

Mayo Anesthesiology Alumni Newsletter

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2007: A Good Year in Rochester

Bradly Narr, M.D.

Dr. Alan Sessler led our department through a period of significant change. I remember him saying many times as we had to make some decision concerning the practice, "if you are not getting bigger you are getting smaller." This year there is a lot of demand for the services and procedures that we perform. The red light has been on at Rochester Methodist Hospital many days in January, February, and March (all beds full), surgical volumes are up, radiology, cardiology, and gastroenterology procedures are up, and all of our performance targets are being hit. During the next year, we will be adding staff to open six new outpatient operating rooms and four state-of-the-art pain procedure rooms on Gonda 15. The view is great from up there. In addition, we have a great new group of anesthesia residents coming aboard and, though things are tight nationally, our basic research efforts are as robust as any time in the past 20 years. The future is bright.

We still have the real world staring us in the face. Not a day or Surgical Committee meeting goes by when I don't hear about "turnaround time." (I am sure this is unusual outside Rochester!) Even though Minnesota has a major exodus of retirees at age 65 due to factors such as our state income tax and the winters, with the first baby boomers coming of age, an increasing percentage of our patient reimbursement will come from the Medicare category. In this setting, our additions have to be planned carefully and strategically, and the consultants we add must take our practice, research, and education programs to the next level. You can see our direction from some of the articles in this newsletter. I want to thank you all for your help and support as we move forward, and please do not hesitate to contact us if you have comments or suggestions.

Editor's Note

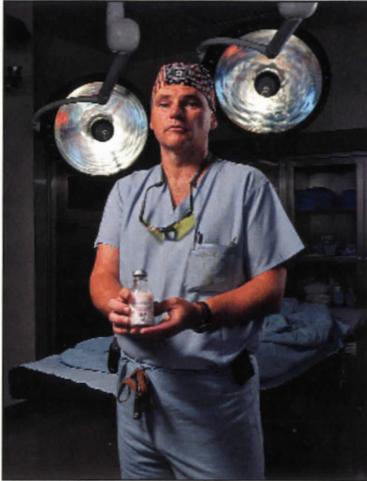
Peter Southorn, M.D.

I am really grateful to our contributors and all who wrote to us. Please keep the correspondence coming.

It Started at Mayo. An Academic Career and Fluorocarbons

Bruce D. Spiess, M.D., FAHA

*Professor of Anesthesiology and Emergency Medicine; Director of VCURES Shock Center
Virginia Commonwealth University Medical Center, Richmond, Virginia*



Dr. Bruce Spiess

The origins of fluorocarbon chemistry date back to the Manhattan Project. In developing the atomic bomb fluorocarbons were found to be ideal non-reactive insulating oils for containing radioactive uranium.

Subsequently, and serendipitously, it was discovered that huge quantities of oxygen could be dissolved in these fluorocarbons. This observation lay dormant until the 1960s when Leland Clark (of the Clark electrode fame) and his

colleagues found the oxygenation of small animals immersed in oxygenated perfluorocarbons (PFCs) was sustained with spontaneous breathing. They hypothesized that such PFC might be valuable in ocean exploration and aiding the escape from submerged submarines. This idea made it into the science fiction movie "The Abyss", and in some sense, now 40 years later, we may be coming back full circle to this idea.

PFCs are unique liquids. In pure form, they can dissolve some 60- to 100-fold more oxygen than plasma and can have an oxygen content 3-5 times that of human whole blood. Because oxygen dissolved in PFC is not chemically bound, its movement is totally dependent on diffusion gradients. Furthermore, PFC emulsions, which became available in the 1970s, have a small 0.1 to 0.4 micron particle size allowing them to travel to areas within the microcirculation where red blood cells, because of their large size, cannot go. The potential clinical capability of these observations was

Figure 1. A rat before (on left) and after exchange transfusion with a PFC emulsion to reduce its hematocrit to one percent. With its resulting "white" eyes, the animal lived in good condition for 72 hours.



demonstrated in rats given a PFC exchange transfusion. These rats survived in apparently good condition with a hematocrit of 1 (Figure 1).

I began my residency in 1980. On reflection, memories of my three years in Rochester come flooding back. Cardiac anesthesia was still a young, growing field. Sait Tarhan, John Tinker, and others nurtured my love for the adrenaline rush associated with these cardiac cases.

I made it a personal goal to never let down John Tinker's expectations. It was clear that cardiac anesthesia would be my first choice of clinical focus. John McMichan, Paul Didier, Peter Southorn, and Martin Abel, as well as others, supported my curiosity in critical care patients through mentoring in the ICUs. I had a special fascination with blood transfusions and oxygen transport in the body. I will never forget warming blood before transfusing in the dedicated microwave located just outside the blood bank at Rochester Methodist Hospital. Wow, we would not do that today! Ronald Faust set an example for me that I have since tried to emulate through his work in the hospital blood transfusion committee and education regarding blood transfusion.

Ron MacKenzie, with his wonderful teaching calmness and patience, was supportive and nurtured these percolating new thoughts. As a young physician learning the trade of anesthesia, particularly cardiac anesthesia, I cannot think of a more wonderful group of caring, supportive, and immensely knowledgeable tutors under whom to study.

It was in this "Mother Mayo" incubator that my life unknowingly first turned to PFC research. In my senior year, a new requirement came down from the department chair, Alan Sessler, and the Education Committee stating that in order to graduate we would have to give an academic oral presentation. Such an edict did not sit well with the rebellious residents, but it was the best thing that happened to my career! The new PFC emerging research would be the center of my required academic presentation. In doing back-

ground reading for this, a few potentially inconsequential sentences spoken at a 1978 Japanese conference on blood substitutes caught my attention. I distinctly remember to this day, sitting on a gurney outside of the operating room entrance at Rochester Methodist Hospital discussing these sentences with Dave Danielson, whom I admired greatly. Apparently, the Japanese had noted that the PFCs carried nitrogen equally as well as they carried oxygen. Bingo! A light bulb went on and a career was born! Dave Danielson agreed with me that somebody ought to try the stuff for treating or preventing air embolism. With Jack Michenfelder and Roy Cucchiara as other early mentors, I well understood the risks of air embolism in neuro and cardiac surgery.

Rush University in Chicago gave me my first academic job. Its chair, Anthony Ivankovich, told me that if I was to amount to anything I needed to do research, and so began my first experiments using a PFC emulsion in a rabbit model of severe venous air embolism. We found that animals treated with PFC and breathing 100% oxygen could tolerate huge amounts of air being embolized into their venous circulation. Ken Tuman (my first fellow), Robert McCarthy, and I got the wild idea that if PFC emulsions could remove air bubbles associated with air embolism, they would be of value in treating decompression sickness. To follow up with this hypothesis, we managed to scrounge an ancient hyperbaric chamber and show that PFC emulsions had profound beneficial effects in preventing death from experimental decompression sickness. We naturally thought the United States Navy would be happy to hear about this and support us. Their response bordered on "please lose our address." They officially told us the United States Navy did not have a problem with decompression sickness.

In 1990, I was recruited to the University of Washington in Seattle. Although my main focus here was heart surgery and my budding interest in blood transfusion, I stayed involved in PFC research with some surgical colleagues.

We demonstrated that PFC added to the prime of a large animal cardiopulmonary bypass machine effectively removed any air bubbles and provided excellent cerebral protection from stroke caused by air embolism. This research led to collaboration with Sir Kenneth Taylor, the chief cardiac surgeon at the Hammersmith Hospital in London, England. This in turn resulted in early human trials of priming the bypass machine with new, more potent and stable PFCs.

In 1999, for family reasons, I moved to the Medical College of Virginia. Just before going there, I received a call from a navy lieutenant at Bethesda, Maryland. He had read about our early work with first generation PFCs and some of our cardiac bypass data. His question to us was, "Were we interested in collaborating with the US Navy investigating and treating decompression sickness?"

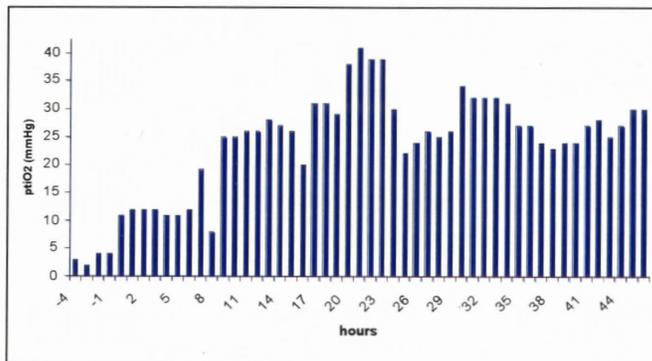
Using the Navy's worst case scenario animal model of severe cardiopulmonary chokes, swine being compressed for 22 hours at 4.5 atmospheres, we found that PFCs and 100% inspired oxygen decreased the mortality of these animals by 85%, and no surviving animal had any neurological deficit in contrast to those who didn't receive PFCs. This work led to ongoing grants from the Department of Defense. Today, some 4.5 years later, our work is an integral part of the United States Navy Disabled Submarine Initiative, and we have a customized hyperbaric laboratory to study this problem (Figure 2).



Figure 2. Customized hyperbaric laboratory used to study decompression sickness at VCURES.

My work with PFCs led to collaboration with the Virginia Commonwealth University Reanimation Engineering Shock Center (VCURES). This facility has more than 40 M.D. and Ph.D. investigators and over \$30 million in extramural funding. Our research has grown and involves close collaboration with neurosurgeons, particularly M. Ross Bullock. A series of brain trauma injury trials demonstrated that early intravenous infusions of PFCs could salvage up to 50% of otherwise at-risk brain tissue. These results led to the FDA giving us permission to perform a pilot trial using PFCs and oxygen to treat 8-10 comatose individuals with severe closed-head injuries. These patients received maximum surgical and supportive ICU care to decompress the brain. Licox[®] tissue oxygen probes showed that PFC increased their brain oxygen levels by 2- to 4-fold (Figure 3).

Figure 3. Brain oxygen levels directly measured in a head injury victim. PFC was administered at time 0 and was followed by an immediate climb in brain tissue oxygen.



The lactate/pyruvate ratio normalized and the axonal leakage of glutamate, a marker of axonal death, came back to baseline. Two patients died but the remaining seven walked out of the hospital neurologically intact. This compares to a historically matched cohort with a comparable level of injury in which there was 40% mortality and 60% major neurological deficit in the survivors. With these encouraging results, we are now planning a larger multi-centered phase II trial. In addition, an animal model of severe traumatic spinal cord injury has yielded similar encouraging results.

My research has led to a fascination with blood, blood transfusion, coagulation and

microvascular oxygen delivery. I have become involved in a number of textbooks on this subject. The first edition of *Perioperative Transfusion Medicine*, Lippincott, Williams and Wilkins, Baltimore, Maryland, was dedicated in part to Drs. Ron Faust and Ron MacKenzie at Mayo. I wanted to honor them for the inspiration they instilled in me for teaching and research into blood transfusion. The second edition of this book was published in 2006.

My intellectual excitement is ongoing! As I write this, I am at 37,000 feet criss-crossing the United States after meeting with a major pharmaceutical firm to address upcoming human trials for both traumatic brain injury and spinal cord protection. In addition, we have trials under consideration for sickle cell crisis, cardiac arrest, stroke, carbon monoxide poisoning, and a number of other applications. The United States Navy convened a conference last May to formulate how PFCs will be taken from the laboratory to ships of the line within the next 3 to 5 years. The day when a decompression victim is successfully treated on a Navy warship will be a personal triumph for all those involved in our work, including myself. I believe we have already saved lives in our initial traumatic brain injury trial. What about other applications of PFCs? Emerging countries often don't have the infrastructure for safe and adequate blood supplies. Perhaps that will be the next 10 years of work. It all started with a casual conversation with Dave Danielson late one afternoon at Rochester Methodist Hospital. It was a lovely spring day, the sun was shining through the windows on the first floor, and new ideas were blooming. Thank you to all who have made the Department of Anesthesiology at the Mayo Clinic a pre-eminent academic training ground. You have touched and saved innumerable people and patients far around the world without it being your direct intention or even within your knowledge. If there is one thing I have learned from my career it is: Never say never.

Leading a Balanced Life

Keith Berge, M.D.



Keith Berge at his work bench.

To the astonishment of friends and family, and to my utter amazement, I have become a goldsmith. I've been asked to tell the why and how of this evolution, which runs the risk of portraying this happening as an orderly and planned series of events which led inevitably to a predetermined outcome. This is anything but the case.

The most frequent question I receive is "How did you get started?" In response, I offer a short version or a long version. I'll start you off with the short one, which is "by using books and videotapes." In this internet era, where it seems all information worth having can be found by a Google search, let me assure you that you would be simply amazed at what can be found in books. With a craft as old and relatively unchanging as metal-smithing, useful information can be found in books that are literally hundreds of years old, as there is little that is new in this craft. One very notable exception to this is the fabulous tool provided by video technology as applied to teaching. I learned enough to make a very good start by this method. When, years later, I finally met the Master that had written the books and made the videotapes, Alan Revere, my first words to him were, "We've never met, but you've taught me everything I know about

goldsmithing." It must have been the right thing to say, as in the years since that meeting we have become good friends. It was not idle flattery, however, but a statement of fact. Actually being able to see an expert perform a task, with the ability to rewind and review until you have mastered the task, provides value beyond measure. This same holds true for almost any physical task one wishes to learn, from goldsmithing to fly-casting to playing an instrument to cooking. Books are wonderful, but videos are beyond wonderful.

The long version of the answer best starts with a "why," as in why did I go down this path in the first place? Basically, I was looking for another mountain to climb. Perhaps as a result of being conditioned to expect a "career change" every several years after leaving elementary school as a result of changes in educational settings, goals, and expectations, I became restless after getting settled into my career track in my "day job." Several years earlier, my wife and daughter had begun making simple jewelry as a hobby. As people saw what they made, requests came to buy their work. From this small beginning grew "Styles by Johanna," which has now become my wife's full-time job. As the business grew, and her needs for different beads grew, she asked me out of the blue, "can you make me high-karat gold beads?" Of course, as I knew absolutely nothing about even how to begin such a project, I said "sure." Why on Earth I would say such a thing is still not clear to me, but in retrospect that was a major fork in the road of my life which has carried me off on a wonderful journey. Thereafter I actively sought the knowledge I needed to create what she desired by the methods outlined above. One of the projects in Alan Revere's book was to make a chain, which I did. I enjoyed the process, and made several more in different variations. This, again, was to lead to a fork in the road.

After some time passed, and my shop and skills grew, Johanna and I visited Santa Fe, New Mexico, which we had heard is a custom jewelry and high karat gold Mecca. It is indeed, and when a gallery owner saw Johanna's chains and asked if I would consign them through his gallery, well, another fork . . . Incidentally, for those who have come to our Fall Open Houses and met the Santa Fe cowboy (Doug Moore) there, he was the gallery owner that gave me my break into the big leagues.



Replica 22 karat gold Etruscan two-way double loop-in-loop bracelet with cabochon ruby, emerald, and sapphire.

As it became clear that I needed to expand my skill set, I began traveling to Alan Revere's school in San Francisco for classes as time allowed. By this I have had the opportunity to meet some amazingly talented, creative, and delightful people. To say that they tend to march to different drummers than my medical friends understates things by a large margin! I found, however, that I shared a deeper common bond with some of these artists than simply jewelry creation, and that is a love of history. Nearly all of my favorite teachers have the deepest respect for



A gold ring with a center mounted diamond. Keith Berge was commissioned to make this ring by the life partner of an ICU patient of Keith's who died. The life partner had the diamond created from the remains of this deceased person.

those who came before in this craft, going all the way back to the amazing craftsmen of the Sumerian, Minoan, Etruscan, Greek, Roman, and Thracian cultures, to name but a few. Out of this interest has grown the style of jewelry I have adopted as my own, the creation of replicas or interpretations of works of these ancient craftsmen. It is humbling to be working with vastly superior tools to what they had to work with (e.g. charcoal and blowpipes, no magnification) and yet be unable to begin to match their amazing skills. That said, in an era where machine mass-production is the norm,

it is personally gratifying to hand-craft pieces similar to those seen inside display cases in the great museums of the world. I've been able to pay for my materials and my classes, plus gradually acquire a supply of marvelous tools, by way of selling my work through several galleries in such places as Santa Fe, New Mexico; Jackson, Wyoming; and Vail, Colorado.

I would be remiss if I failed to acknowledge the debt of gratitude I owe to several of my colleagues in the evolution of my skills as a goldsmith. First is Niki Dietz, who early on understood what I was trying to do and became my earliest customer. I credit her with giving me the courage to believe in my skill and to push it farther. She is proud to wear some of my early, rather crude, items that I desperately wish I could get back and bring "up to code." Another influential friend is Terre Horlocker, who is a serious fan of all things ancient. Terre has brought me the most challenging tasks to complete and has never allowed me to get away with telling her that I have not the slightest idea how to accomplish her design idea. Her stock response is, "I know you'll figure it out, no hurry." These two muses have pushed me in ways I have been grateful to have been pushed, if sometimes only in retrospect.

To conclude, I would encourage all of you, when you come to a fork in the road, to take the one that offers the challenge. People have told me how lucky I am to have found a passion outside of medicine that I can pursue for the rest of my life. Yes, there was an element of luck, but there was also a relentless lifelong quest to find ways to amuse myself. So my advice to all of you is to try stuff. You are good with your hands, or you wouldn't be doing what we do. Don't be tied to such thoughts as "I have no artistic ability." Neither did we, at least not until we tried. By virtue of some decisions that seemed strange at the time, we have been brought to a wonderful new place, with wonderful new friends and adventures to compliment the great friends and adventures we already enjoyed.

Oh, and Johanna is still waiting for me to make her beads . . .

FAER and Mayo Anesthesiology

Peter Southorn, M.D., and Alan Sessler, M.D.

Perhaps Charles H. Mayo said it best: "There are two objects of medical education, to heal the sick and advance the science." Although not all of us are involved in research, we can all agree that it is vital to the ongoing viability and success of our specialty. Not only does such research advance patient care, it also helps to attract the best and the brightest to the specialty. It is in this light that the recent decline in anesthesia research nationally has attracted major attention from leadership of organized anesthesiology (see *Anesthesiology* Vol 106, April 2007). This in turn has led to an increasing appreciation of the importance of the Foundation for Anesthesia Education and



Dr. William Hamilton (on the right), the first President of FAER and Dr. Alan Sessler, the first Vice-President of FAER at Dr. Albert Faulconer, Jr.'s retirement celebration held in the Foundation House, Rochester.

Research (FAER) to our specialty. It is of interest that members of our staff played a significant role in getting FAER up and running and have been involved in its day-to-day operation for many years. Perhaps, more importantly, many of our young faculty and residents at Mayo have been successful in obtaining initial grant support from FAER. In their subsequent careers, the majority of our FAER grant recipients have gone on to have a major positive impact on the specialty and our department.

The American Society of Anesthesiologists (ASA) established FAER in 1986 to manage funds from industry intended to support research in anesthesiology. FAER's task was to support worthy scientific projects by residents,

fellows, and junior faculty. Dr. Gerald Gronert was the first treasurer of FAER and Dr. Alan Sessler its first vice-president. Dr. Sessler assumed the role of executive director of FAER in 1995, and the offices of this organization were moved to Rochester, Minnesota. Initially housed physically within the Department of Anesthesiology and provided with space from Mayo Clinic, FAER eventually acquired its own dedicated office suite, which, although no longer in the department, is still on the Mayo campus. Many of FAER's office staff have been from Mayo Clinic including Ms. Cindy King, Kerry Todd, Linda Van Sickle, Mary Schrandt, and Carol Demulling.

The ASA Research Committee is responsible for reviewing and ranking grant proposals submitted to FAER. It was by this means that Dr. Duane Rorie received a FAER Research Starter Grant and subsequently went on to get NIH funding and have an illustrious research career. This eventually led him to being appointed Chair of the ASA Research Committee and given the responsibility for evaluating FAER grant proposals. Many other Mayo research faculty have been involved in this activity over the years. Currently Dr. Mark Warner serves on FAER's Board of Directors and Dr. Alan Sessler is President.

All told, some 17 residents and junior faculty of our department have been successful in obtaining grant funding from FAER. Their names are Drs. Eduardo Chini, Dorothee Gaumann, Roger Hofer, Terese Horlocker, Philippe Housmans, Joseph Hughes, Christopher Jankowski, William Lanier, Jr., Dwight Legler, Jeffrey Lunn, David Martin, Christina Pabelick, William Perkins, Duane Rorie, Keith Stein, David Warner, and Gilbert Wong. These individuals have, on the whole, remained active in research and become leaders within this specialty. Some have obtained competitive NIH funding to support their subsequent research and several have assumed leadership roles in national

anesthesiology subspecialty societies. Examples of their prowess include an individual who, in addition to his highly successful academic career, has been the editor of a prestigious medical journal for several years and another who now works in industry and is responsible for a major effort to introduce new anesthetic medications.

It is obvious that the relationship between Mayo Clinic and FAER has been mutually

beneficial to both our department and the entire anesthesiology community. As such we must extend our gratitude to those who have supported FAER over the years. Many individuals currently involved in research and education jump-started their academic careers by successfully obtaining a FAER grant. This success, representing as it does only a microcosm from the totality of FAER's work, demonstrates the importance of FAER to this specialty at-large.

Gonda Outpatient Procedure Center

Mary Ellen Warner, M.D.



Leadership of the Outpatient Procedure Center, from left to right: Mary Ellen Warner, M.D., Director; Marilee Hughes, RN, Head Nurse; Marlea Judd, CRNA Supervisor.

June 2nd marks the 4th anniversary of the Gonda Outpatient Procedure Center located on the 7th Floor of the new Gonda Building. For those of you who have not returned to Rochester in a while, the 20-story Gonda Building is the most prominent newer structure in the Mayo complex linking as it does the Mayo Building and the Charlton Building of Rochester Methodist Hospital.

The Department of Anesthesiology had an integral role in the development of the Outpatient Procedure Center. As originally designed, the center provided a coordinated accredited procedural area that could be used by multiple practices requiring monitoring and/or sedation care in their procedural

practice. Plans were made to relocate existing sedation practices from the Mayo Building to this new Gonda facility. It quickly became apparent that there would be other uses for such a facility including using it to decompress surgical suites within the hospitals and modeling "same-day" surgery practices and ambulatory surgery processes. As we evolved, plans were changed from providing a facility devoted to procedural sedation care to one in which both procedural sedation care and ambulatory surgical care could be performed with various types of anesthesia including local anesthesia, monitored anesthesia care, regional anesthesia, and general anesthesia.

Unique to the design of the facility was the need to incorporate both hospital-based and clinic-based procedural and surgical practices in the same facility. The facility is very welcoming to patients and their families because of its structural design. Patients and their family members are assigned small private individual rooms (approximately 100 square feet in size) which can be used for either preoperative or postoperative care. During the preoperative phase, all the necessary assessments are completed, monitoring is initiated, and IV access established. The patient's "chair" then becomes the patient's cart for transport as well as their operating room table. This minimizes the inefficiency of time devoted to transfer of

the patient. Another unique feature of these preoperative/postoperative rooms includes a portable locker on wheels which allows the use of the same room for another patient once the patient goes to the surgical suite.

In addition to the 20 preoperative/postoperative individual patient rooms, the facility has four "traditional" 400 square-foot operating-room suites located around a central sterile core, an additional six smaller procedural rooms (each 200 square feet) and one larger procedural room (350 square feet). All of the procedural rooms are designed so that they can be utilized by multiple specialties.

The primary users of the Outpatient Procedure Center include Ophthalmology, Urology, Hematology/Oncology, Oral and Maxillofacial Surgery, and our own Department of Anesthesiology with the Pain Medicine practice. Other specialties which use our center on occasion include Dermatologic Surgery, General Surgery, Vascular Medicine, and Neurology. Types of procedures performed by the Department of Ophthalmology include cataract extraction, eye muscle surgery, and corneal transplants. Urology's practice ranges from the routine cystoscopy and prostate biopsy to brachytherapy for prostate cancer and prostate resection using laser photoselective vaporization of the prostate (PVP). The Hematology/Oncology practice primarily comprises bone marrow biopsies and lumbar punctures. Oral Surgery utilizes the facility for both their hospital and clinic procedural practice. Pain Medicine has been a major player in the facility with a wide range of pain procedures performed.

The average case volume for the Gonda Outpatient Procedure Center is 55 cases per day. A total of 13,774 procedures were performed in 2006. Our OR utilization in the

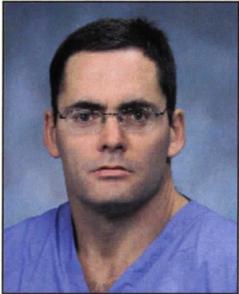
major rooms (Urology, Ophthalmology, and Pain Medicine) ranges from the high 70s to almost 100% in any given month.

One of the unique features of the Outpatient Procedure Center is its RN staffing model. This has allowed us great flexibility and an ability to staff the center according to workload needs. The versatile RN staff perform a variety of functions including preoperative care, intraoperative scrubbing and circulating roles, postoperative care, and sedation care. The "can do" attitude and team approach of our RN, CRNA, and MD staff and our anesthesia assistants has been vital to the success of the center. This work ethic has allowed the center to succeed not only in terms of financial ramifications, but efficiency and, most importantly, user and patient satisfaction and outcomes.

The institution recognizes the success of the Gonda Outpatient Procedure Center on Gonda 7 and has asked the Department of Anesthesiology to play an integral role in the planning and development of a larger outpatient procedure center on Gonda 15 which is currently under construction. This center will probably open in the beginning of 2008 and will include 8 large operating rooms (approximately 500 square feet), 4 large pain procedure rooms, and 21 private preoperative/postoperative rooms modeled after the Gonda 7 design. We are presently in the process of hiring staff for this facility and outfitting the facility with equipment. The primary users of this facility will be Orthopedics, General Surgery, Plastic Surgery, and Gynecologic Surgery as well as an integrated Pain Medicine practice. I look forward to reporting to you on the progress of this new procedure center in the future and invite you to stop in and see either of our facilities if you are in the Rochester area.

Anesthesiology Residency News

Steven Rose, M.D.



Dr. David Cook

Accreditation

We are pleased to announce a favorable decision from the Anesthesiology Review Committee (ARC) regarding the accreditation of our Cardiac Anesthesiology Fellowship by the Accreditation Council for Graduate Medical Education (ACGME). Accreditation in this discipline only recently became available, and Mayo's program is among the first to be accredited. Dr. David Cook serves as program director of the fellowship and Dr. Martin Abel serves as Division Chair. Please join me in congratulating our cardiac anesthesiologists for this achievement.

The site visits for our Rochester core residency program, Pediatric Anesthesiology Fellowship, and Critical Care Medicine Fellowship will be conducted April 17-19, 2007. Preparation for these visits has been ongoing to assure substantial compliance with the general and program-specific requirements of the ARC and ACGME.

National Resident Matching Program

The results of the 2007 National Resident Matching Program (NRMP) recently became available. In Rochester, a full complement of 18 positions (nine in the three-year specialty program and nine in the four-year categorical program) filled through the match. Our Jacksonville and Arizona core residencies also matched a full complement of residents (four and three residents, respectively) and each program reports a highly successful year for recruitment.

Residents matching into our Rochester, Arizona, and Jacksonville residencies are listed below:

Mayo Clinic Rochester:

Stephanie Davison (*University of Minnesota*)
 Joel Farmer (*University of South Dakota*)
 Ryan Gassin (*Medical College of Wisconsin*)
 Shane Gillespie (*Lake Erie College of Osteopathic Medicine*)
 Jonathan Gombola (*Drexel University*)
 Erin Grund (*University of Minnesota*)
 Rebecca Johnson (*Mayo Clinic College of Medicine*)
 Paul Luikart (*University of Minnesota*)
 Westley Manske (*College of Osteopathic Medicine at Des Moines University*)
 Benjamin Marvin (*University of Colorado*)
 Stephanie Neuman (*University of Wisconsin*)
 Jared Olsen (*University of Wisconsin*)
 Nicholas Peterson (*University of Iowa*)
 David Prybilla (*Medical College of Wisconsin*)
 Jessica Stansberry (*University of Iowa*)
 Hans Sviggum (*Mayo Clinic College of Medicine*)
 Shane Taufer (*Arizona College of Osteopathic Medicine*)
 Erica Wittwer (*University of Utah*)

Mayo Clinic Arizona:

Michael Ivancic (*University of Missouri-Kansas City*)
 Lisa Seip (*University of Arizona*)
 Molly Solorzano (*University of Iowa*)

Mayo Clinic Jacksonville:

Anna Glover (*Medical College of Georgia*)
 Marcus Lehman (*Emory University*)
 Michael Rowley (*Ross University*)
 Kristen Vanderhoef (*University of South Florida*)

The future of anesthesiology at Mayo remains bright based on the talent and industry of the residents we recruit to our programs. Please join me in welcoming them to the department.

Congratulations

Congratulations to Dr. David Cook for his selection as Mayo Fellows Association Teacher of the Year in Anesthesiology. We also congratulate Drs. Jason Eldrige, Maria Fritock,

Sarah Garber, and Christine Kenyon in Rochester and Beth Ladlie in Jacksonville for being named chief residents in the 2007-2008 academic year.



Dr. Jason Eldrige



Dr. Maria Fritock



Dr. Sarah Garber



Dr. Christine Kenyon



Dr. Beth Ladlie

News about People

Peter Southorn, M.D.

We regret to announce the death of **Dr. Norbert Schnelle** on March 5, 2007. After a residency at Mayo, he was a member of the staff from 1960 to 1986. He was responsible for introducing anesthetic gas scavenging in the operating room and had a keen interest in the management of patients with insulinomas and in diagnostic and therapeutic nerve blocks. We extend our deepest sympathies to Dr. Schnelle's wife, Hannalise, and his 3 children.

We are also sad to announce the death of **Dr. Jerry Fleischer** on March 1, 2007. Jerry came to Rochester in 1985 to do a fellowship in neuroanesthesiology and perform research. Subsequently he was appointed to the staff of Mayo Clinic but only stayed a short time before returning to the University of California, San Diego. Subsequently he went into private practice in Albuquerque, New Mexico. He maintained many close friends in the Mayo community and all of us extend our deepest sympathy to his wife, Connie, and his 3 children.

We congratulate **Dr. James Eisenach** of Winston-Salem, North Carolina, member of the class of 1985, on his being appointed the Editor-in-Chief of *Anesthesiology*.

We also congratulate **Dr. Mark Warner** on his being appointed to the Editorial Board of

Anesthesiology. Mark also gave the Rovenstine Memorial lecture at the Post-Graduate Assembly of New York State Society of Anesthesiologists in December, 2006. We admire and respect Mark for these and his other accomplishments.

It is a pleasure to announce that **Dr. Christopher Jankowski** has been appointed President-Elect of the Society for the Advancement of Geriatric Anesthesiology (SAGA).

We whole-heartedly congratulate **Richard Belatti, Sr.**, of Madison, South Dakota and a member of the class of 1978, on his being appointed a member of the Board of Regents of the University of South Dakota.

Dr. Alan Sessler was honored recently after serving for many years as a member of the Boards of the Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic and Chair of the Dartmouth-Hitchcock Clinic Board of Trustees.

Congratulations are in order to **Dr. Randall Flick** on his being appointed the new Chair of the Division of Pediatric Anesthesiology here in Rochester.

In this era of increasing difficulty obtaining NIH grant funding, **Dr. Michael Joyner's** grant HL46493 received an incredible score of 1.2 for the 16th-20th year of its funding. Well done, Mike!

Congratulations are in order to **Drs. Martin Abel, Joel Larson, and Roy Cucchiara**, who were last year's recipients of the Clinicians of the Year Award in Rochester, Scottsdale, and Jacksonville respectively.

It has just been announced that **Dr. David Cook** has been awarded the honor of Teacher of the Year by the Fellows Association here in Rochester.

We congratulate the following individuals on their election to the boards of major anesthesiology societies - **Dr. John Dilger** to the Society of Ambulatory Anesthesia (SAMBA), **Dr. Marc Huntoon** to the American Society of Regional Anesthesia and Pain Medicine (ASRA), and **Dr. Christopher Jankowski** to the Society for the Advancement of Geriatric Anesthesiology (SAGA).

Finally it is a pleasure to announce the following individuals who have been named as Mayo Clinic Scholars in 2007: **Dr. Bryan Hoelzer**, Mayo Clinic Scholar in Pain Medicine Fellowship; **Dr. Jeffrey Jensen**, Mayo Clinic Scholar in Critical

Care Medicine Fellowship; **Dr. James Onigkeit**, Mayo Clinic Scholar in Critical Care Medicine Fellowship; **Dr. William Hartman**, Mayo Clinic Scholar in the Clinical Pharmacology Training Program with Dr. Richard Weinshilboum.

Tom Kokesh has sent us a note that **Mr. Roger Wells** was not included in the list of our Department's former administrators in our last issue. Roger succeeded Tom in this position in January 1989. We apologize to Roger for omitting his name.



Dr. Bryan Hoelzer



Dr. Jeffrey Jensen



Dr. James Onigkeit



Dr. William Hartman

