference* (WARC) will be held May 2–4, 2014. Sponsored by Cedars-Sinai Medical Center Department of Anesthesiology, the event will be held at the Intercontinental Hotel, Century City, in Los Angeles. The deadline for submission of abstracts is April 1, 2014.

The organizers will decide which abstracts will be presented as oral or poster presentations. If you don't want to present your abstract orally, you can request a poster presentation only.

WARC is my favorite conference of the year—it is great fun. This time there will be two interesting talks:

- Paul White: Professionalism, integrity, and the medical legal system.
- James P. Bagian: Medical aspects of space flight.

After dinner on Saturday there will be a band, so remember to bring your dancing shoes.

Now is the time to start and finish your studies and/or write up your case reports. The department pays for your flight and hotel expenses only if you are presenting. The closest airport is LAX, and there is no hotel shuttle. A Super Shuttle to the hotel costs about \$15.

If you have any questions please contact me at [brockutn@stanford.edu](mailto:brockutn@stanford.edu). I look forward to seeing you there!

**Conference**  
*May 2–4*

**Los Angeles**

# Faculty Corner

## Journal Publications

Brookfield KF, Goodnough LT, Lyell DJ, Butwick AJ. **Perioperative and transfusion outcomes in women undergoing cesarean hysterectomy for abnormal placentation.** Transfusion. 2013; doi: 10.1111/trf.12483. [Epub ahead of print]

Chu LF, Ngai LK, Young CA, Pearl RG, Macario A, Harrison TK. **Preparing interns for anesthesiology residency training: Development and assessment of the successful transition to anesthesia residency training (START) E-learning curriculum.** J Grad Med Educ. 2013; 5(1):125-9. doi: 10.4300/JGME-D-12-00121.1. [Epub ahead of print]

Schatman ME, Darnall BD. **A practical and ethical solution to the opioid scheduling conundrum.** J Pain Research. 2014(7): 1-3. DOI: <http://dx.doi.org/10.2147/JPR.S58148>.

Darnall BD. **Your psychology affects your response to medical treatments and to pain medications.** National Register for Health Service Psychologists. January 10, 2014. <http://www.findapsychologist.org/your-psychology-affects-your-response-to-medical-treatments-and-to-pain-medications-by-dr-beth-darnall/>.

Giblin K, Newmark JL, Brenner GJ, Wainger BJ. **Headache plus: Trigeminal and autonomic features in a case of cervicogenic headache responsive to third occipital nerve radiofrequency ablation.** Pain Med. 2014; doi: 10.1111/pme.12334. [Epub ahead of print]

Macario A, Tanaka PP, Landy JS, Clark SM, Pearl RG. **The Stanford anesthesia faculty teaching scholars program: Summary of faculty development, projects, and outcomes.** J Grad Med Educ. 2013; 5(2):294-8. doi: 10.4300/JGME-D-12-00246.1. [Epub ahead of print]

Mariano ER, Perlas A. **Adductor canal block for total knee arthroplasty: The perfect recipe or just one ingredient?** Anesthesiology. 2014 Mar;120(3): 530-2. doi: 10.1097/ALN.000000000000121.

Memtsoudis SG, Danninger T, Rasul R, Poeran J, Gerner P, Stundner O, Mariano ER, Mazumdar M. **Inpatient falls after total knee arthroplasty: The role of anesthesia type and peripheral nerve blocks.** Anesthesiology. 2014 Mar; 120(3): 551-63. doi: 10.1097/ALN.000000000000120.

Mudumbai SC, Takemoto S, Cason BA, Au S, Upadhyay A, Wallace AW. **30-day mortality risk associated with postoperative non-resumption of angiotensin-converting enzyme inhibitors: A retrospective study of the Veterans Affairs healthcare system.** J Hosp Med, in press.

Ouyang YB, Giffard RG. **MicroRNAs affect BCL-2 family proteins in the setting of cerebral ischemia.** Neurochem Int. 2013 Dec 25. pii: S0197-0186(13)00324-0. doi: 10.1016/j.neuint.2013.12.006. [Epub ahead of print]

Ouyang YB, Giffard RG. **MicroRNAs regulate the chaperone network in cerebral ischemia.** Transl Stroke Res. 2013 Dec;4(6):693-703. doi: 10.1007/s12975-013-0280-3. Epub 2013 Aug 17. PubMed PMID: 24323423; PubMed Central PMCID: PMC3864745.

Ouyang YB, Stary CM, White RE, Giffard RG. **The use of microRNAs to modulate redox and immune response to stroke.** Antioxid Redox Signal. 2013 Dec 20. [Epub ahead of print]

# Faculty Corner

Ouyang YB, Xu L, Yue S, Liu S, Giffard RG. **Neuroprotection by astrocytes in brain ischemia: Importance of microRNAs.** *Neurosci Lett.* 2013 Nov 19. pii: S0304-3940(13)01015-X. doi: 10.1016/j.neulet.2013.11.015. [Epub ahead of print]

Qiao L, Nishimura T, Shi L, Sessions D, Thrasher A, Trudell JR, Berry GJ, Pearl RG, Kao PN. **Endothelial fate-mapping in mice with pulmonary hypertension.** *Circulation.* 2013. [Epub ahead of print]

Tanaka PP, Tanaka M, Drover DR. **Detection of respiratory compromise by acoustic monitoring, capnography, and brain function monitoring during monitored anesthesia care.** *J Clin Monit Comput.* 2014. [Epub ahead of print]

## Abstracts, Posters, Oral Conference Presentations

Bland BH, Pearce RA, MacIver MB. **Behavioral, systems level and synaptic actions of isoflurane in the rat.** Presented at Neuroscience 2013; San Diego, CA; November 9–13, 2013.

Blumenfeld Y, El-Sayed Y, Lyell D, Nelson L, Butwick A. **Risk factors for prolonged length of stay following cesarean delivery.** Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine; New Orleans; Feb. 3–8, 2014.

Brookfield K, Chao L, Berger V, Naqvi M, El-Sayed Y, Butwick A. **Chorioamnionitis and antenatal steroid therapy: Single vs. repeat course?** [Scored in The Top 5th percentile of submitted abstracts.] Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine; New Orleans; Feb. 3–8, 2014.

Butwick AJ. Three presentations at the Combined ANZCA/ASA South Australian and Northern Territory Annual Scientific Meeting in Adelaide, November 2013: **Massive transfusion protocol for obstetric hemorrhage; Peripartum management of the anticoagulated obstetric patient; and What's new in obstetrics?**

Butwick A, Blumenfeld Y, Brookfield K, Weiniger C. **Ethnic disparities among patients undergoing general anesthesia for cesarean delivery.** Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine; New Orleans; Feb. 3–8, 2014.

Judy A, Chao L, Girsan A, O'Malley K, Lyell D, Blumenfeld Y, Butwick A, El-Sayed Y. **Maternal characteristics and neonatal outcomes in women with eclampsia and preeclampsia.** Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine; New Orleans; Feb. 3–8, 2014.

MacIver MB, Pearce RA, Bland BH. **Behavioral, EEG and synaptic actions of isoflurane in the rat.** Presented at the International Society of Anesthetic Pharmacology 22nd Annual Meeting; San Francisco, CA; October 13, 2013.

# Faculty Corner

Ohno M, Girsan A, O'Malley K, Blumenfeld Y, Lyell D, Butwick A, El-Sayed Y. **Does low-dose aspirin for preeclampsia prevention increase the risk of antepartum bleeding or placental abruption?** Presented at the 34th Annual Meeting of the Society for Maternal-Fetal Medicine; New Orleans; Feb. 3–8, 2014.

Patterson AJ. **Resuscitating in austere environments: lessons learned from developing countries.** Presented at the Society of Critical Care Medicine 43rd Annual Congress; San Francisco CA; January 12, 2014.

Posadas ES, Dagne BA, Sunay MK, Trudell JR, Bland BH, MacIver MB. **Anesthetic and ethanol enhancement of GABA slow receptor-mediated synaptic inhibition.** Presented at Neuroscience 2013; San Diego, CA; November 9–13, 2013.

Snyder R. **Cutting edge soft skills.** Preconference call presented at the 14th Annual International Meeting for Simulation in Healthcare (IMSH); San Francisco, CA; January 25–29, 2014. The class was a “train the trainer” workshop for using established exercises and drills from the theater and business sectors to improve individual performance of healthcare non-technical skills such as: awareness/presence; coping with stress and failure; communication; leadership/followership; teamwork; and respect/empathy. The faculty for the workshop included William Hall, professional actor and founder of Bay Area Theater Sports (BATS), and Rich Cox, business consultant and trainer, improv actor, and executive leadership and innovation coach.

## Honors, Awards, and Appointments

Drs. Brice Gaudilliere, Karl Sylvester, Garry Nolan, and Martin Angst were awarded a grant by the March of Dimes Prematurity Research Center at Stanford University School of Medicine to **characterize the immune signatures in preterm labor with single cell mass cytometry.**

Dr. Andrew J. Patterson was elected to the board of directors (council) of the Society of Critical Care Medicine.

## Grand Rounds

Dr. Jean-Louis Horn presented Grand Rounds to Stanford's Division of Plastic Surgery on December 17 on the topic **“Regional anesthesia: benefits, ambulatory pumps, and the plan for Stanford.”** On December 18 he presented Grand Rounds to the Division of Orthopedic Surgery on the topic **“Update on regional anesthesia.”** On February 1 he presented Grand Rounds at UCSF on the topic **“Ambulatory continuous anesthesia.”**

Dr. Andrew J. Patterson presented Grand Rounds at Massachusetts General Hospital on October 17 on the topic **“Global health: Gitwe Rwanda Project.”**

# Faculty Corner

## Invited Talks and Guest Professorships

Dr. Alex Butwick was the Jose Burnell Visiting Professor and Honorary Lecturer Royal at Adelaide Hospital, Women and Children's Hospital, and Queen Elizabeth Hospital, Adelaide, Australia, in November 2013. He gave the following lectures: "Thromboelastography and other point-of-care devices and recombinant factor VIIa update"; "Vaginal birth after cesarean delivery" (Flinders Medical Center); "Optimizing post-cesarean neuraxial analgesia" (Lyell McEwin Hospital); and Maurice Sando Memorial Lecture, "Management of uterine atony and oxytocin update" (Women and Children's Hospital).

Dr. Ravi Prasad was invited to give a presentation on the "Role of psychology in pain" at the Kaiser Permanente Hayward Medical Center, Hayward, CA, on January 22.

Dr. Emily Ratner was a visiting professor at Dartmouth University, Hanover, New Hampshire, in September 2013. She gave the following lectures: "Physician burnout and resiliency: The facts, the figures and what can we do about it?" (Department of Anesthesiology, Dartmouth Hitchcock Medical Center); "Stanford wellness programs" (Geisel-Dartmouth School of Medicine, Hanover, New Hampshire, September 2013).

## Popular Press

Dr. Beth Darnall authored a column featuring a discussion on what to do when someone doubts your pain, "Ask Dr. Beth, Pain Psychologist"; November 26, 2013. <http://americannewsreport.com/nationalpainreport/ask-dr-beth-people-doubt-pain-8822511.html>.

Dr. Beth Darnall authored a column featuring a discussion on eating behavior within the context of chronic pain, "Ask Dr. Beth, Pain Psychologist"; December 18, 2013. <http://americannewsreport.com/nationalpainreport/ask-dr-beth-stop-overeating-8822659.html>.

Dr. Beth Darnall was the featured guest on 103.3 fm WXOJ radio program (live streamed at [www.valleyfreeradio.com](http://www.valleyfreeradio.com)).

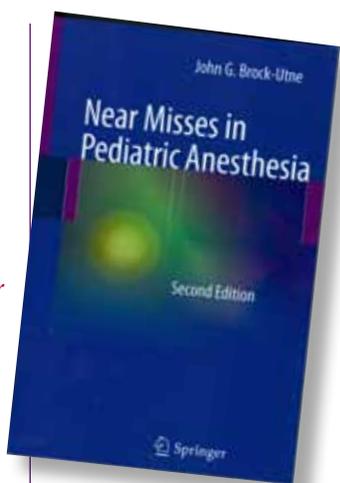
Topics of discussion were pain catastrophizing, pain psychology, and her forthcoming book, *Less Pain, Fewer Pills: Avoid the Dangers of Prescription Opioids and Gain Control Over Chronic Pain*. December 4, 2013.

# Faculty Corner

## Books

Brock-Utne J. *Case Studies of Near-Misses in Pediatric Anesthesiology*. Second Edition. New York: Springer, 2103.

Darnall B. *Less Pain, Fewer Pills: Avoid the Dangers of Prescription Opioids and Gain Control over Chronic Pain*. Palo Alto: Bull Publishing Company. Available for preorder on amazon.com: <http://www.amazon.com/Less-Pain-Fewer-Pills-Prescription/dp/1936693585>. Shipping date July 1, 2014.



## New Library Books

*Clinical Anesthesiology Board Review: A Test Simulation and Self-assessment Tool*, 2nd ed. — by Larry Chu and Bassam Kadry, et al. (Donated by Dr. Chu)

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*The Difficult Airway: An Atlas of Tools and Techniques for Clinical Management* — edited by David B. Glick, Richard M. Cooper and Andranik Ovassapian

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