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Come and Visit

Bradly Narr, M.D.

Galileo proved that Rochester was not the center of the universe (I think that is one of the things he did), but we still had more than 1.8 million patient visits to our clinic in 2006. I have emphasized to our trainees for decades what a privilege it is to care for those we know, and while it is fun to meet up during cardiac evaluations and preps for colonoscopy, it is even better if you just come to visit us socially.

Our electronic environment is maturing and the outpatient record has been "paperless" for years. In 2007, we aim to complete the final hospital steps with Computerized Physician Order Entry (CPOE) and electronic physician notes. (All nursing documentation has been paperless for 2 years). We are using multiple ultrasound machines now. Every cardiac room is set up with transesophageal echo, we have superb new machines to guide invasive line insertions, and we are trying to push the envelope of this technology to assist with peripheral nerve blocks. There are many new interventions in our catheterization laboratories, and for 3 to 6 months every year, we have someone (usually a child) on extracorporeal membrane oxygenation (ECMO) in the intensive care unit. We are fortunate to have excellent facilities that are being designed, built, or remodeled almost continually. The Francis Building still smells the same, but it looks different. Our latest nursing floor in neurology has adapted to the increasing BMI of our nation with ceiling-mounted patient lifts in every room. This technology has been so popular that plans are afoot to have these installed in every patient room.

So please feel free to come and visit. The conversation is still brisk and diverse in the neuro lounge. There isn't as much sunlight in the Rochester Methodist Hospital lounge in the shadow of the Gonda Building. You can visit them all. We will look forward to seeing you.

Editor's Note

Peter Southorn, M.D.

Enjoy this issue. Its contents, thanks to the writers of the articles, reflect brilliantly on all the people associated with our great department and institution. I'd like to echo Dr. Narr's sentiments in hoping you will make the effort to stay in touch with us so that we can do more boasting!
All the best for 2007.

No Boundaries: A Decade of POE

David Danielson, M.D.

The Preoperative Evaluation Center (POE) celebrated 10 years of existence this October. Dr. Brad Narr's brainchild has become an establishment! POE began as a pilot effort on West 12 of the Mayo Building, grew in size enough to necessitate a move to the lobby level (next to the dolphin boy sculpture), then grew some more and moved to its current location in the Gonda Building subway.

Seventy-one thousand patients have gone through POE during the last decade, and the pace is now 12,000 patients per year. The old Pre Anesthesia Medical Examination (PAME) process of sending the patient for lab studies, blood bank draw, ECG, chest X-ray, and consultation averaged 6 hours. Now patients accomplish all of that, and more, in a 75-minute POE appointment.

Dr. Narr and Linda Weise, RRT, the POE Supervisor, were there on the first day and have shepherded the POE through countless evolutionary changes during its first decade. Linda recalls the beginning as the initial processes took form. "The mandate from Dr. Narr was 'No Boundaries.' We tried lots of different things and adopted the ones that worked well. We had total freedom to develop an area that was unlike the traditional model. Our goal was to make the preop process efficient and easy for the patient."

Many of the POE processes that those two and their colleagues developed are unique, both inside and outside Mayo. Visitors from around the world remark that POE staffing models and the flow of patients are truly marvelous. Process changes during the first 10 years include the addition of colleagues from Internal Medicine, the hiring of physician assistants, education of anesthesiology and internal medicine residents, clinical research projects, allergy testing for penicillin, nursing assessment/documentation, and patient education.

POE has succeeded in many areas. Preoperative testing is now more selective and cost effective. Cancellations the day of surgery are essentially zero in patients that go through POE. The flow of patients through the operative day is more efficient when patients have been seen at POE. But all of this pales next to patient satisfaction. Appreciative patients are the true reward for those who work at POE.

Some of the pioneers in establishing and sustaining the POE from left to right: Linda Weise, RRT, Dr. David Danielson, Heidi Walker, RRT, Dr. Brad Narr, Mary Allison, RN.

And the Winner is . . .

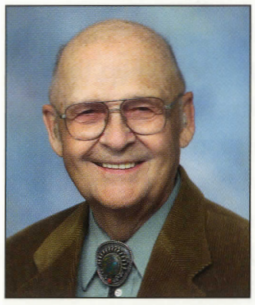
Mr. Steven Jorgensen, Jacksonville, Florida

Granted, it would never be a beauty contest, but winning a contest is how I felt when named the administrator for the Department of Anesthesiology in the summer of 1998. The department had a tremendous reputation for clinical expertise, education excellence, and strong and dynamic research activities. In addition, the department's previous administrators have been some of the most respected individuals at Mayo Clinic. I was the eighth operations administrator for this department. The previous administrators were Hilton Vilen, Ken Smith, John Ostrander, Tom Kokesh, Bill Amery, Jeff Korsmo, and immediately preceding me was Bob Brigham. Dr. Mark Warner, one of the chairs I partnered with, would joke that the administrators seemed to increase in BMI; unfortunately, this is a claim I could not deny. On a positive note, my successor and current administrator, Gwen Amstutz, has broken this trend.

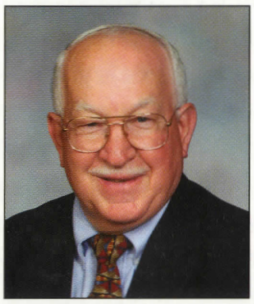
These previous administrators contributed a great deal to the growth and strength of the department that I just inherited. After their assignment with Anesthesiology, they continued to prosper within Mayo and have filled many senior administrative roles including positions with International Medicine, the Mayo Health System, and Jeff and Bob are currently the Chief Administrative Officers for Rochester and Jacksonville, respectively. I know it was not a fluke that they all served in senior leadership roles after their time with Anesthesiology. This department taught my predecessors and me about being focused, effective, and dedicated in whatever we do . . . all while still having fun, supporting one another, and getting the job done.

What a department! In addition to being allowed to work with and learn from gifted and dedicated physician, CRNA, respiratory therapy, technical, and secretarial staffs, these individuals had a desire to make a difference. I can't tell you how enjoyable and invigorating it was to work with clinical staffs that have the ability to collect the important and relevant facts, make a decision, assess the impact, and adjust, if necessary. As an administrator for Anesthesiology, I had the opportunity to be involved in multiple aspects of the practice at Mayo. Anesthesiology was no longer simply in the operating rooms (or surgical lounges) anymore. The Anesthesiology-designed and -directed Preoperative Evaluation Center (POE) was growing at an astounding rate and Mayo Clinic Rochester's first Outpatient Procedure Center (OPC) was designed and operated by the Department of Anesthesiology. The efficiency of the OPC was reported at many levels of the organization, and it became the model for the construction of a new center in the Gonda Building. Other initiatives included the growth of both an outpatient pain clinic and

Administrators for the Department of Anesthesiology.

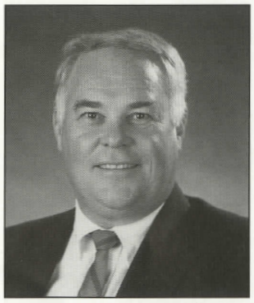


Mr. Hilton Vilen

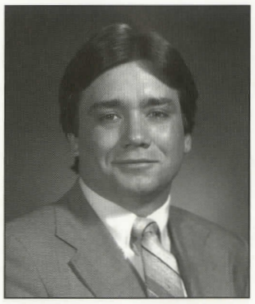


Mr. Ken Smith

Mr. John Ostrander



Mr. Tom Kokesh



Mr. Bill Amery

Mr. Jeff Korsmo

Mr. Bob Brigham

Mr. Steve Jorgensen

Ms. Gwen Amstutz

inpatient pain consult service, establishment of a simulation center and subsequent leadership roles with the institutional simulation center, supporting a growing surgical practice while also becoming leaders in the nation with regional anesthesia, piloting rapid process operation rooms, and developing a fully integrated electronic anesthesia record. What was interesting to me was the fact that many of the issues being instigated by members of the department subsequently became priority issues for accrediting groups like the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Residency Review Committee (RRC). Documented history and physicals and having residents involved in preanesthetic evaluations were already being addressed by the POE Center, protocols for effective inpatient pain management were already in place before JCAHO made this one of their priorities, and prior to the Accreditation Council for Graduate Medical Education (ACGME) and RRC touting the benefits of simulation centers, the department was already involved. It simply showed me that focusing on the needs of the patient will result in doing the right thing. Just to be sure, I checked our invoices for bills from the "psychic hotline," but never found any. Maybe a closer look at the chair's discretionary fund would have been in order.

In addition to a flourishing clinical practice, both the educational and research programs prospered. The Anesthesia Residency Program, multiple fellowship programs, the Master of Nurse Anesthesia Program, and the Respiratory Therapy Program continued to attract the highest quality students and, in the words of one of our educational leaders, "we didn't make them any stupider." Another way to say it is that the learners with the Department of Anesthesiology continued to post some of the highest scores in the country and receive many awards and recognitions at regional and national meetings. The research program also flourished. The level of NIH funding increased, Category I time increased, and members of the department's research efforts were being placed in leadership positions for Mayo.

I don't want to give the impression that everything was a bed of roses or without issues. With a talented and dedicated group of individuals, there always existed strong personalities. Now, if you are thinking, "is Steve talking about me?" I probably am.

There were many red-eared discussions, an occasional pursed lip, and even some good old-fashioned name calling. A former administrator relayed to me that at one of the first meetings he attended, he witnessed first hand these types of behavior. While this somewhat shocked him, what he really remembers is the fact that at the end of the meeting, all parties left the room laughing and joking with one another. This was just their way of getting to the important issues to make a good decision. The department also had a flair for efficiency. An early administrator shared with me that one of his physician leaders saved time by having a stamp that read "bull____." More than once, a memo or request would be returned with this matter-of-fact message embossed over the content. The administrator's job was to try and keep this form of communication within the department and away from Mayo Administration on the 11th floor! I asked the previous administrators what issues they had to face when they were with the department. Staffing, office space, and personalities where mentioned by some, but all reflected that "turnover time" was the main reason cited by surgeons as why more cases could not be completed. If I add "volume variation," we will have two issues for the ages!

Even with the issues and personalities, I am sure all of the former administrators would view their assignments with the Department of Anesthesiology with great regard. It is not often that an administrator gets a chance to work with a talented and dedicated group completely focused on the needs of the patients who also include you as a member of the family. Personally, it was a special time with a very special group of people. While I would not take first place in a beauty contest, I was more than happy to be treated as "Mr. Congeniality" by the department I consider as family.

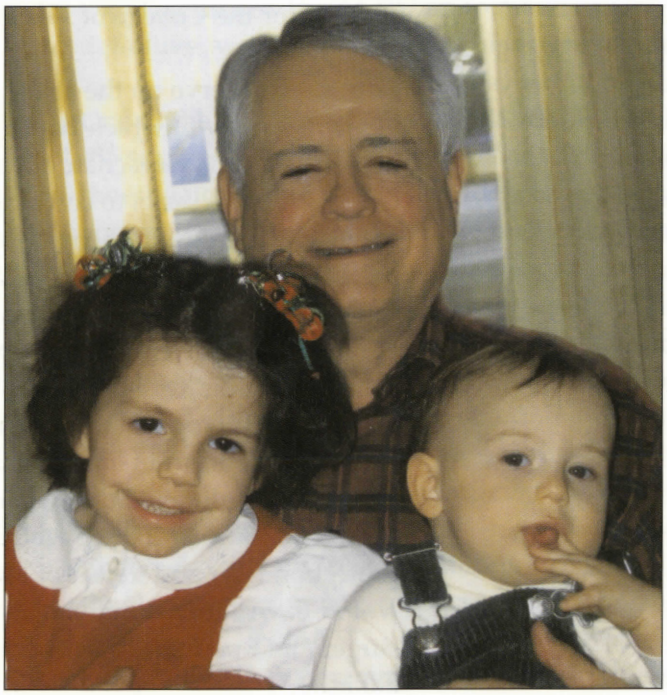
Life After Anesthesiology Practice

James Prentice, M.D., Austin, Texas (Consultant, Mayo Clinic, 1970-1978)

Recently, Peter Southorn asked me to write an article for this newsletter describing some facets of my career after I left Mayo Clinic. Thinking about this, I eventually decided to write about my attempts to lead a successful retirement. Peter jumped at this idea.

Being happily settled in Rochester, we had many misgivings about leaving Mayo, but it was necessary if my wife Linda's career as a pediatric endocrinologist was to progress. We could do this in Austin, Texas, where Linda and I grew up, and the thought of returning there was exciting. Our children would have grandparents, aunts and uncles, and cousins around them; we would be among childhood and college friends; I could practice with my mentors from a 1961 medical school-sponsored externship; and Linda could establish herself in her specialty.

During the first three years I was back in Austin, my anesthesia group had to terminate three former mentors of mine due to age-related physical and/or mental competence issues. These unfortunate individuals all were in their late 60s when retirement was forced upon them. I resolved at that time that I would retire in January, 2002, when I turned 65, hopefully before any committee would call on me to tell me it was time to go. To ensure that there would be no backtracking, I announced my retirement date annually at our anesthesia group meeting. In spite of this, as 2002 approached, I indeed had misgivings. I knew I was still competent, I never had a malpractice suit, I had recently passed the American Board of Anesthesiologists' recertification examination, and furthermore, the economy was in a tailspin. It was apparent that my retirement funds weren't going to maintain the same lifestyle I had enjoyed for many years. Nevertheless, I knew that retiring was the right thing to do. I also knew that I had to be busy in retirement to keep from becoming irrelevant.



Jim Prentice is enjoying his retirement that includes spending time with two of his grandchildren, Ruth and Paul Masters.

So what would I do in retirement?

While in Rochester, I had become involved in various volunteer activities including serving on the board of Community Music, working as a PTA officer in my children's school, and serving in various capacities in my church. This volunteer work lead me to recognize that there were a lot of good and interesting people outside of medicine doing such volunteering that was also rewarding in its own right. With my family and friends in Austin, I envisaged a busy life with civic-, education-, church-, and arts-related activities in our community. I also planned to volunteer my time giving anesthetics to children through the Austin Smiles medical mission program in Mexico and Central America to repair cleft lips and palates. At the time of my retirement, I was serving on the board of directors of a local bank, and I thought this would require more time with committee work. Then, of course, there would be travel, stacks and rows of unread books to tackle, thousands of photographs to cull through to discard or save and catalog, and

hours of Super 8 movie film and various forms of videotape to edit and reformat. There would be gardening which I have always enjoyed, and I had planned to return to the golf course to the game I had given up when I fractured a disk in the Air Force. Finally, I hoped there would be grandchildren.

What have the past five years been like?

First, there has never been a day that I was at a loss for something to do. The books are mostly unread, the photographs, movies, and videos are still in boxes awaiting my attention, and travel has been less frequent than I anticipated due to having less money in retirement and staying busy with other activities. I didn't return to the golf course because, by the time I retired, arthritis in my wrists and thumbs had removed this option. I went on only three medical missions to El Salvador before I realized it was unfair of me to take care of these young patients while at the same time not doing so for the patients back in Austin. The bank got sold and it no longer required my services. But despite these events, I am still busier and happier than I ever thought possible without a regular job.

My hope for grandchildren did materialize, and we have five ranging from one to five years of age. Three live in Austin where their parents both practice law. Linda and I babysit these children often and have lots of fun with them. Our other two grandchildren live in Buffalo, New York, where their mother is a pediatric neurology resident and their father is a mathematics professor. It has been proven that the geographic distance is not too great to prevent us from seeing them and their parents two or three times a year. In addition, the family equation includes our very elderly mothers in Austin. I spend a couple of hours each week with my 96-year-old mother who, while being quite frail, continues to live in her own apartment. My visits entail talking, paying bills, taking her to various appointments, or just having lunch together.

In 2002, anticipating our retirement, Linda and I bought a lake home on an acre of land on Lake LBJ about 60 miles from our Austin home. It has been a source of continuous satisfaction for us to entertain our friends and family at the lake. My enjoyment of gardening has also been fulfilled as I restored the lawn and the flower beds at the lake. Since then it has remained a challenge to keep things looking good at both our home and at the lake through Texas's hellishly hot summers.

My only work for pay in retirement has been a small part-time job in my home monitoring charts of errant anesthesiologists and pain management physicians for the Texas Medical Board. This has given me a little extra retirement income and is incentive to keep my own medical license and, therefore, the necessity to acquire continuing medical education. I am also involved in several University of Texas activities, serving on the advisory council and executive and membership committees for the College of Natural Sciences, on the board of the University of Texas Foundation, and on a select commission charged with making recommendations to be implemented by its 150th year of existence in 2033. In 2002, I had the great personal honor of being the commencement speaker for the College of Natural Sciences.

I continue to serve on the Travis County Medical Society of which I am a former president. Currently, I am chair of its Mediation Committee that seeks to solve disputes between patients and their physicians. Three years ago, I was chair of the statewide gift campaign for the Texas Medical Association Foundation. I have also been able to attend every one of the Texas Medical Association-sponsored days when physicians lobby their own legislators, and I am especially proud of the meaningful tort reform we helped get passed into law in 2003 as well as patient protection laws and defeat of legislation which would have allowed optometrists to perform surgery and podiatrists to operate above the ankle.

For many years, I have served on the boards of the Austin Theatre Alliance which operates two historic downtown theaters and the Austin Symphony Orchestra of which I was vice president for individual gifts two years ago. The retirement activity I've gained the most satisfaction from is serving on the board of St. David's Community Health Foundation which this year gave approximately $12 million to health-oriented non-profit organizations in the Austin and Central Texas area. Work on this activity is almost a full-time job during its funding cycles each April and October. I also serve as a representative from my church on the board of West Austin Caregivers, a faith-based organization of volunteers who drive elderly and disabled people still living independently to their appointments or on grocery and drugstore errands. Each Thursday, I drive a route for Meals on Wheels, and I also help the chef of our church on an as-needed basis to prepare meals for special occasions.

Absolutely the best part of retirement for me has been living without an alarm clock. I've always been a night owl and not a morning person, so getting up to the buzzing of an alarm was for 45 years the worst part of each day. Now it is just wonderful to wake up when I am ready, to have breakfast leisurely with the newspaper, and then get on with my day. It is also nice to be able to attend a daytime lecture at the University of Texas or to see a traveling exhibit at a museum. These and daytime board or committee meetings can be performed without finding coverage from my partners. Likewise, we can visit my mother or babysit the grandchildren on short notice. These are the real perks of retirement.

Would I retire again so arbitrarily?

I think I would. I believe there is a finite time during which physicians perform at their best, and I am glad I retired before I became another "too old" doctor. At first, I missed the camaraderie of the operating room, but I have never missed the ever more complex schedules with earlier and earlier starting times, ever longer days, and less careful pre-admittance evaluation of surgical patients who, during my years of practice, became older, sicker, and/or heavier. Fortunately, the camaraderie of the operating room has been replaced with that of people I do volunteer work with and through other social avenues. I am now about as busy as I was practicing medicine, but with much less stress. It is a happy time. Life is good, and I hope to continue in this way for several more decades.

And there are still books to be read and photographs to be edited.

Mayo Clinic Arizona

David Seamans, M.D., Daniel Cole, M.D., and Leslie Milde, M.D.

Clinical Practice

In 1987, 40 physicians, recruited primarily from Mayo Clinic Rochester, created an integrated subspecialty clinical practice in Scottsdale under the leadership of Dr. Richard Hill. Among these 40 were three anesthesiologists: Drs. John McMichan and Jesse Muir, both from Rochester, and Dr. Kent Weinmeister, a graduate of Mayo Clinic who had been in private practice.

These consultants provided anesthetic care for patients in three locations including the Mayo outpatient surgical facility (constructed in 1990, the first of its kind in Mayo history). By 1989, growth in the surgical workload permitted the anesthesiology section to consolidate their hospital-based work to one hospital. This growth also required the recruitment of several new anesthesiology consulting staff including Drs. Joel Larson and Jeff Lunn.

In 1992, Dr. McMichan relinquished his position as section head and Dr. Lunn was named his replacement. This transfer coincided with anesthesiology being designated a department

Mayo Clinic Hospital opened in 1998.

rather than a section within the institution. Additional staff were recruited which included Drs. Froukje Beynen, Leslie Newberg Milde, Renee Caswell, and John Leslie.

In 1997, Dr. Lunn stepped down as chair of the department and was succeeded by Dr. Milde. By this time, building Mayo Clinic Hospital in Arizona had become an objective of the institution, and in preparation for this, new consulting staff were again recruited. These individuals were Drs. Jeff Mueller, Karl Poterack, Terrence Trentman, David Seamans, and Peter Frasco.

New Hospital

In 1995, Mayo Clinic Scottsdale purchased state land in northeast Phoenix to build a hospital – the first ever planned, designed, and built by Mayo Clinic. The hospital opened in October, 1998, and the Anesthesiology Department began seeing patients in a state-of-the-art operating suite designed and developed with their assistance. Currently, there are 18 operating rooms and up to 10 locations outside of the operating rooms which require anesthesia care. Total surgical volume in 2005 was over 14,000 cases. Anesthesiologists with subspecialty skill were required to work with new surgical disciplines with the opening of Mayo Clinic Hospital. These new anesthesiologists included Mayo graduates Drs. Pamela Mergens, Edward Grayden, and Daniel Simula. Other physicians recruited include Drs. Lopa Misra (Regional), Steven Morzowich (Cardiac), David Rosenfeld (Pain), and Harish Ramakrishna (Cardiac).

The department leadership changed hands again in 2003 after Dr. Milde was named to the Board of Governors of Mayo Clinic Arizona. After an extensive search, Dr. Daniel Cole was recruited from Loma Linda University. Since arriving at Mayo Clinic, he has overseen additional growth within the department, the development of additional subspecialty practices within the department including cardiac and liver transplantation and, with the help of Dr. Caswell, the creation of an Anesthesiology Residency Program which welcomes its first residents in 2007.

Nurse Anesthetists

In 1988, the model of an anesthesia care team was adopted at Mayo Clinic Scottsdale. This model was a fairly novel concept for the Phoenix area where most anesthesiologists practiced without nurse anesthetists. The first certified registered nurse anesthetists (CRNA) to join Mayo Clinic Scottsdale were Pauline Bisel and Jack Hostak, both from Mayo Clinic Rochester. The number of CRNAs has increased to its current number of 34 full-time and 10 part-time anesthetists led by CRNA Manager Chuck Oligmueller. Besides Pauline and Jack, others who can trace their origins to Rochester include Jane Brady, Joe Enright, Patty Fowl, Mary Laney, Robin Needham, Ellen Schoenbeck, and Mark Tiede.

The Pain Clinic

With the opening of Mayo Clinic Scottsdale, Drs. Weinmeister and Muir began treating patients who had acute postoperative pain, chronic pain, or cancer pain. In 1992, a Pain

Clinic was created adjacent to the ambulatory surgery center. Dr. Weinmeister was appointed as the first head of the Pain Clinic, and Dr. Muir succeeded him in this position in 1997. Currently, the staff of the Pain Clinic comprises the current director, Dr. Trentman, and Drs. Caswell, Seamans, Muir, Weinmeister, and Rosenfeld.

The Preoperative Medical Evaluation Clinic (POME)

Originally, Dr. Larson was the only physician working in this area but was gradually joined by other members of the department. In November, 1997, Dr. Susan Hagstrom, an internist, was appointed medical director of the POME Clinic. Her contributions have added a valuable dimension to patient care provided by the Anesthesiology Department. Additional staff have been added including Dr. John Demenkoff, a pulmonologist, and Bill Religo, a physician assistant.

Critical Care

In January, 1997, Drs. Lunn and Larson founded the Department of Critical Care. The critical care unit at the new Mayo Clinic Hospital has two 10-bed pods for patients who require critical care and an additional 10-bed pod for patients who need intermediate care. The Department of Critical Care has continually grown under the dedicated direction of Dr. Larson.

Education

In the late 1980s, residents from Rochester started rotating to Scottsdale. These rotations in Scottsdale included various subspecialties and soon became popular. In 1992, the Residency Review Committee approved Mayo Clinic Scottsdale as an integrated institution, allowing residents to spend more time in their training in the department with the approval of our own residency. We look forward to welcoming our first class of residents in the summer of 2007. The Residency Review Committee for Anesthesiology approved a fellowship program in pain medicine which became effective in 2000. We have had several superb pain physicians graduate from this program.

The department continues to support residents rotating from other Mayo sites and other institutions, primarily the University of Arizona in Tucson. Likewise, medical students rotate through the department on a monthly basis taking advantage of the wide range of cases offered at the hospital.

Future

In the 20 years since its inception, Mayo Clinic has become firmly established in the southwest with over 100,000 patients treated in 2004. For the 6th consecutive year, the hospital was recently again named the number one hospital by consumers in the Phoenix Metropolitan

Standing from left to right: Drs. Harish Ramakrishna, John Leslie, Steven Morozowich, Terrence Trentman, Daniel Cole, John McMichan, Jesse Muir, Karl Poterack, Kent Weinmeister, David Seamans. Sitting from left to right: Drs. Lopa Misra, Renee Caswell, Leslie Milde, and Froukje Beynen. Missing: Drs. John Demenkoff (POME), Susan Hagstrom (POME), Pamela Mergens, Jeff Mueller, Dave Rosenfeld, and Daniel Simula.

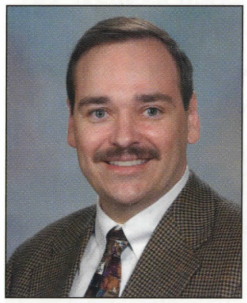
area. Currently, Mayo Clinic Arizona employs 332 physicians and scientists. Construction is nearly complete on a 172,000 square foot specialty building adjacent to the hospital that will house surgical specialties, Radiology, the POME Clinic, and Radiation Oncology. Construction has just begun on an additional two floors at the hospital which will bring the number of inpatient beds to 280. Other current projects include the expansion of the Emergency Department and the hospital dining room. On the Mayo Clinic campus there are two dedicated research buildings conducting basic and clinical research in a wide variety of disciplines.

These are exciting times for Mayo Clinic Arizona. The Department of Anesthesiology wishes to thank all who have devoted their lives to building Mayo Clinic Arizona and advancing the Mayo mission in the southwest. We look forward to working with our colleagues in Rochester and Jacksonville as we sustain the excellence in patient care that we are known for while achieving our goals in research and education.

Anesthesia Clinical Research Unit

Curt Buck, CRNA, RRT, and Wayne "Nick" Nicholson, M.D., Pharm.D.

Mr. Curt Buck



Dr. Wayne "Nick" Nicholson

Beginning in 1992, a group of clinical staff dedicated to the establishment of a clinical studies research program in anesthesia and critical care started developing what eventually became the Anesthesia Clinical Research Unit (ACRU). From its beginnings with one RN searching through thousands of anesthesia records for data and a few physicians stealing time from their families to analyze the data, the ACRU has grown to become a robust research unit supporting anesthesiology- and critical care-based clinical research. Joining other resources devoted to performing clinical trials in the intensive care units has aided this growth. Under the medical leadership of Dr. David Warner, the ACRU now includes a permanent staff of nine clinical study coordinators and a part-time biostatistician. This multidisciplinary group includes a CRNA, respiratory therapists, and registered nurses. Curt Buck serves as the Associate Director of the ACRU managing its daily activities.

Together with physician investigators from the clinical ranks of the Department of Anesthesiology and Mayo critical care practitioners, the ACRU performs a wide range of clinical research. In addition to supporting both critical care and anesthesiology quality projects such as the APACHE database, the ACRU is currently managing 21 active research projects. These projects include Mayo's participation in the ARDSNetwork, a NIH-sponsored group of institutions performing multicenter trials into therapies for the management of patients with acute respiratory distress syndrome. The ACRU also supports projects funded by extramural grants on transfusion-related lung injury, the impact of periopertive beta blockers in elderly surgical patients, and smoking cessation in the perioperative period. A Mayo-funded project studying the use of gabapentin as part of a postoperative pain regimen in thoracotomy patients has just joined several other Mayo-funded studies into various facets of perioperative care. Drs. Juraj Sprung and Fran Whalen are leading a group investigating the impact of various ventilation strategies on the prevention of perioperative lung injury and atelectasis.

Using the efficiencies gained by a group of dedicated research staff, the ACRU also supports unfunded projects designated by the department research committee as worthy of support. These are usually chart review studies that often serve as springboards for further investigations into important clinical questions. A current example of this type of research is a project conceived by Dr. Jim

Staff of the Anesthesia Clinical Research Group front row left to right- Shonie Buenvenida, RN, Lavonne Liedl, RRT, Dave Folkert, RRT, Steve Holets, RRT, Back Row left to right- Curt Buck, CRNA, RRT, Anita Baumgartner, RN, Melissa Passe, RRT, Greg Wilson, RRT. Not pictured, Laurie Meade, RN.

Hannon who thought that he noticed an increase in cardiac-related morbidity in patients who had left ventricular hypertrophy (LVH) on the preoperative ECG. Currently, Dr. Hannon and the ACRU team are reviewing 450 cases to look for evidence of a relationship between LVH and increased perioperative morbidity and mortality. If signs of a relationship are found, this project will lead Dr. Hannon and the ACRU on to more definitive work on the findings.

One of the primary purposes of the ACRU is the support and development of new clinical investigators. The ACRU provides the support and guidance for clinical staff with important research questions but little experience in the complex regulatory research environment and the practical aspects of getting a project done in a busy clinical setting. Dr. Michelle Kinney is a good example of a young investigator who is leading the Mayo-funded gabapentin project as her first foray into large-scale clinical research. External research funding is extremely difficult to obtain, and the hope is that by developing investigators with a proven track record, the ACRU will help make them competitive in the extramural research funding processes.

Expansion of departmental clinical research is one of the goals of the ACRU. In this regard, research that focuses on new therapies is often expensive and requires adequate staffing. One mechanism for expansion of these research efforts is to form select industry partnerships. These collaborations offer several advantages to our department including access to new compounds, providing additional research and publication opportunities to our staff and residents, and the ability to seek funding for the ACRU. Recognizing the need for further development with industry-sponsored trials, Drs. Mike Joyner, Mark Warner, Brad Narr, and David Warner worked with Mayo administration to create a position for a clinical pharmacologist to join our staff to facilitate pharmacologic projects within our department. Recently, Dr. Wayne "Nick" Nicholson has accepted this position and is actively working on obtaining new industry-sponsored clinical projects in addition to working on the General Clinical Research Center with Dr. Joyner and his lab.

An example of a recent industry partnership is collaboration with Organon by Drs. Juraj Sprung, Chris Jankowski, and Nick Nicholson with an intraoperative sugammadex study. Sugammadex is a novel cyclodextrin compound used for the antagonism of steroidal

neuromuscular blockade. The clinical efficacy data gathered by our department for this unique agent is quite promising. Projects of this type allow our department to work with cutting-edge compounds while providing funding for our staff. There are several other industry partnerships on the horizon. Drs. Sprung and Hofer are currently working along with Hospira to explore some additional uses for dexmedetomidine. Dr. Flick is in the early stages of assisting Organon with gathering additional pediatric information on rocuronium. Dr. Mike Hooten has been working along with Eli Lilly and Pfizer to design studies that may be implemented in the Pain Rehabilitation Center. These new collaborations, combined with past ACRU experience, will continue to accelerate the future growth of anesthesia research.

Working at Mayo

Richard Lundborg, M.D., Hilo, Hawaii

In late June of 1962, as I drove toward Rochester from my recent U.S. Army posting at Fort Lewis, Washington, I thought about the challenges ahead as a newly appointed anesthesiology resident in the Mayo Clinic program. Would I enjoy my training and would I measure up as an anesthesiology specialist?

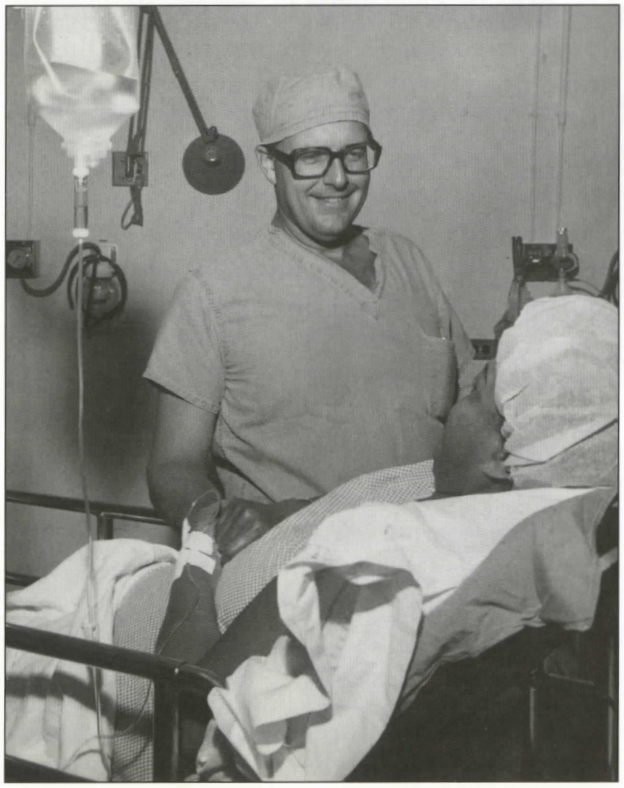
My medical experience during the three years of my Army duty had been quite interesting and varied. It included a "rotating internship" at Tripler U.S. Army Hospital in Honolulu for one year, spending three months each on the medicine and surgery services and two months each on the pediatrics, Ob-Gyn, and anesthesiology services. In the latter, I had used ether (both open drop and vaporized with nitrous oxide), ethylene, cyclopropane, and pentothal, and did many spinals and a few caudal epidurals. During the Ob-Gyn rotation, I had delivered over 60 babies and given many "saddle blocks" and a couple continuous caudal blocks. Army anesthesiologist, Bob Weaver, had urged me to consider anesthesia as a career.

Dick and JoAnn Lundborg and their children in their Rochester home, 1971.

Arriving in Rochester, I checked in with Dr. Albert Faulconer, Jr., the chair of the department. Dr. Tarhan, another new resident, and I were assigned to Dr. Tom Martin at the Methodist Hospital. He was to be our primary mentor during our initial training. The first thing he told us was to "forget everything we ever knew about the administration of anesthesia" and learn HIS WAY. Later he would say, "When you have been exposed to every other mentor, develop your own system that is best for you." The clinic ran full operating schedules six days a week. After Tom Martin had decided we were ready to move on, we then rotated with other anesthesiology staffers at Methodist including Al Gould, Charlie Restall, Paul Didier, Paul Leonard, and Tom Seldon. At Saint Marys Hospital, I was mentored by Emerson Moffitt, Robert Devloo, and Alan Sessler in cardiovascular anesthesia, Bob Jones in diagnostic and therapeutic pain blocks, Virginia Hartridge in obstetrics, Brian Dawson in pediatric surgery, John Paulson and Norbert Schnelle in general and orthopedic surgery, and Jack Michenfelder, Ed Daw, and Howard Terry in neuroanesthesia.

In the fall of 1962, the "Cuban Missile Crisis" caused Mayo Clinic Administration to generate a letter stating that in the event of nuclear war, the Lundborg family was assigned a small space in one of the corridors of the Mayo Building to be used as a temporary shelter. In the meantime, my wife, JoAnn, and I had purchased a small rambler near Elton Hills School. JoAnn was now busy with a teaching job in the Rochester school system and looking after the first two of our three children. That year was also an election year, and I had always been interested in politics. Because of President Kennedy's handling of the "Bay of Pigs" invasion, which occurred during my Army stint and involved several of my officer friends from my unit, I decided to work for the Republicans. I became a "block captain" for the GOP, active in the Young Republicans, and worked my way up in the party to "alternate delegate" at the State GOP Convention.

In the summer of 1963, I spent three months rotating through the anesthesiology department of the Los Angeles Children's Hospital. This was an elective rotation at that time. Under Dr. Digby Leigh's guidance, the department trained about six fellows each quarter from around the country and from Canada, Dr. Leigh's original home. It gave me considerable experience with newborn anesthesia. Back in Rochester in the early fall, I began my rotation through the Worrall Hospital. It was the site of the vein surgery service in the morning and proctologic service in the afternoon. I was busy doing caudal blocks on that fateful afternoon in the fall of 1963 when we heard over the radio in the nurses' lounge that President Kennedy had been assassinated.



Dick Lundborg taking care of a patient in Hawaii.

For the last six months of my residency, I returned to Saint Marys Hospital to work in neuro, cardiovascular, and pediatrics and to do pain blocks. During the end of my cardiovascular rotation, Dr. Emerson Moffitt, the head of the Saint Marys Hospital anesthesiology section, invited me to join the cardiovascular anesthesia staff team provided I took an additional year of training. This I did and I joined the staff officially in July, 1965, working with Emerson Moffitt, Alan Sessler, Bob Devloo, and Sait Tarhan exclusively until 1969 when Dr. Moffitt asked me to take over the obstetrical anesthesia duties and introduce a regional block program. I agreed to do this for a three-year trial.

I arranged to visit Dr. Jim Evans at Grady Hospital in Atlanta and Dr. Brad Smith at Jackson Memorial in Miami. Jim was a friend from the Midwest Anesthesia Resident's Meetings who was a pioneer in continuous epidural blocks. Brad was active in obstetrical anesthesia and had a special interest in infant resuscitation. Their input was very helpful as I began to organize the obstetrical anesthesia service at Saint Marys. Continuous epidural block was becoming very popular with patients because of its remarkable labor pain-relieving capabilities and its low incidence of side effects. Dr. Rungson Sittipong was the first resident I trained in obstetrical anesthesia, and he contributed immensely to the early round-the-clock coverage of this service.

In 1971, near the end of my three-year commitment to obstetrical anesthesia, I received a contract offer from the Hawaii State Department of Health to become the first anesthesiologist on the island of Hawaii (the Big Island) and to organize the anesthesiology department, the emergency medical services, and the respiratory services in the existing five hospitals. The main hospital was located in Hilo, but the fast growing area of Kona needed major attention, too. After a visit to check out the situation

there, JoAnn and I decided to accept the offer. I resigned from Mayo, and on January 1, 1972, began my work on the Big Island. By the end of 10 years, the organization was complete, the contract was terminated, and I became more involved with medical politics.

In 1986, because of the worsening medical malpractice situation in the state and because I had just come through a six-year malpractice case along with several other physicians who had NEVER seen the patient in question, I took a sabbatical leave to work at the Hawaii legislature with the Hawaii Medical Association. During this effort, I was warned by a top malpractice lawyer, a former legislator, that they didn't like what I was doing there (i.e., testifying for tort reform) and if I ever went back to my practice in Hilo, they would "keep their eyes on me and make me toe the mark."

Later in the session, the Republican Party in Hawaii asked me to run for the State Legislature. They had a great candidate running for governor, and I concluded that even if I did not win, I could campaign hard for this excellent candidate. Upon losing my race and our candidate losing in the governor's race, it came time for a decision regarding my anesthesiology career. JoAnn and I decided to continue working in politics which we did for eight more years. That is another story. But the lesson here is physicians must stay involved in the political process. Every special interest in the country is hard at work getting their views before the elected officials. Physicians are trained to solve problems and they make difficult decisions every day. In my view, they make superb legislators. I urge every physician to get involved and stay involved in whatever manner suits his/her situation.

A Road Less Taken: Dr. Brian Richardson

Brian McGlinch, M.D.

CPT Brian F. Richardson, M.D. (right) is sworn into his commission with the United States Army Individual Readiness Reserves by Brian McGlinch, LTC, MC, USAR.

Brian Richardson, M.D., has finally begun his training in anesthesiology! What makes Brian's story remarkable is the path he took to get here. After graduating from Loyola in 2001 with an Army scholarship, Brian was assigned to Tripler Army Medical Center in Hawaii for his internship year. During that time, the Army offered Brian an opportunity for anesthesiology training in one of the military residencies. Brian declined the offer because he had been offered a position in the Mayo anesthesiology residency to begin when his Army obligations concluded. Maybe he should have taken the Army up on its offer.

At the conclusion of his internship, the Army assigned Dr. Richardson to a base in Germany as the General Medical Officer responsible for several hundred soldiers. These soldiers (and their General Medical Officers) were some of the first soldiers and medical personnel reaching Baghdad during the 2003 invasion. Brian spent 12 months in Baghdad functioning as a physician with the Army caring for our United States military personnel as well as the sick and injured Iraqis. Upon completion of this tour, Brian returned to Germany, but on his fourth day there, the Army emergently reactivated Brian's division due to the sudden spike of insurgent activity and sent the troops back into Iraq. Brian spent another three months in the war zone before finally completing his rotation and returning to Germany. Brian, being the remarkable person he is, always accentuates the positive aspects of this experience although many of us would find reasons to complain.

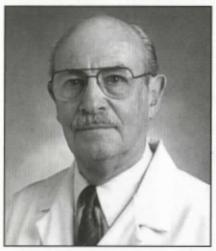
Please take a moment to thank Brian for his contributions to our military and our department (richardson.brian@mayo.edu). Few have faced such significant consequences for their desire to train with us.

Mayo Clinic Alumni Reception at the ASA Annual Meeting

Mayo Clinic Anesthesiology Alumni reception held in Chicago on October 14, 2006. This event was extrordinarily successful and enjoyed by all who attended. Photographs courtesy of Drs. Brian Hall and Mary Ellen Warner.

News about People

Peter Southorn, M.D.

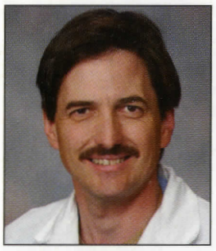


Dr. Maurice Albin

The University of Alabama recently honored **Dr. Maurice Albin** for his numerous contributions to our specialty by establishing the Maurice Albin Professorship in Anesthesiology.

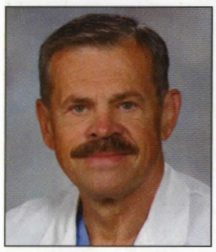
Dr. Steven Rose

We are pleased to announce that **Dr. Steven Rose,** the Chair of our Education Division, has been named Vice Dean of the Mayo School of Graduate Medical Education. He will be joining Dr. Mark Warner who is the Dean of the Mayo School of Graduate Medical Education. This appointment brings much credit to Steve and also indirectly to the success of our residency program.



Dr. Keith Berge

We congratulate **Dr. Keith Berge** on his election by the staff of Mayo Clinic Rochester to represent them as a Councilor for Surgery and Surgical Specialties. This election was held on Thursday, November 16, 2006.



Dr. Robert Lennon

Dr. Terese Horlocker

Congratulations are due to **Drs. Robert Lennon** and **Terese Horlocker** and their colleagues in Orthopedic Anesthesia who received an award at the 2006 Medical Book Awards ceremony held by the American Medical Writer's Association. Their book, *Mayo Clinic Analgesic Pathway: Peripheral Nerve Blockade for Major Orthopedic Surgery*, was given an honorable mention.

At their recent meeting, the Illinois Society of Anesthesiologists awarded their guest speaker, **Dr. Terese Horlocker,** with the William O. McQuiston, M.D., Award for her outstanding professional and scientific contributions to the practice of anesthesiology.

Dr. Denise Wedel

Dr. Denise Wedel has received the Malignant Hyperthermia Partnership Award for 2006. The Malignant Hyperthermia Association of the United States (MHAUS), in making this award, recognizes malignant hyperthermia hotline experts. Dr. Wedel deservedly received this award for her assistance with a particular case that was called into this hotline.

Dr. Davud Warner

Dr. Michael Joyner

Drs. David Warner and **Michael Joyner** are among the leaders of a major institutional effort which recently lead the National Institute of Health (NIH) to award Mayo a $72 million 4-year grant to conduct clinical and translational research.

In the last newsletter, we failed to point out that the four residents graduating from the Jacksonville Anesthesiology Residency program, namely, **Drs. Stephen Aniskevich, III, Raquel Buser, Teresa Cherry,** and **Christopher Robards,** were the first such residents to graduate from the Jacksonville program. We would like to congratulate these residents again on their graduation and also congratulate the Jacksonville program for such a significant first.

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