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From the Chair

Bradly Narr, M.D.

Welcome to this edition of the *Mayo Anesthesiology Alumni Newsletter*. Dr. DeElla Ray has put together a fantastic primer for residents seeking any job, and the details provided make her article "required reading." This article will be a reference to many for years to come. The teaching capabilities of the department have recently been greatly enhanced with the opening of the Mayo Clinic Multidisciplinary Simulation Center, and Dr. Laurence Torsher, our leader in the field, describes this important event and the work of the center. Dr. Ron Faust has a Porsche passion. His impeccable logic and counsel should allow any of us to make a case to wives, loved ones, and most notably ourselves about the positive financial and spiritual return of these investments. Dr. Scott Atchison provides us with a very nice historical review of Mayo Clinic West, and I am indeed honored to function as the titular chair of Anesthesia Physicians Limited! Dr. Steve Rose includes an update on our training and education programs. Finally, the newsletter is initiating a "Letters to the Editor" section.

Please do not hesitate to contact us. We are always looking for new contributions. Any letters sent to the attention of this publication will be read by our team and action taken.

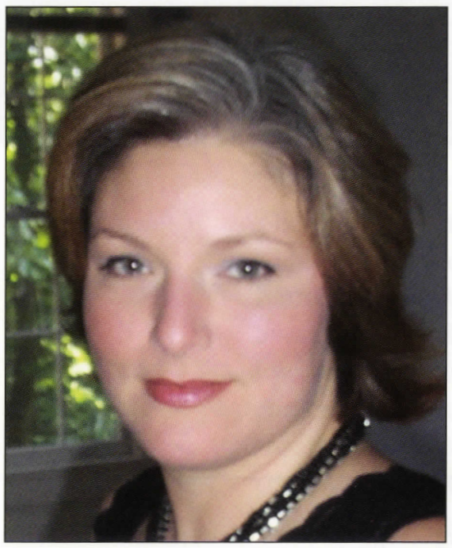
Editor's Note

Peter Southorn, M.D.

A personal thanks to the contributors of this edition. This issue is rewarding due to you. Two innovations occur with this edition—we are publishing an interesting letter we received and we are printing the newsletter in color—the latter all the better to show off those Porsche cars! As Dr. Narr says, please keep the correspondence coming.

Getting Established in Private Practice

DeElla Ray, M.D., Hot Springs, Arkansas



Dr. DeElla Ray

I was recently asked by Dr. Southorn to write an article for the anesthesia residents giving some pointers on how to go about establishing oneself in private practice. Compared to academic medicine, there are some unique aspects to private practice. Most of these derive from the sheer diversity of private practice models. That incredible heterogeneity means that there are a lot of decisions that you'll need to make, so even in the CA-2 year it is not too early to start thinking about life after residency. You need to decide what type and size of private practice setting you desire. Do you want a "physician only" group, providing all your own anesthetics? Are you comfortable with a mix of doing your own cases and supervising anesthetists? Do you want to primarily supervise CRNAs?

Would you rather be in the big city or will a mid-sized community work best? Are you geographically limited to a certain area of the country? Do you want to work at a hospital where all types of cases, including complicated pediatrics and obstetrics or trauma, are performed? Not all complex cases are done in large academic centers. Are you looking for a single-specialty practice such as only cardiac or neuro-anesthesia? Are you just looking for a place "to land" for a while or are you hoping your new job takes you all the way to retirement? The first step in your job search is to honestly answer some of these questions. Knowing what you want will help you get what you want.

By now you have searched gaswork.com dozens of times. But there are a lot of other sources of job information. Just to name a few, I have used merritthawkins.com, deltamedcon.com, locumtenens.com (which contains permanent as well as locums positions), gasjobs.com, comphealth.com, and many more. Some job listings can be found in the back pages of *JAMA, Anesthesiology,* and other medical practice journals. The ASA Web site and some state medical boards will also post job openings. Your Mayo consultants often communicate with former residents and may be able to help you "network."

Instead of waiting for the job you are looking for to present itself, you can easily take steps to flush it out. Use state hospital association Web sites to locate hospitals (and grade them) and clinics located in areas you want to work. Then use the individual hospital Web sites, state medical board Web sites, and ASA delegate listings to locate the appropriate contact people. (This is a good idea no matter what path you choose to become gainfully employed.) The information gleaned from these searches can help you build a good base of information about the practice, the hospital, the people, and the community. If an interview follows, you will have a lot to talk about.

No matter which route you take to locate a job, at some point you are going to have to pick up the phone. The first contact with a potential employer is always stressful. Prepare yourself. Get out some paper and make a list of questions you want answered. Really think about this list. Be thorough and complete. There are 900 jobs on gaswork.com alone. You don't have time to fret over the ones that won't really work for you.

Below are some of the things I think are important to consider.

The List

What is the working environment of the job you are considering? Will you be doing anesthesia for neuroradiology, cardiac cath lab cases, cardioversions, ECT, or work out of a litho van in the parking lot? Are you expected

to manage the ventilators or place all central lines in the ICU? Are you staffing a preoperative clinic? You need to know what will be expected of you if you join this practice.

What is the acuity of the patients? Are they primarily ASA 1 and 2 or do you have a fair percentage of ASA 3 and 4 patients? Are patients generally worked up well prior to OR time or are you functioning as a primary care clinic physician as well as an anesthesiologist?

Are you respected as a member of the medical community or is your job as an anesthesiologist viewed as a "para-professional surgical adjunct." For example, do you have the authority, when necessary, to veto a case when you feel the patient is not medically optimized for the proposed surgery? Carefully phrase this so it doesn't look like you are out to perform indiscriminate cancel-ectomies. This really can be a touchy issue when there is more than one hospital or anesthesia group in town.

Consider your work hours and how they will compare to the other members of your group. Is your call schedule on par with everyone else's? Are some members never on call? Are you okay with that? Are the weekends divided up fairly? Does the call schedule tighten up every time someone goes on vacation? Some groups will quote, for example, call responsibilities every fourth night except when someone is on vacation. That could mean that for half of the year the call schedule is really every third night. Are you off post-call or just "early out?" Will you be taking in-house call or beeper call from home?

Lots of groups advertise large salaries. The devil is in the details. Many times, these high salaries include the dollar amounts of the benefits. Depending on the benefits, the difference between what is advertised and what is offered can be substantial. Make sure you know the amount of actual working salary. This amount is generally negotiable. What is the raise schedule? Is it every year or not until partnership? Is there a buy-in and, if so, is it tied to the first few years of practice at more work and less pay? It is not unheard of for groups to promise wonderful things at partnership and then never deliver. How many people have left the group in the last five or six years and how many of those were partners? What is the projected growth in income and workload over the next several years?

Most, but not all, groups will offer some type of retirement package. Will you be eligible to participate right away? What is the vesting schedule? Is the plan a 401k that has the added benefit of profit-sharing, and if so, how much has been invested in recent years. Is the plan self directed or limited by the trustee?

Disability insurance is often part of the benefits package. If it isn't, obtaining coverage is a personal decision, but I do recommend it. Medical, dental, and sometimes vision coverage for yourself, spouse, and dependents is fairly standard but won't come close to what you are used to at Mayo. When malpractice insurance premiums are included, a group's benefits sometimes can make up for what looks like a lower salary. Total benefits can often add up to between $60,000 and $80,000 a year.

You must become familiar with malpractice insurance. What kind of coverage are you getting and who pays? An occurrence-based policy covers you for any act committed during the time of coverage regardless of when the claim is filed and is the more expensive of the two types of policies. The other, claims-made policies, offer coverage for acts committed during the coverage period as long as the claim is also made within the coverage period. You can see the problem with that type of policy immediately. Claims-made policies require tail coverage, an additional policy or "rider" that has to be added if you terminate your coverage with the company that originally issued your claims-made policy. Tail coverage is expensive and goes up every year you practice until year 5! I could buy a car for the nearly $20,000 I would have to pay if I needed tail coverage today. If your group isn't going to buy occurrence-based insurance, you

should negotiate who has to pay the tail coverage should you decide to leave your job. Insurance is complicated and very important. Get copies of your paid-up, active policies before putting your hands on a patient. Every state has an insurance regulatory department that, along with the state medical board, can answer your malpractice insurance questions.

These days a lot of groups are offering sign-on bonuses. Nice, but be careful. More and more, the sign-on bonuses and even the typical $10,000 moving bonus are being paid for by the hospital in an effort to attract qualified anesthesia candidates from a dwindling applicant pool. This almost always obligates you to serve not just the anesthesia group, but also the hospital for a defined amount of time. If the hospital foots the bill for a sign-on bonus, you can expect a fat packet of papers from their legal department. Make sure you know who pays the sign-on bonus and how much of your life you are selling.

Consider that a job offering ten weeks of vacation with no post call days off may not be as good as a job offering six weeks of vacation with post call days off, especially if the call burden is high. If time is money and vacation and post call days are time--well, do the math. Keep that in mind when you compare jobs. Continuing medical education time and vacation are often grouped together. You will likely be expected to maintain ACLS, NALS, etc., on your own time. Can you take vacation a day at a time or a week at a time? Will you have bookend weekends free? This, as you know, turns five days into nine and can mean more time on a warm sunny beach sipping your favorite beverage.

Of course you will have no trouble obtaining your ABA Board Certification because you are a highly qualified, Mayo-trained anesthesiologist. It never hurts, though, to find out exactly what the group's stipulations are. Are they going to show you the door in three years if you don't get board certified or, more commonly, will it be after five?

If the group works with CRNAs, whom do they "belong" to? Are they employees of the group or the hospital? This can influence working relationships. How well do the MDAs and CRNAs get along? Is there underlying hostility, or passive/aggressive behavior? Will you work with students from any program, i.e., CRNA, respiratory therapy, or EMT?

Before you spend all your energy hammering out a great contract with a group, make sure the group has a recently negotiated contract with the hospital that isn't going to expire the day after tomorrow. What if the group you sign up with gets fired or replaced by the hospital after you've plunked down your whole family and all your belongings in this new place? That stuff really happens! Seeing is believing, so ask both sides to show you the contract.

Contracts often have professional restrictions written in to protect the hospital and the group. These are usually non-compete clauses and sometimes other restrictions that can be more far-reaching. Know the extent of the non-compete clauses. Will you be prevented from engaging in locums coverage if you desire? More importantly, will you have another option for employment or will you have to move if this job doesn't work for you? Read the language carefully.

After working so diligently to find and cultivate a job, it's hard to imagine that you need to engineer an escape plan. Getting out of your group and hospital contracts is tricky especially if you received a sign-on bonus for a minimum time commitment. You can try to prorate the bonus for "time served." Obviously this is in your best interest, but commonly, the involved parties expect all the money back and sometimes with interest. Sixty- to 90-days written notice of intent to resign is fair. Personally, I try to negotiate a 60-day "out" clause and a prorated bonus with no payback of moving expenses. Tail coverage will be an issue, too, if you have a claims-made malpractice policy. But don't forget an escape clause

works both ways. You could find yourself on the receiving end of an intent-to-terminate letter. This is what helps sell the paragraph to the potentially-reluctant parties and keeps everybody honest.

Planning Your Visit

Your prospective group, usually along with hospital administrative personnel, will arrange an itinerary for you. If you have the names of people you are supposed to meet, get some information about them. It never hurts to know a bit more about the people you have to impress. Behave as if you need to impress everyone because you do. The secretary who offered you coffee or the volunteer who pointed the way may have a direct line to administration.

If practical and not already arranged, ask to meet with the hospital CEO. Try to get a sense for how each "side," administration and the anesthesia group, feels about the other. This is hard to do in a first visit, but sometimes you can find clues. Is administration happy with the services and scope of practice provided by the group? Have there been any complaints by the surgeons about the anesthesia group? Does administration know of any pending malpractice claims against the group? How long has the anesthesia group had a(n) (exclusive) contract with the hospital?

Remember to bring a set of scrubs and some shoes. Try to spend at least half a day in the OR. See how smoothly things run. Does the schedule "move?" Can they actually get cases done, or do you see the same total knee listed four hours later? Ask how late they finish up on any given day. How many cases were added the day before? How many overnight cases were done? Were they really emergencies or for the surgeons' convenience? What was the total case count for the day? Did it take 16 hours to do 20 cases? Talk to the people who work in the ORs, other MDAs, CRNAs, AAs, etc. Do they appear to enjoy their jobs? Are they congenial and collegial? A colleague of mine tells the story of being literally pulled into a broom closet at one interview and warned in whispers about how miserable the situation really was at that hospital.

Ask for the names of anesthesiologists who have recently left the group. Form your own opinions and then call people who used to work there. Usually, you can find these people on the ASA's Web site in the delegate directory and then track them to a particular hospital with a few internet searches. During the negotiation period for my present job, I tracked down and called a former employee who is now living in Alaska!

Most itineraries will have time built in for you to tour the community, usually with a realtor. Keep in mind this person has been hand picked by the hospital to show you the best parts of town. Get out on your own and see the not-so-great parts of town, too. Really imagine having to buy groceries, get gas, send your kids to school in this community. Are you and your family going to be happy living there?

Go home. Assimilate all the information you have gathered. Talk to family members, colleagues and mentors. Review, revise, and update your list of questions. Call back to clarify lingering issues.

Soon you will be receiving your contract proposal in the mail. There are a whole bunch of ways to get the short end of the stick in your new job. It's not personal. It's business. Your prospective employers are out to make the best deal they can for themselves and you are an expensive proposition. My best advice for you at this point is get it in writing and get a lawyer. Typically, the fee charged by contract lawyers to review your document ranges from $500 to $1000. If you need to revise some of the content, you may pay a little more but it will be worth it and it's tax deductible. You can bet your Rice Krispies the hospital and the group have their lawyers working for them, so put one to work for you.

For those of you who knew all this stuff already, hooray for you! Personally, I didn't know the first thing about getting an anesthesia job when the time came to actually get one. I was too busy worrying about passing the boards and finishing residency. I learned all this on the fly and some of it the hard way. I weeded out hundreds of jobs and talked to a truckload of recruiters and anesthesia groups in the southern half of the US. Finally, I chose three to visit. I was offered contracts at all three places. Basically, I had my pick of my pick. Not a bad place to be just after residency. More recently I decided to move closer to home and went through this whole process all over. Again, I got the job I wanted and so far I couldn't be happier. I wish you the best as you begin your transition from resident to real life. Life is good.

Our Department has become an Active Participant in Simulation Training

Laurence Torsher, M.D.

Modern adult learning theory suggests that participants acquire knowledge more effectively if they are actively involved with the educational activity. In contrast, didactic presentations with learners passively listening tend to be less effective. The American Heart Association has enthusiastically embraced this concept. An Advanced Cardiac Life Support (ACLS) course taken five or six years ago was lecture-based whereas today it consists of a series of cases that a small group works through together. Many medical schools throughout North America, including the Mayo Medical School, are moving away from a lecture-based curriculum to one that has more emphasis on working as a team to solve problems.

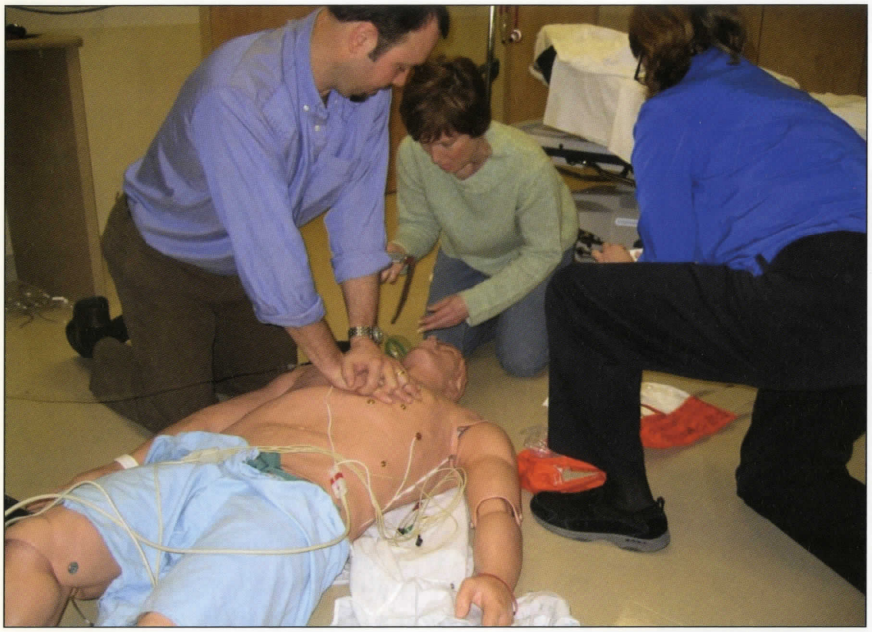
At the start of the day, Dr. Laurence Torsher describes to the participants what will occur throughout the day, what the rules are, and some of the background of the center and simulation concepts (see text).

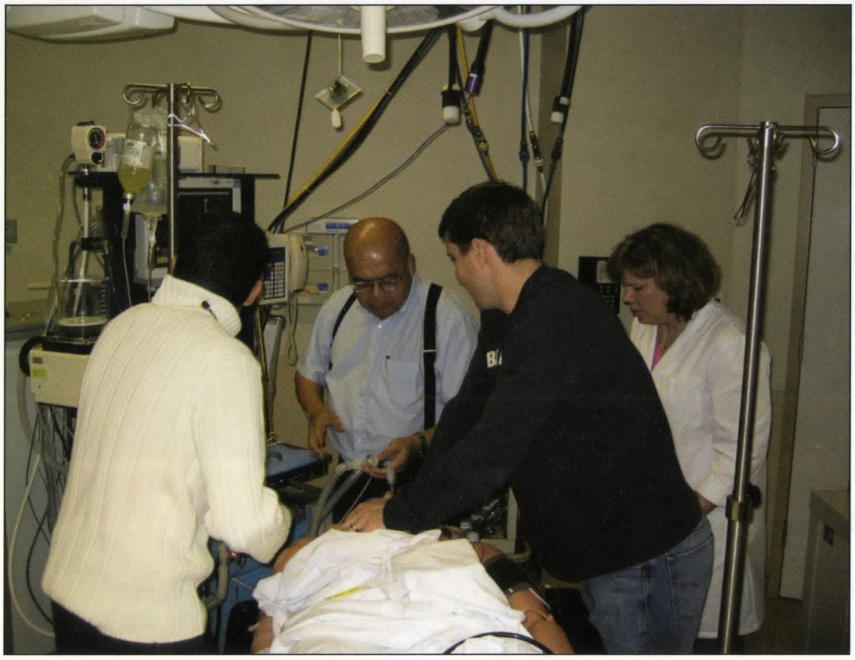
Postgraduate anesthesia training at Mayo has traditionally had a strong educational component that, although including a didactic portion, placed emphasis on hands-on experience in a supervised setting. The challenge with that system was and is getting all of the trainees exposed to a similar breadth of cases, particularly unusual patient presentations. To accomplish this and provide a richer educational experience for trainees and staff, we have recently opened a simulation center.

Simulation was first introduced to the anesthesia community in 1987 by Dr. David Gaba, now at Stanford. His vision was providing a system which emphasizes crew resource management (CRM) concepts in managing challenging cases. CRM principles arose out of the aviation industry to optimize the performance of flight crews through more effective delegation of roles, better communication, and recognition of common performance errors. Through vigilance, one observes a problem or potential problem, defines what is potentially occurring, develops and then executes a plan, observes the outcome, and if necessary, refers back to and redefines the problem and works through the sequence again. The role of simulation has evolved dramatically beyond the CRM beginnings to include management of rare problems, rehearsals of complex tasks, and assessment.

Simply owning the mannequins is not sufficient. The mannequins are not something that a learner can "just go play on." They are not amenable to self study. Mannequins seem to be most useful when used in a simulation scenario by a group of learners who then have a debriefing or discussion about what occurred, what went well, and what might be done differently. In addition to learning the material, it helps the trainee to become reflective about his/her own practice and develop habits of self evaluation.

Drs. Tim Curry, Margaret Weglinski, and Paula Craigo attend to a patient found unresponsive and pulseless in an exam room.





Drs. Carlos Mantilla, Rungson Sittipong, John Eisenach, and Ms. Cheryl Paulson attend to a patient deteriorating in an operating room.

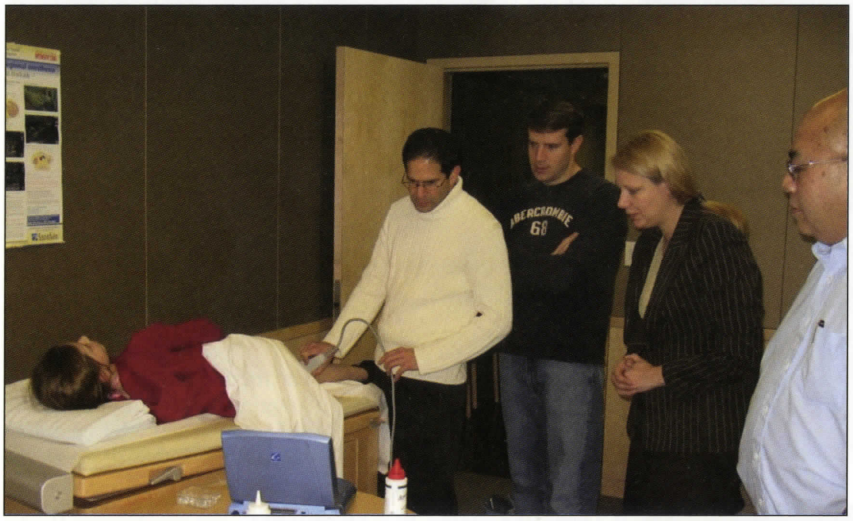
Another aspect of the simulation experience is attaching an emotive component to the experience. Think about the dramatic cases you have been involved with throughout your career. You probably remember nearly every detail of them. With thoughtful scenario construction and staging, it is possible for the trainee to become very engaged in it and elicit many of the emotions that a caregiver might experience in a real situation. In the same way emotive aspects of real cases make the details of the case stick in your mind, emotive aspects of a simulation experience can help recall the content of a scenario and subsequent debriefing far more effectively.

The Anesthesiology Department took delivery of a METI ECS mannequin in October, 2004. It resided in two modified patient rooms on the old medical ICU of 3 Alfred at Saint Marys Hospital. This initiative was shared with the Department of Emergency Medicine. Residents from anesthesia and emergency medicine, SRNA students, medical students, and respiratory therapy staff had simulation experiences there throughout winter, spring, and summer of 2005 under the supervision of Drs. Deepi Goyal and Laurence Torsher.

The mannequins are like Resusci-Annies on steroids from head to toe! They have eyes that blink, a voice, a mouth and upper airway that can be modified, heart sounds, breath sounds, a chest that moves with ventilation, palpable pulses, and physiological parameters (e.g., HR, BP, oxyhemoglobin saturation) and breathing pattern that can be remotely controlled. This lets an operator set up a clinical problem as part of a simulation scenario that the trainee must then work through with actual clinical equipment.

October of 2005 saw the opening of the Mayo Clinic Multidisciplinary Simulation Center on the ground floor of the Stabile Building. This is a state-of-the-art facility with simulation rooms set up to look like an OR, an ER, an ICU, and an interventional radiology suite.

Drs. Tim Curry, Paula Craigo, and Margaret Weglinski try their hand at removing a gall bladder with a virtual laparoscopic trainer.



Dr. Carlos Mantilla, Dr. John Eisenach, Ms. Ellen Clements (clinical tutor from Sonosite), and Dr. Rungson Sittipong image Evelyn Torsher's sciatic nerve with ultrasound.

There are six standardized patient rooms, debriefing rooms, and a conference room. Audio and video recording equipment in every room allows capture of performance and debriefing sessions. There are also a number of task trainers, devices designed to allow rehearsal of a specific task (e.g., cystoscopy, bronchoscopy, retinal surgery). This is a true multidisciplinary initiative with input from the Departments of Anesthesiology, Surgery, Internal Medicine, Emergency Medicine, Nursing, and many others. We have provided simulation experiences for individuals from anesthesiology, emergency medicine, critical care, general surgery, urology, pediatrics, family medicine, nursing, code teams, Mayo Medical School, and the Mayo School of Health Sciences. There are a number of research projects arising out of the center as well. It is staffed by clinical facilitators: Drs. Bill Dunn, Dave Farley, Chris Farmer, Deepi Goyal, and Laurence Torsher, Jackie Arnold, RN, and Jeffrey Ward, RRT. We have received great technical support from Thom Belda and clinical technical support from members of the Respiratory Therapy Service including Cheryl Paulson, Mike Craft, Bob Clifford, Pete Smith, and John Framsted.

The American Society of Anesthesiologists (ASA) has organized a task force to make recommendations as to how ASA-approved simulation training might be used to provide continuing medical education (CME) throughout the country. You can review the white paper on this subject and make comments through the ASA Web site at www.asahq.org.

On February 25, 2006, in conjunction with the ASA's Simulation Saturday, a number of our department's staff experienced what our residents have been experiencing for the last 16 months. The accompanying photographs show them managing a simulated anaphylaxis, VT → VF, and using both bronchoscopy and laparoscopy trainers. They also had an opportunity to try ultrasound-guided percutaneous procedures.

In the future, simulation will play a larger role in medical training from day one of medical school all the way through to CME. It will also likely figure into assessment and testing of medical competence as the technology matures.

My Automotive Avocation

Ronald Faust, M.D.

Hobby, avocation, obsession, addiction; whatever you call it, everyone needs a passion. Our medical careers are so rewarding they can consume us. The Mayo way is for physicians to get experienced at practice and really good at administrative and research contributions in the second half of their careers. Avocations gradually slip away, and the long-dreamed-of retirement becomes an empty goal.

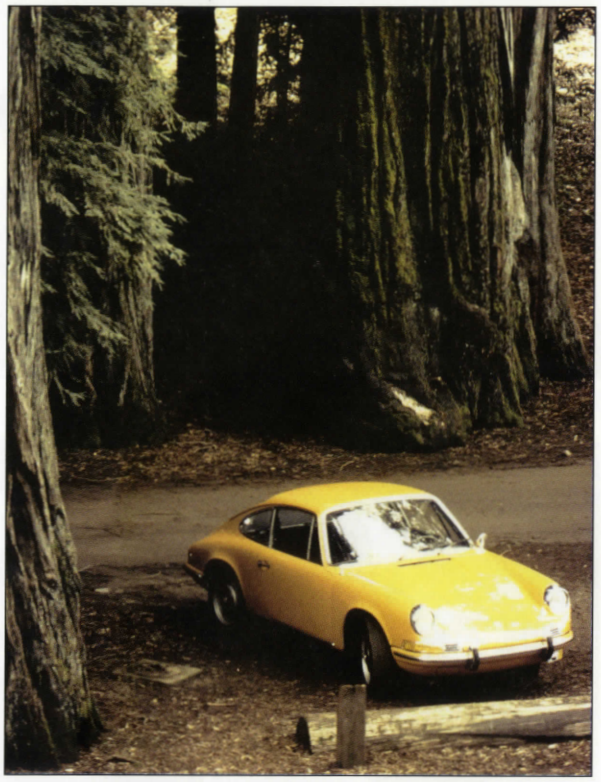
Porsches have been my passion for 35 years. While golf, boating, and horses have more appeal to most, those things can get expensive. Almost everyone needs an automobile anyway; your car is a hobby that you can enjoy every day, even if it is only while driving to work.

Of course, living in Minnesota makes driving a really good car to work every day impossible; most good cars and all boats are stored for at least four months of the year. This is not totally a bad thing. When you roll that baby out in spring, it is as if it is brand new again; the thrill of the first drive is a ritual of Spring.

An old friend, the 1964 356C in the Foundation House driveway. How could Porsche create a car that's still fun to drive 57 years after it was designed?

Here are some car rules that work for me:

1. You never know how expensive a car is until you sell it. In 1971, after saving almost enough for it on my tour of duty in Vietnam, I bought my first Porsche for $5600. I drove the 1970 911T six years (including some Minnesota winters) and sold it for $400 less. My second Porsche was also bought new. I drove that one thirteen years and sold it for three grand less than the sixteen I had paid for it. My third and fourth Porsches are vintage cars now; their escalating values have "outperformed" the stock market during some years.



The 1970 911T in the California redwoods, 1972. My wife, Claire, and I explored California in this one after meeting in San Francisco.

2. Expensive foreign car maintenance is a myth. My Ford mechanic charges about as much as the Porsche guys, but I see him more often because of the lack of reliability built into the car and its parts. For busy people, how often you have to go to a mechanic is what is most important.

3. The supply of collectible vintage cars is bigger than the number of people who want to fool with them. This keeps them relatively undervalued. Very few rise in value significantly, but if chosen wisely and taken care of, many will retain most of their intrinsic value or rise slightly.

The 2001 Boxster S, the "new" Porsche.

The 1980 911 coming through Turn 5 at Road America, Elkhart Lake, Wisconsin (photo by Edmund Lacis).

4. The technology in new cars is light years ahead of old cars. My 2001 Boxster S weighs about the same as my 1980 911, but has 50% more power and still gets the best gas mileage of any car I've owned. From the tires to the top, everything works better. New computer driven stability management systems have even lowered accident and injury statistics significantly.

5. New cars do depreciate. New car prices have been relatively stable while technology continues to improve. This drives the value of used (2- to 5-year-old) cars down quickly, creating a buyers' market for used Porsches. Many have very low mileage and are essentially new cars. Yet there are few thrills in life like picking up your new Porsche at the dealership.

6. Tinkering on an older car is a hobby in itself. There's always something you can work on; the game is figuring out what you can do or learn to do before you make a drivable car into one that has to be towed to a professional mechanic. Living in Rochester adds to the challenge as it's a long tow for most Porsche problems. The mechanical information is "out there" now. Some Web sites even rate repairs based on difficulty to help you decide how deep the water is before you jump in.

7. The right tool for the right job is an important rule in the garage. Some repairs mean you might have to add a new tool or two to your collection, and that's a good thing.

8. If you use a tool once, you'll use it again, so you may as well buy it. As amateurs, we rarely wear our tools out, so you may as well get a good one.

9. The $$-per-horsepower relationship is shaped like the intracranial elastance curve. The steep part is very steep; costs rise astronomically for only a little more speed. There are many people in amateur racing in this country. Speed is such a "rush" it can suck you past your budget quickly. It's real important to keep the big picture in focus. The rookie who drives up to the track in his $5000 Porsche 924 has a lot more fun than the big shooter who's built a race car for 20 times more if the race car breaks or gets bent during the weekend.

10. My "racing" hobby is a misnomer. Contrary to rumor, what I do at the track is a time trial (actually called "Drivers' Education"). We practice all weekend on Brainerd International Raceway's three-mile, ten-turn road course. Then they get out the timers, and we race the clock to see what our lap time is. There's no passing in the corners, so if you have problems, it is you who made a mistake. Like skiing, some people drive out of control, but most never go off the road. Even preparation for the track--your car, your tools, your mind--is a fun process.

11. The Porsche Club does organize real fender-to-fender racing. You start with a real nice car, add a roll cage so it's real hard to get in, and then stiffen the suspension until it's uncomfortable on the street. Then you start pouring gobs of money into the engine. Don't forget the tow truck and the trailer. It's a rush, but I've avoided the addiction so far.

12. An avocation that's totally absorbing is a good thing. It's very therapeutic to be totally absorbed in something that's non-medical once in a while. On the track, total focus and concentration are necessary to drive fast; this could be the most intensely absorbing nonthing you can do not related to work. Beepers, cell phones, or worrying about your next late, committee presentation, or grant application are out. Distractions will make you slow at best, or lead to an "off-track excursion" at worst.

I can help you rationalize almost anything about cars. Just call me. And continue to enjoy your hobbies.

Anesthesia Physicians Limited — Mayo Clinic West

Scott Atchison, M.D., Sioux Falls, South Dakota

Anesthesia Physicians Limited (APL) is the official incorporated name for the so-called "Mayo Clinic West" group of anesthesiologists that have defected from Rochester over the past three decades. Currently, APL consists of thirteen anesthesiologists, of which all are alumni of the Mayo Clinic Anesthesia Residency Program. Over half of the APL anesthesiologists were at one time or another staff at the Rochester campus. APL is an independent, self-governed group which is under exclusive contract to practice within the Sioux Valley Health Care System. Headquartered in Sioux Falls, South Dakota, the Sioux Valley System includes hospitals and clinics in South Dakota, Minnesota, Nebraska, and Iowa. The Sioux Valley Clinic is comprised of over 300 physicians while Sioux Valley Hospital is the 560-bed tertiary "mothership" for the system and the largest hospital in South Dakota.

The thirteen members of APL cover anesthesia duties specifically for Sioux Valley Hospital. Ironically, the initial founding member of APL, Dr. Ed Anderson was the only non-Mayo physician to be part of the group. Dr. Anderson was recruited as an independent anesthesiologist to Sioux Valley Hospital in 1978 with the intention of starting up the cardiac program. From the onset, the workload was overwhelming with 24-hour call and long days in the ICU and operating rooms. Dr. Richard Belatti joined Dr. Anderson out of residency and, at the urging of the hospital administration, formed an incorporated group practice in 1981. Prior to that time, anesthesia was provided by a mixture of nurse anesthetists, Dr. Anderson, Dr. Belatti, and another anesthesiologist, Dr. Ed Daw (Mayo, 1960). Dr. Daw elected to practice independently until retirement from Sioux Valley Hospital in 1989.

As the practice grew, new partners were added to the group. There clearly was no structured "growth plan" or "master strategy" involved in subsequent hiring of new anesthesiologists. However, because of Dr. Belatti's ties to the institution, initial new partners were from the Mayo Clinic Anesthesia Residency Program. Both Drs. William Horner, the present senior member of APL, and Lester Steidl were recruited to work with the founding APL members. Since then, the group has sought to aggressively mine talented clinicians who seek a busy and challenging private group practice career. Approximately half of the APL physicians have done fellowships in a variety of subspecialties including pain, ICU, pediatrics, and neuroanesthesia.

The practice at APL was modeled after Mayo's Anesthesia Department. Sioux Valley Hospital maintains some of the finest nurse anesthetists in the Midwest who perform a diligent role on

Group picture left to right (with residency and fellowship completion dates): Jack Gaspari ('97), Tom Christopherson ('92), Gary Halma ('85), Scott Atchison ('83, pain '84), Robert Grady (neuroanesthesia '96), Kevin Ronan ('89, ICU '90), R.J. Lunn ('88, pediatric anesthesia '89, ICU '95), Mike Johnson ('02), Mac Sanders ('97, internal medicine '94). Not pictured: Bill Horner ('83), Doug Bell ('87), Greg Heib ('03, cardiac anesthesia '04), Barry Hein ('04, pain '05). Alumni: Dr. Ed Anderson, Dr. Richard Belatti ('79, retired), Dr. Lester Steidl ('83, cardiac anesthesia '84, Montrose, CO), Dr. Steve Kunkel (Mayo, '83, retired), Dr. Arne Sorenson (Mayo, '85, Minneapolis). Unofficial APL members: Dr. Hugo Raimundo, Dr. Jeff Lunn, Dr. Rungson Sittipong. Titular chair: Dr. Bradly Narr.

the anesthesia care team. All regional anesthesia, central venous access, and difficult airway manipulations are personally managed by the anesthesiologists. Again, like the current practice at Mayo, all general anesthetics must be attended at induction, emergence, and during any critical periods. Every patient is seen for preoperative evaluation and examination by the specific attending anesthesiologist. This necessitates that the workday start around 5:30 a.m. in order to ensure that every patient has been seen by the 6:30-7:30 a.m. OR start time. Without exception, APL staffs the hospital 24/7 with call responsibilities including OB, the main OR complex, and the four intensive care units. Call is shared equally among partners. Yes, even the "geezers" over age 50 take night and weekend call at APL! (Double espressos, Red Bull, and Geritol come in handy.) Several of the APL partners staff the Pain Clinic where just over 2000 patients are seen annually.

The key to APL's success has been the fortunate affiliation with a dynamic, growing system like Sioux Valley. The current number of main OR, same-day surgery, cardiac, thoracic, major vascular, obstetric, and pain cases continues to grow. This summer sixteen new surgical suites will be ready, and, in 2008, the Sanford Children's Hospital will open on the Sioux Valley Campus.

Members of APL are intimately involved in the administrative work at Sioux Valley Hospital and Clinics. APL members chair medical staff committees, manage the expanding OR practice, and serve on the corporate board of trustees.

On a day-to-day basis, the clinical practice is probably not greatly different from the Mayo Clinic practice. Most differences involve the lack of residents to teach and the emphasis on recreation over publication at "West!"

One of the most memorable partners at APL was the "father" of the group. A Notre Dame graduate who did his anesthesia training at Bethesda Naval Medical Center in 1978, Dr. Edward Anderson went on to be one of the most revered members of the Sioux Falls medical community. Although Ed had outside interests like canine obedience, horses, and gardening, his major passions involved the care of patients and the Roman Catholic Church. He rarely missed a meeting, a work-sponsored function, or a party. Towards the end of his career, he worked as hard as anyone despite the fact that he had crippling bilateral gonarthrosis of the knees. Dr. Anderson retired from APL shortly after bilateral total knee replacements in 2003. He then elected to enter the seminary (Blessed John 23rd National in Weston, Massachusetts). He intends to return to the Sioux Falls area in 2007 as Father Ed Anderson with the hope of serving a local parish or hospital.

Anesthesiology Residency News

Steven Rose, M.D.

National Resident Matching Program

For the first time, all three Mayo sites participated in the National Resident Matching Program (NRMP) to populate Mayo's separately-accredited residency programs (Rochester, Jacksonville, and Scottsdale). All positions at all three programs "filled" through the match enrolling talented individuals who will initiate their training in anesthesiology in July, 2007.

Rochester

Daniel Beistline (U of Nevada)
Scott Cantwell (Mayo)
Eric Deutsch (U of Missouri)
Andrea Dutoit (U of Colorado)
Jonathan Faust (U of Minnesota)
Antolin Flores (Med Univ of Ohio)
Halena Gazelka (U of Minnesota)
Kendra Grim (Michigan State U)
Barton Iverson (U of Minnesota)
Scott Kerr (U of Minnesota)
Brian Pallohusky (U of TX, San Antonio)
Eduardo Rodrigues (Brazil)
Ryan Rowberry (George Washington U)
Troy Russon (U of Virginia)
Brandon Sloop (South Australia)
Arun Subramanian (U of Melbourne)
Christopher Sykes (U of Utah)
Rebekah Wheatley (Mayo)

Jacksonville

Kathryn Bietenholz (U of Florida)
Joseph Cartwright (U of Tennessee)
James Freidenstein (U of Tennessee)
Shermian Daniel (U of Medicine & Dentistry of New Jersey)

Scottsdale

Eric Cornidez (Stanford U)
Carla Dormer (U of Arizona)
Allen Shoham (Oregon Health Sciences U)

Midwest Anesthesia Residents Conference

Under the supervision of Dr. Michael Walsh, Mayo had another highly successful showing at the Midwest Anesthesia Residents Conference (MARC) recently held in Chicago. First place awards were received by Drs. Bryan Hoelzer, Ryan McHugh, Jennifer Rasmussen, Juanita Rivera, and Kimberly Wynd. Dr. Bryan Hoelzer also received the top prize for best presentation in the clinical sciences. Mayo trainees gave 31 presentations, all of which were outstanding. Thanks to the residents and their faculty advisors for their hard work in preparation for this event. On to St. Louis in '07!

Gulf Atlantic Anesthesia Residents Research Conference

The Gulf Atlantic Anesthesia Resident Research Conference (GAARRC) will be conducted in April in Tampa, Florida. Nine residents from Jacksonville will participate.

Chief Residents

The chief residents for the 2006-2007 academic year were recently selected. As always, choosing among so many highly qualified candidates was an extremely difficult task. Please join me in congratulating Drs. Justin Evans, Jeff Jensen, Chris Monson, and Ryan Smith as incoming chiefs.

Dr. Bryan Hoelzer

FAER Scholarship

Dr. Bryan Hoelzer was recently chosen to receive support from the Foundation for Anesthesia Education and Research (FAER) as an academically promising CA-1 or CA-2 resident in our program. Sixty of these awards were presented nationally. We are confident Bryan has a bright academic future and will represent the department well.

Canadian Resident Award

Dr. Kimberly Wynd

Congratulations to Dr. Kimberly Wynd for receiving the Mayo School of Graduate Medical Education (MSGME) Robert J. Filberg Vancouver Foundation Fellowship award recognizing her accomplishments as an outstanding Canadian resident physician enrolled in a Mayo residency or fellowship program.

Dr.William Hartman

Mayo Brothers Distinguished Fellowship Award

Dr. William Hartman will be honored at the annual Mayo Fellows' Association banquet as one of six trainees selected to receive the Mayo Brothers Distinguished Fellowship Award. This award is open to residents in all specialties across the three Mayo sites and is the most prestigious award given to trainees by the MSGME.

Teachers of the Year

Drs. Jeffrey Pasternak and Richard Rho will be recognized at the Mayo Fellows' Association banquet as "Teachers of the Year" in anesthesiology and pain medicine. This is Rick's second award in his brief tenure on our faculty.

Mayo School of Health Sciences Education Awards

Congratulations to Dr. Robert Chantigian for his receipt of the 2006 "Physician Educator" award at the recent nurse anesthesia program graduation. Dr. Ronald Faust, no stranger to education awards, was also recognized with a "Special Recognition" award for his career-long contributions in education.

Thanks to our department residents, faculty, and all of our alumni who contribute to our collective success.

Letter to the Editor

Maurice S. Albin, M.D., M.Sc. (Anes. '62)
University of Alabama at Birmingham, Birmingham, Alabama

Wow! Dr. James Munis' coverage in the January, 2006, issue of the *Mayo Anesthesiology Alumni Newsletter* on "Neuroanesthesia Division: 2005" has certainly resulted in a flood of memories. I can still visualize Howard Terry and Ed Daw patrolling the short neuro-corridor at St. Marys with Howard occasionally having to placate his distant relative and Chief of the Section of Neurosurgery, Dr. J. Grafton Love, because the induction of anesthesia (with ether) was "prolonged!" I don't think that the contribution of Howard Terry to the development of the Neuroanesthesia Section has been totally appreciated. Howard was a pioneer in this subspecialty, a very low key yet sophisticated Southern gentleman and highly respected by the neurosurgical staff and residents, always looking for ways to improve the delivery of anesthetic care for the neuro patient. One of the problems was the recalcitrance of Dr. Love to allow any new anesthetic techniques into his operating room. Dr. Love was a world-class neurosurgeon, a pioneer in the use of air myelography but possessing a difficult and brittle personality. Yet Howard Terry was able to convince Dr. Love to enter the "modern" world of anesthesia by gentle and unremitting persuasion.

Personally, I will always be indebted to Dr. Terry since he delineated the options for me in order to pursue a career in the very nascent subspecialty of neurosurgical anesthesiology. Dr. Terry helped to convince me to spend an extra year going into the Medical Sciences Building for a Masters of Science degree, with my primary advisor being the

superb neurologist-neurophysiologist, Dr. Ed Lambert, he of the Eaton-Lambert Syndrome fame.

In the description of the Neuroanesthesia Service, Dr. Munis notes that Gilbert Abbott, the patient anesthetized by William Thomas Green Morton and operated on by John Collins Warren on October 16, 1846, was a "sitter." Conversely, it should be noted that the *Medical Gazette* in 1833 included an article by the same John Collins Warren who operated on another "sitter," Nancy Bunker from Trenton, Maine, for the excision of a breast mass. Cardiovascular cardiorespiratory collapse occurred signaled by a prolonged hissing sound during the breast resection. Resuscitation was of no avail and the patient died of probable venous air embolism.

News about People

Peter Southorn, M.D.

We extend our deepest sympathies to the family and friends of **Dr. Robert Jones** who died, aged 93, on December 22, 2005. After a distinguished career in the United States Army, he joined our department in 1954. He was a noted authority on diagnostic and intraoperative nerve blocks. He and his wife, Dorothy, retired in 1974 to their wonderful home on the banks of the Mississippi River near Wabasha, Minnesota, where they were hosts to many friends in the department.

Our profound sympathies are also extended to the family and friends of **Dr. Robert Hansen, Sr.,** who died, aged 87, on September 21, 2005. He completed a residency in anesthesiology at Mayo after service in the Korean War and subsequently practiced in Baton Rouge, Louisiana.

We also extend our sympathy to **Dr. Lee Nauss** on the recent death of his dearly beloved wife, Maria.

We wish a speedy recovery to three consultants who have had medical problems recently – **Dr. Eric Bloomfield** in Jacksonville, **Dr. Rungson Sittipong** in Rochester, and **Dr. David Seamans** in Scottsdale.

Drs. David Martin, Ines Berger, Christopher Sletten, and **Brent Williams** won first place in the American Academy of Medical Acupuncture research competition for their paper "Symptomatic Improvement of Fibromyalgia with Acupuncture: Results of a Randomized Controlled Trial."

In the last issue of the newsletter, we announced that **Dr. Martin Abel** was a recipient of the Mayo Distinguished Clinician Award. We have since learned that **Dr. Roy Cucchiara** in Jacksonville and **Dr. Joel Larson** in Scottsdale received the same honor last fall. This is an amazing coincidence bringing credit not only to these individuals, but the department as a whole.

Dr. Roy Cucchiara

Dr. Joel Larson

We wholeheartedly congratulate **Drs. Martin Abel, Gregory Nuttall,** and **William Oliver, Jr.,** on being made Professors in Anesthesiology in the Mayo Clinic College of Medicine.

Dr. Martin Abel

Dr. Gregory Nuttall

Dr. William Oliver, Jr.

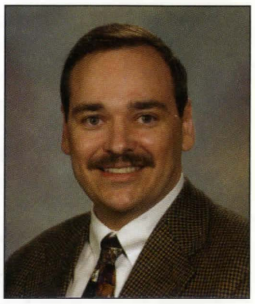
It is a distinct pleasure to announce that **Dr. Keith A. (Tony) Jones** has been appointed the chair of the Department of Anesthesiology at the University of Alabama in Birmingham. We also congratulate **Dr. Wolf Stapelfeldt** on being appointed chair of the Department of Anesthesiology at the University of Florida Shands Hospital in Jacksonville.

The department has a full complement of Mayo Foundation Scholars. **Dr. Matthew Ritter's** fellowship in critical care and cardiac anesthesia and **Dr. Christopher Duncan's** fellowship in regional anesthesia and general clinical research will finish next year. This summer, **Dr. Tracy Harrison** is beginning a combined pediatric anesthsia and pain fellowship, **Drs. Adam Jacob** and **Hugh Smith** will begin their regional anesthesiology fellowships, and **Dr. Dawit Haile** will begin a pediatric anesthesiology fellowship. In early 2007, **Dr. Katherine Arendt** begins a fellowship in obstetric anesthesiology.

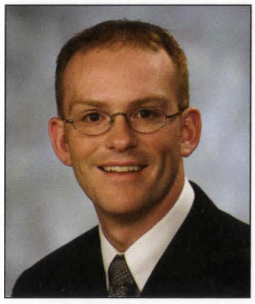
Several new consultants will be joining the department this summer. **Dr. Y. S. Prakash** will be dividing his time between the basic science laboratory and the operating suite, **Dr. Wayne Nicholson,** is a clinical pharmacologist, and **Drs. Daryl Kor, Daniel Diedrich,** and **Thomas Comfere,** having completed their Critical Care Fellowships, will be dividing their clinical commitments between critical care and the operating suites.

Finally, we wish every success and happiness to **Mr. Steve Jorgensen,** the department's capable administrator, who recently accepted a position in senior administration at Mayo Clinic Jacksonville. We welcome **Ms. Gwen Amstutz** as our new administrator.

Dr. Y. S. Prakash

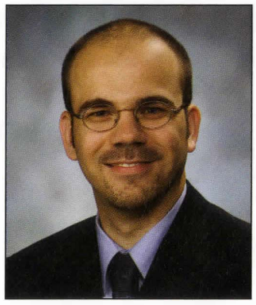


Dr. Wayne Nicholson



Dr. Daryl Kor

Dr. Daniel Diedrich



Dr. Thomas Comfere

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