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Mayo Anesthesiology Alumni Newsletter

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Please Help Us Maintain Our Resident Education

Bradly Narr, M.D.

Another academic program year for our anesthesiology residents has begun. It is a very exciting time, and many firsts will be etched in detail forever in the memories of these new residents. Their teachers, though, may not recall the same events by the following week. Duane Rorie walked me through my first spinal anesthetic in room 31, and I still organize my tray and stand the same way I was taught that day. I missed a nasal tube for a dental surgery on my first rotation, and Dave Healow walked slowly to the head of the bed and exhibited the most gentle feat of physical power I had ever seen (the head was lifted right off the bed) to place the nasotracheal tube. "Can we really do that?" Of course the best stories are about call. Prior to joining anesthesiology, I had been an internal medicine resident at Mayo, so I was a natural to cover the first Saturday of the first quarter. Will the originator of the statement "Don't touch anything; you're dangerous" please write us a note?

We could each go on and on. Education is one of the Mayo shields. It's fun, exciting, and rewarding as well as frustrating and less efficient at times. The end product is all of us and should leave no doubt in any of our minds that this is a tremendously important activity. I would like to enlist your help in keeping this teaching machine working.

Currently, there are approximately 300-400 practicing anesthesiologists who graduated from one of the Mayo programs working in 41 different states. We also have many retired alumni from these programs. You all have different connections to the political process. The Centers for Medicare and Medicaid Services (CMS) teaching rule applies the concurrency rules for covering two cases with our residents. Teaching surgeons may supervise trainees in two overlapping operations and collect 100% of the fee for each case. An internist may supervise trainees in four overlapping outpatient visits and collect 100% of the fee for each when certain requirements are met. A teaching anesthesiologist collects only 50% of the Medicare fee supervising trainees in two overlapping cases. We would like to eliminate this distinction between surgeons, internists, and anesthesiologists as they provide needed services to our elderly patients.

The CMS teaching rule penalty along with the planned fee reductions will increasingly strain our teaching program. Many of our best teaching cases are Medicare patients, and I hope that this patient group continues coming to Mayo for surgical care. Please contact your senators and representatives and help us plead our case by asking them to co-sponsor legislation to restore full funding for anesthesiology teaching programs. (Reference file code H.R. 5246, H.R. 5348, or S.2990 [Teaching Anesthesiologists]. For further details see http://www.asahq.org/asarc/teachingrule.htm and http://www.asahq.org/news/hr5246.htm.) Thank you.

Editor's Note

Peter Southorn, M.D.

Thanks to our contributors, this issue offers a variety of interesting articles. I am very indebted to them and indeed everyone who has been in contact. Your input enhances the newsletter's value, so keep those ideas and thoughts coming.

The First Year of Practice

Candace Sabers, M.D., Ph.D., Minnetonka, Minnesota

Candace Sabers and her husband, Steve Sabers, at Ronald Faust's retirement party on July 28, 2006.

The first six months out of your residency will probably be the most stressful of your career. You are establishing your style of clinical practice, forming professional relationships, learning about business practices, and hoping each day you don't go and do something stupid. The most essential ingredient to your success is choosing the right group. A good group will want you to succeed and will take steps to ensure your success. They won't abuse you, they will back you up when it hits the fan, and they will always be happy to be your sounding board.

Your success in your first year will be defined by how well you take care of patients as well as by the professional relationships you form with your partners, surgeons, OR staff, CRNAs, and to some extent with the physicians and nursing staff outside the OR.

Your Colleagues

Good relationships with your colleagues are absolutely essential to delivering high quality patient care. You will develop relationships with your partners, your surgeons, and CRNAs if you work in a combined practice setting. You need rapport, trust, and effective communication.

Your partners

Find a practice that is equitable, where everyone works (more or less) the same for (more or less) the same pay. That's the start of a good relationship with your partners. Everyone works harder and helps one another out more when no one feels taken advantage of. You want to feel like you can call on these people for help and ask their opinion without being made to feel lesser for it. What do they want from you? They want you to be efficient, technically proficient, work hard, get along with everybody, and be a resource for them when needed. And, oh yes, don't whine.

Your surgeons

Surgeons are fairly easy to understand. Don't slow them down, be pleasant, and prevent them from killing their patients. Help them to be efficient, and when the time comes when you do need to put the brakes on, they will be far more likely to stand back and let you do your job. If you need to cancel one of their cases, cancel it. In general, they will appreciate your vigilance. They really don't want to operate on someone who will have an MI that

night. Always have a reason for what you do, and be prepared to discuss it with them. They will rarely try to talk you into changing your mind, but they will need to know what to ask the primary care provider for if their patient needs more preparation. Don't be afraid to call the primary doc. You will be more likely to get what you need done and less likely to offend them for canceling their patient.

You also need to keep in mind that despite all you do, certain people will never be happy and can always find something to complain about. Don't take it personally. Just remember that you are young and chances are good you will outlive them.

CRNAs

If you work in a combined practice environment, you will medically direct CRNAs. You will likely be very busy between Preop, PACU, starting cases, and finishing cases, with blocks and lines in between. You rely on your CRNAs to not only provide a good anesthetic, but to call you when problems arise. You need to be able to trust them to call, and they need to be able to trust you to come when they need you. When you first start in a practice, try not to micromanage. Observe closely, and you will learn who you trust implicitly and to whom you might offer more direction. If you watch, you will also learn some very useful tips from the senior anesthetists.

Talk to your CRNAs about your patients. Most anesthetists I work with want to hear about the medical history of the patient, hear the anesthetic plan I think is appropriate, and be able to offer their input. They want to be treated as a colleague. When you have a reason for doing something, share it with them. Cite your literature – they'll be interested, and they'll appreciate what you can teach them.

Observe the local practice style and ask questions about "how they usually do things" for this surgeon or that type of case. Attempts to hijack the anesthetic style of your hospital will result in more over- or under-narcotized patients, weak patients, and just plain crappy anesthetics. You will influence the local practice style in time. Nudge it along once you have earned the trust of those with whom you work. If you have something completely new to add to the practice such as peripheral nerve catheters, start with one or two surgeons who are interested. It may catch on quickly, or you might quickly become aware of some systemic inadequacies. You do not work in a vacuum. Systems need to be in place to take care of your patients once they leave your care – i.e., educated nurses and physical therapists, order sets, etc.

Patient Care

You are coming from a great training program. You know how to take good care of patients. However, there are a few differences between what you dealt with as a resident and what you will deal with in private practice.

Can we get that Echo report?

The biggest surprise for me in my first year of practice was the lack of adequate preoperative evaluation and the lack of information available to me. At Mayo Clinic, your patients almost without exception have been well-evaluated, tuned up, and you have access to every piece of information you could possibly need. However, if you are going to a non-academic practice, you will be receiving patients from a great variety of primary care practices. There will be little uniformity in how they are prepared preoperatively. At my hospital, we draw patients from all over Minnesota who have been cleared for surgery by primary care physicians with greatly differing styles. As you have already seen by now, only the rare internist understands what we need in order to do our job, or what stresses various surgical procedures will place on their patient. You will see histories and physicals that consist of a laundry list without pertinent specifics - 1. HTN, 2. CHF, 3. CAD – without supporting documentation, but with "cleared for surgery" scrawled across the bottom. The interview becomes not a confirmation of the information you've

already reviewed, but a way of finding all the information you need. You will use the NYHA classification system for heart failure. You will know the ACC/AHA guidelines for cardiac evaluation for non-cardiac surgery. You will utilize the fax machine heavily. And you will occasionally need to cancel a case.

Tag, you're it.

I hope that you find yourself in a practice where people routinely ask one another for advice and help. You can't get that art line? You've just got too much going on? Call a buddy for help. But there will come a time when everyone is busy, or it's the middle of the night. There's no consultant looking over your shoulder, no one to give you a hand, just you. I don't really have any advice. You'll get used to it. You'll be fine.

The big crisis

Look at this as a great opportunity to show how well you perform under pressure. Example: one of my partners was dropping off her patient status-post CABG in the ICU when she heard a commotion in the room next door. She walked in and saw the Pleur-evac filling with blood rapidly, very rapidly. The purse-string suture had come off the right atrial appendage. She splashed the chest with Betadine, clipped the chest wires, put on a sterile glove and pinched the atrium closed. She rode on the bed to the OR and into legend. I had a patient for an elective C section (a lawyer). Following her spinal, she developed bradycardia, asystole, and V. fib, in that order, all in the space of about 30 seconds. It was my first opportunity to perform chest compressions on a pregnant woman. Both she and the baby are fine. I have had a patient bleed from uterine atony to a hemoglobin of 4. I have had a patient get 10 mg of epinephrine injected into the shoulder capsule for his arthroscopy, unmasking his previously asymptomatic 3 vessel coronary disease. I have had a patient succumb to massive venous air embolism during a craniotomy. You will encounter very similar situations. Don't dread them. They will make you a seasoned anesthesiologist.

The best advice about handling a crisis is still "take your own pulse first." That moment you take to assess the situation and formulate your best guess as to what is going on will help you to appear calm and decisive. Tell people what you want them to do: get a surgeon, get blood, put in an IV. In the face of serious calamity, put in the big lines, delegate all the other tasks, and keep a handle on the situation as a whole. The people around you in these situations want you to tell them what to do, want you to be calm, confident, and take the responsibility. If you are, they will work effectively. If you panic, they will too.

Bad outcomes

At some point, due to no mistake of yours, and despite giving your all, something terrible will happen to someone under your care. You may feel awful and second-guess everything you did for awhile. That's okay. You will then need to find something to take out of the experience, whether you can hone your knowledge, judgment, or bearing. Realize that you did not give the patient their disease, nor did you put them under the knife. You have to do the best with what you are given, remember your training, keep learning, and move on.

You leave residency with the tools you need for your practice. You may not know what a billing slip is, but who cares. You'll figure that out as you go along. The relationships you form with your colleagues and the experiences that hone your skills are important because they make you a good clinician. Keep in mind that nothing magic happens at the end of the first year. You may relax a little, but the experiences keep coming: difficult personalities, patients trying to die, even mundane frustrations that test your professionalism. Remember who you are, where you came from, and keep some perspective. You are in this for the long haul.

The Central Division at Saint Marys Hospital

Michael Brown, M.D.

The Central Division at Saint Marys Hospital may be a new term to some. It was formerly the Orthopedic Division at Saint Marys. Many changes have been made since Paul Leonard and Virginia Hartdridge roamed these halls, and the name change reflects the considerable evolution of the practice that occurred after adult reconstructive orthopedics moved to Rochester Methodist Hospital. The term "Central" was chosen a few years ago to describe the geographic location of the division in the Saint Marys operating suite. Central consists of sixteen anesthetizing locations, and the current practice mix calls for a broad range of anesthetic skills in the provision of care to patients undergoing thoracic, vascular, major spine, orthopedic trauma, hand, and plastic surgery as well as interventional therapeutics outside of the operating suite and cast room care. Thoracic epidurals, one-lung ventilation, invasive and evoked potential monitoring, and massive transfusion are part of the everyday practice in the Central Division.

At present, eleven consultants are assigned to the Central Division. Collectively, they make substantial contributions to the department, institution, and specialty in practice, education, research, and administration. The group takes pride in their clinical care, resident advocacy, research productivity, and ability to attract talented new faculty to the division.

From left to right: Drs. Tom Wass, Beth Elliott, Steve Rose, Jim Hannon, Mike Brown, DJ Kor.
Not pictured: Drs. Eduardo Chini, Tim Curry, John Eisenach, Tim Long, Y. S. Prakash.

The long-term members of the division are Drs. Beth Elliott, James Hannon, and Steve Rose. Dr. Elliott served as division chair for ten years and has been medical director of the Nurse Anesthesia Program in Mayo School of Health Sciences since 1991. Dr. Hannon has made impressive contributions in basic scientific research in addition to his clinical work and is an accomplished distance runner. Dr. Rose has served as program director of the Anesthesia Residency Program since 1994 and was more recently appointed Associate Dean for Surgery and Surgical Specialties at Mayo School of Graduate Medical Education.

Dr. Michael Brown, who is chair of the Central Division, and Drs. Tim Long and Tom Wass are members who have received awards for excellence in both clinical care and education including "Teacher of the Year," "Distinguished Clinician," and "Distinguished Educator" honors. Tim and Mike actively pursue a broad range of sports including basketball, football, golf, and swimming. They eagerly await the Wisconsin vs. Michigan football game to determine office bragging rights. Tom is an avid cyclist and, every July, is glued to the computer determining how many seconds Team Discovery is ahead of the peloton.

Central boasts several other productive researchers as well. Dr. Eduardo Chini is an accomplished scientist with original contributions published in high-quality journals. In his free time, Eduardo spends time with his children, preparing them for team Brazil's World Cup entry in 2014 . Dr. John Eisenach is active in Mike Joyner's physiology lab and has obtained dedicated extramural funding for his research.

The newest members of the division include Drs. Tim Curry, Daryl (DJ) Kor, and Y. S. Prakash. Tim is a M.D./Ph.D. with ongoing research activities in physiology. Prakash started the residency as an Associate Professor at Mayo, having worked in the anesthesiology research laboratory for several years before medical school. DJ completed a Critical Care Medicine fellowship and is widely regarded as one of the most talented and energetic persons we have ever trained.

An obvious factor in the success of the division is working well together as a team, valuing each other as physicians and friends coupled with a sincere desire to advance the department across a wide front. We look toward the future with great enthusiasm based on the talent and industry of the members of the group.

Mayo ala Gerald A. Gronert

Gerald Gronert, M.D., Albuquerque, New Mexico

Mayo was first mentioned when I was a 20-hour/week lab tech during my medical school years at the University of Illinois Medical School, Chicago. My endocrine physiologist boss was unhappy with the Nobel award to Mayo -- she bemoaned the fact that the award had not been awarded to Hans Selye who had laid the groundwork for stress theories and cortisone functions. Selye, forward and obnoxious, had likely ruined his own chances.

After residency and five years of private practice in Denver, I visited Mayo to attend a cardiac surgical conference with a Denver cardiac surgeon. While there, Saint Marys' anesthesia chief, Emerson Moffitt, offered me a position with opportunities for teaching and research. We moved to Rochester in August, 1966. Others arriving at that time included fellows Joe Messick and Sheila Muldoon and my medical student preceptee Roy Cucchiara. Neuroanesthesia was to occupy 18 of my 20 years at Mayo. In this period, we performed a variety of clinical research including helping define the use of Doppler ultrasound to detect air embolism. I still have the original audio tape of patients' air embolism episodes. I

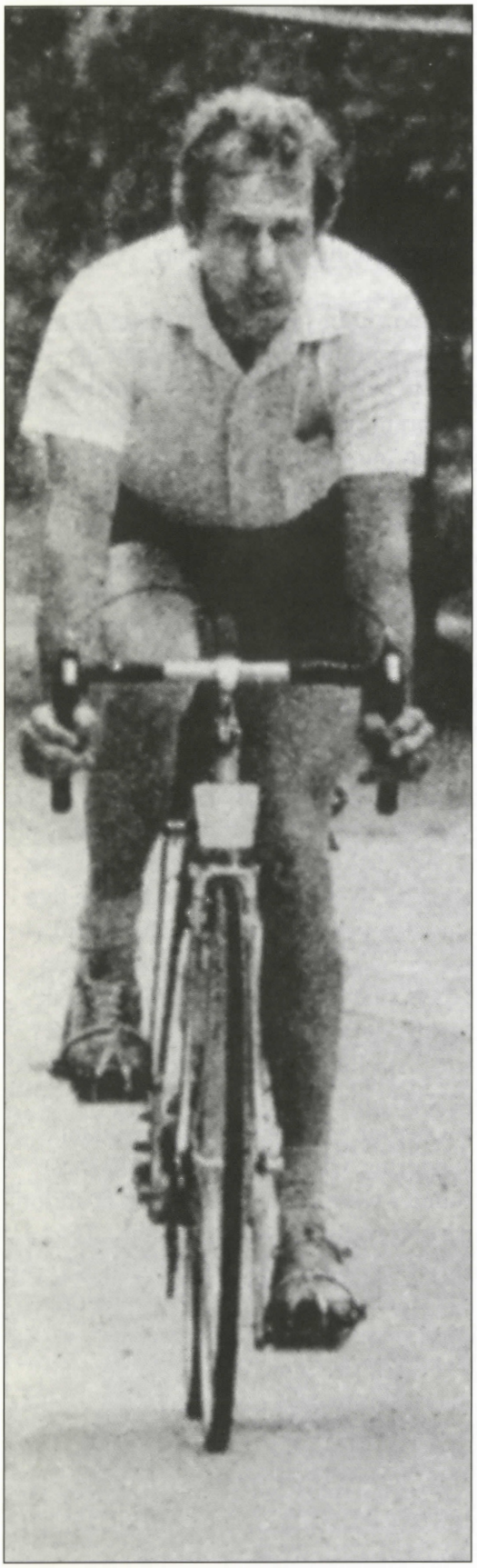


Photo from Post-Bulletin *article about Dr. Gronert's commute to work along the Douglas Trail (see text).*

enjoyed teaching and was selected as "Teacher of the Year."

In 1967, I was drafted and assigned to the US Army burn unit in San Antonio. Our basic training at Camp Bullis included wriggling under fences in sand and sand burrs while 50 mm machine gun fire blasted 18 inches over our heads (no helmets), once in the afternoon and again after dark, so we could see the tracers.

My first burn unit publication concerned giving halothane anesthetics every four days to permit debridement or grafting. Halothane did not alter hepatic function even after ten to twenty anesthetics.

At that time, succinylcholine (SCh) was under a vague cloud regarding the probability that it could cause cardiac arrest when used in patients with thermal trauma. This problem was solved by the landmark report of Tolmie, Joyce, and Mitchell regarding a burn patient in Vietnam. They demonstrated that SCh caused extreme hyperkalemia. Others found that same problem in patients with specific motor neurological deficits including direct muscle trauma. This response was due to proliferating extra-junctional acetylcholine receptors.

We studied SCh in burn unit patients and outlined patterns of potassium response following burns. Previously healthy adult patients with severe burns lost 40-60 pounds during convalescence. The burn-related hyperkalemic response developed in seven to ten days after the burn and returned to normal when the patient was doing well, gaining weight, and becoming mobile, generally after about two months. Patients with motor neurological deficits or direct muscle trauma developed the hyperkalemic response to SCh about four days after injury. Their recovery to normal depended on the type of lesion. If the muscle healed or totally atrophied with time, there was no abnormal muscle to respond to SCh and no hyperkalemia. With upper motor neuron lesions such as produced by stroke or spinal cord transection, the muscle was viable and the hyperkalemic response could be permanent. The muscle in patients at risk to SCh hyperkalemia also became resistant to non-depolarizing muscle relaxants at the same time. My supposition is that a return to a normal response for non-depolarizers indicates a reversal of the hyperkalemic response to SCh.

When I returned to Mayo in 1969, I wanted to see why burn patients with only skin burns developed a muscle-related sensitivity to SCh. The burn literature suggested a pig model due to its human similarities. Dick Theye was my mentor and was superb, focusing on logic and objectivity. The Animal Care Committee reluctantly approved the study. On our first day, several researchers assembled in the hall outside Dick's laboratory to prevent the study. Dick, as was his reputation, cruelly, crudely, and profanely dispersed them. Jim Milde, Dick Koenig, Becky Wilson, Bill Gallagher, and Marilyn Oeltjen were capable techs. Pigs were anesthetized and their backs briefly dipped into hot water to produce discrete full thickness burns. These burns were painless because there was no second degree burn. I washed them twice a day and covered the wound with sulfamylon. No pigs became infected or died;

they were not in pain, they ate well, and they gained weight. We failed in that hyperkalemia did not occur during halothane/SCh anesthesia. We succeeded in providing a laboratory home barbecue (which was acceptable in that era)!

Our next project determined the amount of potassium released from skeletal muscle when exposed to SCh. We measured potassium release in four canine gastrocnemius skeletal muscle preparations: normal, following a month-long denervation (sciatic section), a T 6 spinal cord section, or disuse atrophy (produced by casted immobilization of the pelvis and one hind limb). We measured total blood flow across the muscle and determined oxygen consumption and potassium release. Potassium release was huge following denervation and cord section. A well-regarded Medical Intelligence article summarized this field.

One of our burn pigs developed malignant hyperthermia (MH), opening another research window. Jim Milde, Bill Gallagher, Dick Koenig, and I brought oxygen, halothane, dantrolene, and bicarbonate to the farm of a Poland China pig farmer. We identified MH-sensitive pigs by their rigidity when breathing halothane, and if their response went too far, we gave dantrolene and bicarbonate via the huge porcine ear veins. Our early studies, in addition to those of others, defined increases in oxygen consumption and lactate production that occurred in this condition. Our varied studies of MH included muscle contracture data that identified susceptible pigs and humans. Another of Dick Theye's research approaches provided the means to determine MH responses of various organs, e.g., muscle, brain, heart, liver and gut, sympathetic nervous system. Only muscle and lymphocytes were involved in the MH mutation. Dick unfortunately died in the fall of 1977 from the bulbar form of amyotrophic lateral sclerosis. Our review of MH was published in 1980.

In June 1981, Thor Sundt, the incredible neurosurgeon and one of my two heroes in life, Bob Lennon, and I cared for a young woman with an intracranial aneurysm who, pregnant, had a simultaneous C section and aneurysm clipping. She did well overall, as did her son, and we have maintained contact, most recently at his 25th birthday.

Other Mayo studies with Jack Michenfelder included examining the development of tolerance to barbiturates, as they were being used for brain protection. I also performed research on muscle disuse atrophy and, its converse, exercise fitness conditioning. Both of these altered the potency of non-depolarizing muscle relaxants: disuse increased it and exercise reduced it. This seemed to be related to numbers of endplate acetylcholine receptors. Mayo added funds to my NIH grant which helped immeasurably to accomplish my research.

In February, 1979, I took up cycling and began an everyday commute of 34 miles round trip on the crushed gravel Douglas Trail (see photograph). It was a great ride, doable five to six months per year, isolated, delightful, through the woods, and practical after long neuro days since I could ride home without lights in the dark. I had two problems: an occasional strolling skunk blocked the trail and kept her/his butt end aimed at me and forced a detour. The other was formidable thunderstorms; when the lightning flashes and thunder were close together, I'd abandon the bike and settle under a low bush. The trail sometimes accumulated six inches of water. Later, the trail was paved, extending the riding season. At Pine Island, our 100-year-old farm home was at the top of the hill on southwest County Road 13.

In 1986, I left Mayo for the University of California at Davis for collaborations with the veterinary school and veterinary residency. My research continued to examine MH and acetylcholine receptor responses.

An Englishman in Rochester, 1969-70

David Hatch, F.R.C.A., The Royal College of Anaesthetists, London, England

I still vividly recall arriving in Rochester in early June, 1969, with my wife and three children under age six and surviving the unaccustomed heat in a one-bedroom apartment without air conditioning. Several days passed before all our three children were asleep at the same time, so it was in a fairly trance-like state that we found ourselves listening to an anti-British oration by some civic dignitary during the July 4th celebrations. Our five-year old son waved his American flag with great gusto at every opportunity!

Fortunately, before leaving the United Kingdom (UK), our church helped us get in contact with an ex-pat staff haematologist, Walter Bowie, and his wife Trudi. They helped us find more-suitable accommodation on Mayo Park Drive where Mrs. Hill, the wife of a gastroenterologist who rented homes to many foreign visitors, had established a little community of overseas fellows and their families. I also recall the generous way in which Dick Lundborg, one of the cardiac anesthesiologists, lent me his old Borgward station wagon until I was able to buy an Oldsmobile F85 of my own.

My one-year senior fellowship in Albert Falconer's department was planned to involve eight months in cardiac anesthesia and four months in intensive care, though I later negotiated a six-month extension as Kai Rehder's first research fellow. Both the cardiac and ICU experiences at that time were arguably the best available in the world. The teaching I received from Emerson Moffitt, Bob Devloo, Sait Tarhan, and Dick Lundborg in the operating room and Alan Sessler with the remarkable respiratory therapist Bernie Gilles in the small ICU gave me the basis for my subsequent career at Great Ormond Street Children's Hospital in London. The cardiac surgeons were Dwight McGoon, from whom I also learned a great deal, "Bunkie" Ellis, Bob Wallace, and later Gordon Danielson.
I was one of the mad few residents who liked to replace the nurse anesthetist rather than supervise them, but this meant preparing my operating room in the Alfred Building before the morning meeting which I think started at 7:45 a.m. Since the operating room doors were never unlocked this early, it meant climbing into the room through the laundry chute. We also had to clean up after the case which included washing out the used glass syringes (no fear of Hepatitis B or HIV in those days).

David and Rita Hatch with their family on a tour of the United States following his fellowship at Mayo Clinic.

My decision to apply for some research time with Kai Rehder in his newly established human volunteer laboratory was one of the best I have ever made. Not only did Kai teach me the importance of meticulous study design and data collection, but the weekly meetings "downtown" at the clinical sciences building gave me exposure to some of the giants of respiratory physiology of that Comroe era. These included Bob Hyatt, Earl Wood, Fred Helmolz, and of course Ward Fowler. There was also a startling array of visitors including Jerry Mead, Peter Macklem, and Jo Milic Emili. Although Kai nearly drowned me once in an experiment in the hydrotherapy pool, the love of research which he gave me has lasted all my life. Brian Dawson also contributed to my wider education by teaching me to play the craps tables in Las Vegas en route to a pediatric anesthesia meeting in Los Angeles.

At the end of my fellowship, I hitched a tent trailer to the Oldsmobile and took my family, my parents, and an aunt to Yellowstone before returning to the UK on one of the last passenger liners to sail the Atlantic from Montreal.
During the trip, the ship's surgeon and I treated a seaman with a ruptured spleen, but that's another story.

Anesthesiology Residency News

Steven Rose, M.D.

Eighteen residents from the Mayo Rochester Anesthesiology program completed their residency training in anesthesiology at Mayo School of Graduate Medical Education this year. All have accepted outstanding employment opportunities or have been accepted in desirable fellowships. Please find a list of our graduating residents and their plans for the coming year below:

Katherine Arendt - Mayo Foundation Scholar, OB Anesthesiology Fellowship, Mayo Clinic Rochester
Andrea Benson – Pediatric Anesthesiology Fellowship, Mayo Clinic Rochester
Ryan Bortolon – Private Practice, Minneapolis, Minnesota
David Bruck – Cardiovascular Anesthesiology Fellowship, Mayo Clinic Rochester
Craig Donelan – Private Practice, Sioux Falls, South Dakota
Paul (PJ) Fronapfel – Pediatric Anesthesiology Fellowship, Arkansas Children's Hospital
Dawit Haile – Mayo Foundation Scholar, Pediatric Anesthesiology Fellowship, Mayo Clinic Rochester
Adam Jacob – Mayo Foundation Scholar, Regional Anesthesiology Fellowship, Mayo Clinic Rochester
YS Prakash – Staff, Mayo Clinic Rochester
Anne Ptaszynski – Pain Medicine Fellowship, Mayo Clinic Rochester
Juan Pulido – Critical Care Medicine Fellowship, Mayo Clinic Rochester
Thomas Sanneman – Private Practice, St. Paul, Minnesota
Surjya Sen – Pain Medicine Fellowship, Mayo Clinic Rochester
Daniel Simula – Staff, Mayo Clinic Arizona
Hugh Smith – Mayo Foundation Scholar, Regional Anesthesiology Fellowship, Mayo Clinic Rochester
Matthew Sunderlin – Private Practice, Muskegon, Michigan
Todd Turley – Pain Medicine Fellowship, Mayo Clinic Rochester
Tyler Yeates – Staff, University of Utah

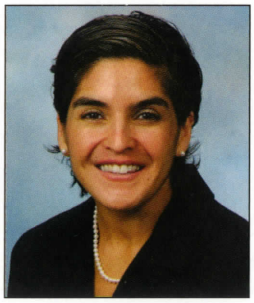
Front Row (left to right): Ryan Bortolon, David Bruck, Dawit Haile, Tom Sanneman, Adam Jacob, Todd Turley. Middle Row (left to right): Juan Pulido, Craig Donelan, Andrea Benson, Matt Sunderlin, YS Prakash, Surjya Sen, Katie Arendt. Back Row (left to right): Dan Simula, Anne Ptaszynski, Hugh Smith, PJ Fronapfel. Not Pictured: Tyler Yeates.

The fifth annual senior resident appreciation dinner was conducted at Mayo Foundation House on June 5, 2006. The group photograph shows the residents who attended the dinner. We will miss this stellar group of residents, but welcome them as our newest alumni!

Four residents from the Mayo Clinic Jacksonville Anesthesiology program completed their training. Their photographs and future plans are as follows:

Stephen Aniskevich, III – Staff, Mayo Clinic Jacksonville
Raquel Buser – Pediatric Anesthesiology Fellowship, DC Children's Hospital, Washington, DC
Teresa Cherry – International Pain Medicine Fellowship, University of Vermont Fletcher Allen Health Care, Burlington, VT
Christopher Robards – Regional Anesthesiology Fellowship, St. Luke's Roosevelt, New York, NY

Dr. Stephen Aniskevich, III



Dr. Raquel Buser

Dr. Teresa Cherry

Dr. Christopher Robards

Several fellows have completed or will soon complete their training in the Department of Anesthesia during the 2005/2006 academic year. Please find a list of their names and the fellowship completed below:

Aaron Tebbs – Cardiovascular Anesthesiology, Mayo Clinic Rochester
Scott Raffo – Cardiovascular Anesthesiology, Mayo Clinic Rochester
Adam Locketz – Pain Medicine Fellowship, Mayo Clinic Rochester
William Thom – Pain Medicine Fellowship, Mayo Clinic Rochester
Thomas Comfere – Critical Care Medicine Fellowship, Mayo Clinic Rochester
Dan Diedrich – Critical Care Medicine Fellowship, Mayo Clinic Rochester
Daryl (DJ) Kor – Critical Care Medicine Fellowship, Mayo Clinic Rochester
Matthew Ritter – Critical Care Medicine Fellowship, Mayo Clinic Rochester
Gloria Walters – Neuroanesthesiology Fellowship, Mayo Clinic Rochester
Tracy Harrison – Pediatric Anesthesiology Fellowship, Mayo Clinic Rochester
Chiwai (Eddy) Chan – Pain Medicine Fellowship, Mayo Clinic Scottsdale

The department welcomed seventeen new residents to the program summer quarter. Although there is considerable change in graduate medical education, much remains the same. Our new residents are mentored by more-senior residents and by faculty volunteers during the first few weeks of their training and we still conduct the "Introduction to Anesthesia" course in the afternoon. The annual infusion of talented, intellectually curious, energetic, and enthusiastic new trainees renews those traits in us all.

The 2006 Department of Anesthesiology Awards Banquet was conducted June 29, 2006. The format of the banquet had evolved over time. The traditional "roast" is gone, but not forgotten! Several awards were presented at the banquet. They are as follows:

Awards selected by Staff

Distinguished Clinicians
Dr. Sandy Kopp
Dr. Francis Whalen
Distinguished Educator
Dr. Paula Craigo
Distinguished Resident
Dr. Juan Pulido

Awards selected by Residents

Distinguished Clinician
Dr. Martin Abel
Distinguished Educator
Dr. Rick Rho
Distinguished Resident
Dr. Hugh Smith

Academic Awards

In-Training Examination Award
Dr. Dean Dewald
Theye Research Award
Dr. Surjya Sen
Rorie Research Award
Dr. Anantha Santhanam

CRITICAL CARE MEDICINE AWARDS

Fellow Awards:

Critical Care Academic Clinician Award:
Dr. Daryl Kor
Critical Care Teacher of the Year Award:
Dr. Matthew Ritter
Chief Fellow Award for Critical Care Anesthesiology: **Dr. Matthew Ritter**

Staff Awards:

Clinician of the Year Award:
Dr. Francis Whalen
Teacher of the Year Award: **Dr. Mark Keegan**

Thanks to our alumni for your continued support of our training programs. If you identify talented prospective residents and/or fellows, please let us know!

ASA - Mayo Reception

Brian Hall, M.D., Chair, Anesthesia Alumni Liaison Committee

The Mayo Clinic Department of Anesthesiology is pleased to announce plans for the Alumni Reception held annually in conjunction with the American Society of Anesthesiologists' meeting. This gala event, occurring Saturday, October 14, 2006, will be hosted in the Versailles, Terrace, and Glass Rooms at the Ritz Carlton Hotel, 160 East Pearson Street, Chicago. Festivities will begin at 6:30 pm and continue until 9:30 pm. In the past, these gatherings have been very well attended, and we are hopeful that you can join us if you are planning to be in Chicago for the ASA.

News about People

Peter Southorn, M.D.

We regret to announce the death of **Dr. E. Paul Didier** on May 30, 2006. Recent Newsletter editions highlighted Paul's numerous accomplishments and interests. He was one of the founders of the Critical Care Service and the Respiratory Therapy Program at Mayo. We extend our heartfelt sympathies to his wife, Lynn, and other members of his family.

We were also saddened to learn about the death of two other individuals connected to our department. After his anesthesiology residency in the class of 1961, **Dr. Peter Verrill** returned to the United Kingdom to become a consultant at University Hospital College Hospital in London. He had a distinguished career at that institution including being the Dean of its Medical School. We extend our profound sympathies to his wife, Christine, and his family. **Dr. William Douglas**, a member of the Mayo Clinic's Department of Thoracic Disease and Critical Care Medicine also passed away recently. In 1972, he became one of the first Thoracic Disease consultants to work in Critical Care at Mayo and, as such, interacted with many anesthesiologists. We also extend our deepest sympathies to Bill's family, especially his wife, Nan.

Mayo Clinic Jacksonville celebrates its 20th year of existence this year. Its Anesthesiology Department has been an integral component of its success.

The leadership of two of the department's working sections in Rochester changed recently. **Drs. Jukka Räsänen** and **Christopher Burkle** have respectively stepped down from leading the Multispecialty Division at Saint Marys Hospital and the South Division at Rochester Methodist Hospital. **Drs. Roger Hofer** and **Michael Walsh** have respectively been appointed to succeed them. We wish Roger and Mike every success in these new positions of responsibility.

Dr. Roger Hofer

Dr. Michael Walsh

We were pleased to learn that **Dr. Mark Warner** has been appointed Dean of the Mayo School of Graduate Medical Education.

We wholeheartedly congratulate **Drs. Bhargavi Gali** and **Paul Carns** for receiving the Karis Award. The Karis Award was established by the Sponsorship Board (a collaboration between the Sisters of St. Francis and Mayo Clinic) to formally recognize the many caring persons at Mayo Clinic Rochester who go out of their way to serve patients, visitors, and colleagues.

Dr. Bhargavi Gali

Dr. Paul Carns

Several consultants have left our department, and we wish them every success and happiness in the future. **Dr. Diana McGregor** returned to Stanford University, **Dr. Casey Husser** has moved to Sioux Falls, South Dakota, and **Dr. Drew Chacon** has gone to San Diego, California.

Dr. Ronald Faust retired in August. Ronnie has had a distinguished career on many fronts and will be particularly remembered for his leadership of our department's residency education program for many years. For their retirement, Ronnie and his wife, Claire, have built a beautiful lake home in northern Minnesota. We wish them every success and happiness in the future.

Dr. Ronnie Faust's retirement party. From left to right: Drs. James Munis, William Lanier, Keith Berge, Diana McGregor, Ronald Faust, and Margaret Weglinski.

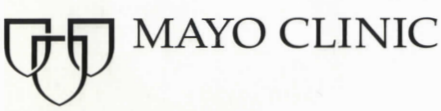
Annual Department Picnic

Peter Southorn, M.D.

Drs. Mary Ellen and Mark Warner again graciously hosted the annual Anesthesia Department summer picnic at their beautiful home in southwest Rochester on July 29, 2006.

As the photo montage shows, everyone who attended enjoyed themselves. Despite it being one of the hottest days on record in Rochester, nobody got heatstroke!

Annual Anesthesia Department picnic at the home of Drs. Mary Ellen and Mark Warner. Photographs courtesy of Dr. Mary Ellen Warner.



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