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Society for Ambulatory Anesthesia

Ambulatory Anesthesia SM

PRESIDENT'S MESSAGE

Say 'Cheese:' President Proud of SAMBA's Success

By Richard A. Kemp, M.D.
SAMBA President

The past year has provided SAMBA with new challenges and directions as the anesthesia and surgery landscape continued to change. There is a current best-selling book that deals with change and all of the confusion, uncertainty, excitement and joy that it can bring to everyone. *Who Moved My Cheese?* by Spencer Johnson, M.D., is a story that features four interesting characters looking for "cheese" – which turns out to be a fitting metaphor for what we want out of life. It is a marvelous book, and one that is most appropriate for anesthesiologists.

I would now like to turn your attention closer to home by announcing that this year's selection for the SAMBA Distinguished Service Award is Wallace A. Reed, M.D., co-founder of the Phoenix Surgicenter. Dr. Reed succeeded in demonstrating that high-quality, safe anesthesia care could be provided in a setting separate from a hospital, effectively moving the "cheese" of doctors and hospitals over the next decade. In a 30-year span, outpatient surgery has come to account for well over half of all anesthesia care procedures.

During the past 20 years we have witnessed SAMBA's very inception and this year, we welcome our 15th Annual Meeting. The proud originators' expectations have been exceeded as SAMBA programs have met with great success nationally, and have been looked upon as a resource internationally. But SAMBA too has found that its "cheese" has moved, and that new opportunities and challenges await.

The growing movement and enthusiasm for office-based surgery and anesthesia has presented new challenges. Last year, American Society of Anesthesiologists (ASA) President, John B. Neeld, Jr., M.D., spoke at our annual meeting about the alarming patient death rate of one in 5,000 liposuction procedures. This information became common knowledge when *USA Today* published two articles and an editorial on January 17, 2000, about a study in the *Journal of Plastic and Reconstructive Surgery*.

A core group of SAMBA members working this past year under Chair Rebecca S. Twersky, M.D., Lawrence, New York, ASA Committee on Ambulatory Surgical Care, tirelessly prepared a document titled, "Guidelines for Office-Based Anesthesia." These guidelines were accepted by the ASA House of Delegates in October 1999. Acknowledgment should be given to Dr. Twersky as well as to Harry C. Wong, M.D., Salt Lake City, Utah, who provided a reasoned, sensitive approach at key moments. Burton S. Epstein, M.D., Bethesda, Maryland, provided, as always, similar expertise and practical wisdom. Jeffrey L. Apfelbaum, M.D., Northbrook, Illinois, and Scott R. Springman, M.D., Madison, Wisconsin, also played key roles. It was an enormous effort of which I was, in the end, glad to be a part.

These guidelines as adopted are some of the nation's most comprehensive for office-based anesthesia care. They provide the anesthesiologist with guidance regarding questions about involvement with office surgery.

Richard A. Kemp, M.D.

Thirty years ago, Dr. Reed developed the surgicenter, which emphasized exceptional patient care in a pleasant atmosphere. Technical excellence was demanded and uncompromising attention to patient safety was paramount. This model has been followed both in hospitals and free-standing facilities. Subsequently, surgery today is safer than ever before. It should be no less safe in the office setting.

It is estimated that within five years 10 million procedures will be performed in physicians' offices. Currently it is estimated that 40 million inpatient and outpatient surgeries are performed annually. SAMBA educational activities are acknowledging the challenge and are

Continued on page 11

EDITOR'S PAGE

The True Seat of Power

Recently I had the privilege of testifying at a congressional hearing in our nation's capital, site of the upcoming SAMBA 15th Annual Meeting, May 4-7, 2000. As I walked to my hotel the night before the hearing, I was rehearsing the points that I wanted to make over and over in my mind. To say that I was apprehensive would have been an understatement. Gazing up at the many ornate and imposing structures on Pennsylvania Avenue, many with offices still lit well into the night, I was struck with the awesome realization that here, in this town, reside the workers of the most powerful and influential nation in the world. Thousands of public servants, many sitting at small desks in cramped offices, are each in their own way responsible for their own small part of this mighty economic and political juggernaut. I really had to stop and reflect on the immensity of it all.

The next day at the hearing was, of course, not as horrific as I thought it would be. Testifying to members of Congress pales in comparison to dealing with incorrigible surgeons, cavalier anesthesia trainees or sweaty hands when I have that inevitable difficult airway. But what impressed me the most on that day was how genuinely interested, attentive and obviously dedicated those congressmen on the committee were.

For almost seven hours, without a break for lunch, they probed, questioned and carried on a very intense dialogue with those testifying. It definitely renewed my previously somewhat soured opinion of our national legislators. These people really cared about what they were doing, just as we ambulatory anesthesiologists care about our patients.

I would encourage all of those attending the SAMBA Annual Meeting in Washington, D.C., to take the time to personally visit your representatives and senators. It really does not take that much time. You can find out who they are and make contact with them through the congressional Web site at <www.congress.gov>.

Let them or their staff know your feelings on the issues of the day. I believe you will be pleasantly surprised at the genuine interest and concern from the people who we elect to public office. Here is an added incentive for you to do this: based on availability, members of Congress can provide their constituents with tickets for VIP passes to several key congressional tours (the Capitol building, White House, Federal Bureau of Investigations, etc.)

Walter G. Maurer, M.D.

Lastly, don't forget to vote this year. In fact, that brings me to the real point of this editorial. We, the American voters, are where the true seat of power lies. For as Franklin D. Roosevelt said, "Inside the polling booth, every American man and woman stands as the equal of every other American man and woman. There they have no superiors. There they have no masters, save their own minds and consciences."

— Walter G. Maurer, M.D.
Editor
SAMBA

CONTENTS

President's Message 1
Editor's Page. 2
Pressures and Challenges of Office-Based Anesthesia. 3
Propofol-Ketamine Update: A Seven-Year Experience 5
ASA Office-Based Anesthesia Guidelines 6
Ambulatory Anesthesia 2000 Montreal, Quebec, Canada 8
Readers Respond to Latest Online Survey 11
Medical Ethics and Ambulatory Anesthesia: Production Pressure 12
Committee on Awards Seeks Nominees for Distinguished Service Award. 16

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Pressures and Challenges of Office-Based Anesthesia

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Office-based anesthesia is becoming the wave of the future. Some anesthesiologists may have believed that the shift of the surgical venue from the hospital to the surgery center was the final frontier. What they did not figure on was surgery moving to even less intensive settings such as physicians' offices. In fact, it is estimated that this year nearly 20 percent of all surgery will be performed in doctors' offices.[1] It is hard to imagine that only four years ago the first article concerning modern-day office anesthesia appeared in anesthesiology literature![2] Office-based anesthesia presents a unique set of pressures and challenges to anesthesiologists who are committed to providing the same caliber of care that is expected from more traditional venues.

The pressures and challenges involved in office-based operations include facility and patient selection, operator credentials, financial difficulties and establishing guidelines of practice.

Facility Pressures — *Where Will I Provide Care?*

One of the practical pressures faced by an office-based anesthesiologist revolves around facility limitations.[3] Regardless of whether or not the facility is accredited, it is extremely important to preview the facility where the anesthetic will be given. Ideally, this may occur prior to the day anesthesia is provided. This offers an opportunity to inspect for general cleanliness, sterility, documentation, staffing, adequacy of monitoring, as well as the breadth and depth of anesthetic supplies and medications. It is also a suitable time to review the education and experience of the surgeon.

During your office visit, and again before the case, it is imperative that you be quite definite as to what you consider the limitations of the facility and where your comfort level exists. Both you and the surgeon must be in agreement about the anesthetic plan, particularly the meaning of intravenous sedation and monitored anesthesia care. Hopefully, these precase discussions will obviate the pressures that might occur directly before or during the procedure, or when the surgeon decides the level of sedation is not sufficient. It is up to us to judge what is a reasonable environment for providing safe, high-quality care to our patients but it is equally important to convey this assessment to the surgeon before the case.

Operator Credentials — *Which Surgeons Should I Provide Care For?*

Another practical pressure revolves around the decision to provide anesthesia for a particular surgeon or not. The office-based anesthesiologist may be pressured to provide care for surgeons with questionable credentials. Most surgeons operate in their office for the sake of convenience, efficiency, cost-savings and patient privacy. However, a few retreat to their office to obfuscate the hospital credentialing process. The anesthesiologist must go beyond "being lawful" and weigh the ethical pressures of providing care in these settings.[4] We should consider what is usual and customary in the area where we provide care, legal mandates, the education of the surgeon and the experience of the surgeon performing the procedure under consideration.

Patient Selection — *Which Patients Are Eligible to Receive Anesthesia Care?*

Together with the surgeon, the office-based anesthesiologist has the unique task of evaluating and selecting which patients will receive anesthesia in the office setting and which patients might be ideally served by having their procedure performed in a hospital setting.[5] Again, one needs open avenues of communication with the surgeon, who should ideally alert the anesthesiologist well in advance of a patient's potential medical problems. Office-based anesthesiologists are also often pressured to do cases on patients who are not appropriate candidates for the office setting. It is important to know one's limitations and to not succumb to this pressure, even though refusal to do a case may mean you will not be invited back. Refusing to provide care for an American Society of Anesthesiologists (ASA) Physical Status III or IV in the office setting has different ramifications than in the hospital or surgery center.

In the case of a surgeon who provides office-based procedures exclusively (e.g., dentists, podiatrists, plastic surgeons or gastroenterologists), there are three potential "real-world" resolutions: 1) the case is canceled, 2) the surgeon provides his or her own anesthesia and 3) the procedure is performed under local anesthesia only. Remembering that there are studies refuting the correlation between ASA Physical Status and poor anesthesia outcomes, many office-based anesthesiologists would speculate if the patient is best served by their refusal to provide care.[6] We walk a fine line. A good rapport with the surgeon who knows you and trusts your medical judgment can often lead to a dialogue in which you weigh the alternatives together and decide the most prudent course of action.

Back-up — *You Are Truly on a Desert Island*

Another potential problem for the office-based anesthesiologist is the lack of other anesthesiologists, specialists or technicians in the immediate vicinity to help out during an

Continued on page 4

Pressures and Challenges of Office-Based Anesthesia

Continued from page 3

emergency. You are *it!* In addition, lack of redundant equipment, supplies and a limited breadth and depth of medications and anesthesia accouterments can only heighten the ambivalence many anesthesiologists experience. Fears can often be assuaged by recalling that anesthesia in the office is not new and that plenty of surgeons, nurses and dentists have been providing it for years with much less equipment and much less formal education and training!

This lack of immediate back-up serves to underscore the importance of facility and patient selection, as well as the need to develop a customized mobile anesthesia unit [MAU].[7] A portable MAU is useful in offices where anesthesia medications and supplies are limited. Above and beyond the absence of back-up help, a MAU, facility limitations or any other factor, the judgment, training, experience, expertise and preparedness of the anesthesiologist form the cornerstone of safe office-based anesthesia.

Financial Pressures — *Watch Your Wallet*

Although office-based anesthesia is susceptible to many of the same financial pressures as other anesthesia practices, there are some issues unique to this type of practice. Many insurance companies require a physician to have hospital privileges in order to become one of their "preferred or participating physicians." Since office-based anesthesiology, by definition, is an office-based medical "specialty," the relevance or need for hospital privileges is obscure. Nonetheless, depending on the geographic area, many exclusively office-based anesthesiologists are often excluded from a variety of health plans and are considered "out-of-network providers."

When patients avail themselves to out-of-network providers, they often incur higher copayment or deductible payments. This is an especially difficult issue when the surgeon is a participating provider but the anesthesiology provider is not. After all, a patient may have sought the services of the surgeon specifically because that physician is a participating provider and the patient expects to have no out-of-pocket expense for the procedure. Subsequent receipt of an anesthesia bill often brings bad will. And it is blatantly illegal to routinely waive copayments and deductibles.

Even if an office-based anesthesiologist is fortunate enough to become a participating provider, many insurance companies will not pay for anesthesia in an office setting. The popular assumption is that procedures done in an office, by definition, do not require anesthesia. If the exact same procedure were done in a hospital, the insurance would not question the need for anesthesia care. Many carriers purport that the change in venue somehow negates the need for anesthesiology service.

No discussion of financial pressures would be complete without mentioning "captive contracts." In these situations the surgeon or other third party is a profiteer. They legally own the anesthesia group, collect the entire anesthesia billing and then salary the anesthesiology providers.

Although captive contracts take many shapes and forms and are often presented as a "good deal," they usually serve to exploit and take advantage of anesthesiologists. Even more worrisome, these arrangements may violate federal and state antireferral and antikickback laws, so it is imperative to seek legal counsel prior to entering into such an agreement.

Putting It All Together — *Practice Accreditation*

The greatest challenge of all is defining the framework in which we work and then successfully administering an office-based anesthesiology practice. But which guidelines should a new office-based anesthesiologist follow?

There is no shortage of office-based anesthesia practice recommendations or guidelines. For instance, ASA has worked arduously to successfully develop a fine and highly useful document to guide practitioners. In addition, many surgical societies and state legislatures have weighed in with their version of office-based anesthesia practice recommendations. Most of these formulations fall short in meeting all the needs of an office-based anesthesia practice. Some lack flexibility, while others have components that are out of touch with usual and customary office-based anesthesia practice.

The Accreditation Association for Ambulatory Health Care (AAAHC) has used a multidisciplinary approach to develop practice guidelines that are highly useful, relevant and flexible. They serve as a useful adjunct to the ASA guidelines. Practices that have gone through enormous effort, energy and time to comport with the AAAHC parameters may undergo a two-day evaluative survey. Last year, the AAAHC became the first organization to accredit office-based anesthesiology practices! Similar to a "Good Housekeeping Seal of Approval," this accreditation process lets patients and surgeons know that an organization has successfully completed an exhaustive peer-reviewed evaluation, and also acknowledges the extensive work that underlies this accomplishment.

The future of office-based anesthesiology rests on the shoulders of those who provide service and who successfully tackle the day-to-day clinical, administrative and financial pressures.

Editor's Note: *References are available on request from the SAMBA Office or on the SAMBA Web site <www.sambahq.org> — W.G.M.*

Propofol-Ketamine Update: A Seven-Year Experience

By Barry L. Friedberg, M.D.
Locum Tenens Anesthesiologist
Office-Based and Ambulatory Surgery Center Practice
San Francisco, California

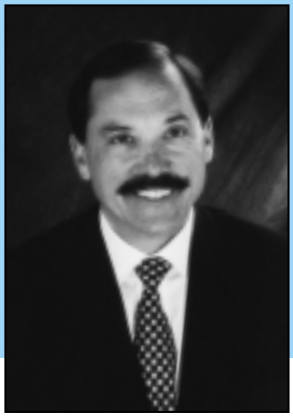
The first American publication of propofol-ketamine (P-K) technique, as derived from Vinnik's diazepam-ketamine technique, appeared in this newsletter.[1,2,3,4] P-K is a room-air, spontaneous ventilation (RASV), dissociative monitored anesthesia care (MAC) approach designed to maximize patient safety in the remote (office) location.[5] I gave the first P-K, opioid avoidance RASV/MAC on March 26, 1992, in Newport Beach, California. This update includes the 1,847 patients who have received this anesthetic approach up to June 15, 1999. To date, there have been no hallucinations or hospitalizations for postoperative nausea and vomiting (PONV) or pain.

There are two fundamentally different approaches that one may take when attempting to provide safe anesthesia in the office setting. One may seek to recreate the same environment in which one is already familiar in the freestanding surgicenter model, i.e., change the office environment to incorporate an anesthesia machine, dantrolene, scavenging, fiberoptic laryngoscopic equipment and a recovery room with dedicated recovery trained personnel. Alternatively, one may adapt one's technique to cope with the existing environment. P-K/RASV/MAC is such a technique. The medical liability carriers' demand for the presence of oxygen, ambu bag and suction do not impose an undue burden on most offices that perform surgical procedures. Crash carts and defibrillators have become the norm in California since the implementation of AB595.

P-K/RASV is specifically exempted from this legislation because ketamine intensifies the laryngeal or "life-preserving" reflexes.[6] I recently testified to this point at the Medical Board of California (MBC) hearing on office-based surgery and was not rebutted by any members, including the chairman, Thomas A. Joas, M.D., San Diego, California.

In southern California recently, a hospital-based anesthesiologist administered an opioid premedication, vapor and endotracheal intubation to an obese, middle aged, white female who was then placed prone for a fat transfer procedure. Before much of the epinephrine-containing local anesthetic had been injected, the patient experienced a severe bradycardia that the attending anesthesiologist promptly treated. The treatment produced a tachycardia that progressed to a pulseless ventricular fibrillation. The patient was successfully defibrillated, transferred to the nearby hospital and was discharged in satisfactory condition after a four-day, $30,000 ICU stay! The additive effect of the opioid predisposing the patient to bradycardia, plus the additional vagal tracheal stimulation from the tube, was the likely genesis of the severe bradycardia. While it is true that bad experiences can happen with any anesthetic approach in a given patient, I had personally administered P-K/RASV/MAC at this office to over 600 patients without any severe bradycardia, including blepharoplasties which often feature strong traction on the periorbital fat near the extraocular muscles.

Many, but not all, office-based anesthesiologists practice in multiple sites, often within the same day, but not necessarily in the same building. This translates into a keen demand for S.A.F.E. anesthesia, with the very minimum amount of equipment being required for interoffice transportation.[7] There are a growing number of anesthesiologists who provide office anesthesia as an itinerant practice. For them, P-K/RASV/MAC is a useful tool. Why would an institution-based, single-site anesthesiologist choose to consider this technique? Because continuous quality improvement (CQI) programs invariably flag postoperative PONV as an



Barry L. Friedberg, M.D.

indicator. The traditional paradigm reads:

1. Surgery is painful,
2. Opioids are painkillers,
3. Therefore all surgery requires the routine use of opioids.

The best PONV rate I could find for the traditional approach was recently published by McKenzie, et al.,[8] at 8.3 percent using a combination of droperidol and ondansetron prophylaxis. Avoiding the routine use of opioids, ondansetron, droperidol or metoclopramide, a recent report using P-K/RASV/MAC demonstrated a 0.6 percent PONV rate (15 times less than the McKenzie study) in a large anecdotal series of patients (1,264) in which one-third had had prior PONV.[5] No special measures were done for the patients with positive histories of PONV. All of the patients in this series had procedures performed without the benefit of routine bispectral index (BIS) monitoring.

After I began routinely using the BIS monitor in December 1997, patients were subsequently titrated to a BIS value between 60 to 70, which is compatible with a light hypnotic state. The lack of effect of a dissociative (50 mg) dose of ketamine on the BIS-measured level of propofol hypnosis was recently reported.[9] This

Continued on page 15

ASA Office-Based Anesthesia Guidelines

By Rebecca S. Twersky, M.D.
SAMBA Immediate Past-President
Chair, ASA Task Force
on Office-Based Anesthesia

Growing concern about the rise of fatalities and other adverse outcomes of office-based surgery prompted the American Society of Anesthesiologists (ASA) and SAMBA to embark on a collaborative project nearly one year ago to establish new guidelines for office-based anesthesia. As a continuing measure of SAMBA's and ASA's efforts in promoting safety and quality anesthesia care in office-based anesthesia, the "Guidelines for Office-Based Anesthesia" were presented and approved by the ASA House of Delegates at the ASA Annual Meeting in Dallas, Texas, October 13, 1999. A committee, chaired by Rebecca S. Twersky, M.D., worked cooperatively with the SAMBA Committee on Office-Based Anesthesia and the ASA Ad Hoc Task Force on Office-Based Anesthesia and representatives from various ASA and SAMBA committees. Input was actively sought from physicians directly involved in office-based anesthesia and from those familiar with accreditation organizations and regulatory and legislative processes.

The guidelines are intended to assist anesthesiologists who are considering practicing office-based anesthesia (OBA). These recommendations focus on quality anesthesia care and patient safety in the office. They were written as minimum guidelines and could be exceeded at any time based on the judgment of the involved anesthesia personnel. As with any guidelines they would be subject to periodic revision as warranted by the evolution of federal, state and local laws, as well as technology and practice.

Since OBA is a subset of ambulatory anesthesia, the guidelines build on the existing ASA "Guidelines for Ambulatory Anesthesia and Surgery" and other ASA standards and guidelines that are applicable in the office setting.

There are special problems that anesthesiologists must recognize when administering anesthesia in the office setting. Compared with acute care hospitals and licensed ambulatory surgical facilities, office operations currently have little or no regulation, oversight or control by federal, state or local laws. Therefore, anesthesiologists must satisfactorily investigate areas taken for granted in the hospital or ambulatory surgical facility such as governance, organization, construction and equipment, as well as policies and procedures including fire, safety, drugs, emergencies, staffing, training and unanticipated patient transfers.

In addressing the practice of OBA, it became apparent that provision of anesthesia care varied with regard to the qualifications and experience of the providers. Therefore, ASA approved a "Statement on Qualifications of Anesthesia Providers in the Office-Based Setting" as a preamble to the OBA guidelines. Various ASA policy documents contemplate that all anesthetics will be delivered by or under the medical direction of an anesthesiologist. ASA recognized, however, that Medicare regulations and the laws or regulations of virtually all states contemplate that where anesthesiologist participation is not practicable, nonphysician anesthesia providers must at a minimum be supervised by the operating practitioner or other licensed physician.

ASA believes that anesthesiologist participation in all office-based surgery is optimally desirable as an important anesthesia patient safety standard, and it will always support such a standard. It does not oppose, however, regulatory requirements that, where necessary, speak merely in terms of "physician" supervision. Those requirements should, however, require that the supervising operating practitioner or other licensed physician be specifically trained in sedation, anesthesia and rescue techniques appropriate to the type of sedation or anesthesia being provided and to the office-based surgery being performed.

Rebecca S. Twersky, M.D.

ASA believes that specific anesthesia training for supervising operating practitioners or other licensed physicians, while important in all anesthetizing locations, is especially critical in connection with office-based surgery where normal institutional back-up or emergency facilities and capacities are often not available.

The most important aspect of the OBA guidelines is that it calls for the anesthesiologist to take part in the perioperative phases of the procedure, as well as the maintenance of the facilities and equipment. The guidelines are meant to bring the quality of office-based anesthesia as close to the level of hospital-based procedures as is reasonably possible, recognizing that the office is not a hospital.

The OBA guidelines address both administrative and clinical care. The section on administration and facility highlight responsibilities for governance, quality of care, facility and safety. The section on clinical care discusses patient and procedure selection, perioperative care, monitoring and equipment and provisions for emergencies and transfers. Anesthesiologists should feel confident that the following issues are addressed in their office setting so that they can provide optimum patient safety and reduce the risk of liability.

There are now various physician

groups, medical boards and other related organizations that are encouraging their state legislators to establish regulations quickly since the rate of office-based surgeries is on the rise. These guidelines are now recognized as the authoritative voice in office-based anesthesia and can greatly assist anesthesiologists in their state efforts. The ASA Task Force on Office-Based Anesthesia is now completing the final phase of a document that will provide more detailed recommendations for practicing anesthesiologists.

STATEMENT ON QUALIFICATIONS OF ANESTHESIA PROVIDERS IN THE OFFICE-BASED SETTING

Approved by the ASA House of Delegates on October 16, 1974 and last amended on October 13, 1999)

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This statement should be read in conjunction with ASA's "Guidelines for Office-Based Anesthesia," adopted by its House of Delegates in October 1999.

GUIDELINES FOR OFFICE-BASED ANESTHESIA

Approved by the ASA House of Delegates on October 16, 1974 and last amended on October 13, 1999)

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Administration and Facility.

Quality of Care

The facility should have a medical director or governing body that establishes policy and is responsible for the activities of the facility and its staff. The medical director or governing body is responsible for ensuring that facilities and personnel are adequate and appropriate for the type of procedures performed.

Policies and procedures should be written for the orderly conduct of the facility and reviewed on an annual basis.

The medical director or governing body should ensure that all applicable local,

Continued on page 14

The
Society for Ambulatory Anesthesia
Presents…

SOCIETY FOR AMBULATORY ANESTHESIA

Ambulatory Anesthesia 2000

June 3-4, 2000
Hotel Wyndham Montreal
Montreal, Quebec, Canada

MONTREAL

Presented in Conjunction with the
12th World Congress of Anaesthesiologists

Ambulatory Anesthesia — 2000

Presented in conjunction with the 12th World Congress of Anaesthesiologists

If you are planning to attend the 12th World Congress of Anaesthesiologists on June 4-9, 2000, in Montreal, Canada, make it a point to arrive a day early to attend **Ambulatory Anesthesia – 2000,** presented by the Society for Ambulatory Anesthesia (SAMBA), the leader in ambulatory anesthesia education. This pre-Congress symposium will be presented on Saturday and Sunday, June 3-4, at the newly renovated Hotel Wyndham Montreal in the heart of downtown, within a five-minute walk of the convention center.

Program Chair Frances F. Chung, M.D., Professor, Toronto Western Hospital, Toronto, Canada, and the program committee have assembled a faculty of internationally renown experts to present a program on such pertinent topics as "Preparation for Ambulatory Anesthesia," "Optimal Ambulatory Anesthesia," "The Ideal Anesthetic Agent and Device," "Controversies in Ambulatory Sugery," "Update in Ambulatory Anesthesia" and "New Horizons in Ambulatory Anesthesia." Interactive question-and-answer sessions with the speakers are scheduled so that attendees can take full advantage of their participation.

Social activities, including breakfast and coffee and tea breaks on Saturday and Sunday, and a Saturday luncheon, provide registrants with the valuable opportunity for informal gatherings with their colleagues from around the world to discuss solutions to present-day concerns.

The majority of international ambulatory anesthesia organizations have pledged to promote **Ambulatory Anesthesia – 2000** to their members by distributing registration brochures and information. Mark your calendar now and reserve June 3-4, 2000, to attend what promises to be one of the largest educational events of its kind in the new millenium. Join your colleagues from around the world at **Ambulatory Anesthesia – 2000,** presented in one of North America's most exciting cities, Montreal, Canada.

Registration Tuition

The tuition for **Ambulatory Anesthesia – 2000** is $175 (U.S.) for active and affiliate SAMBA members, $200 (U.S.) for nonmembers and $100 (U.S.) for residents. The tuition includes a course syllabus, all scientific and educational presentations, coffee and tea breaks, continental breakfasts on both mornings of the symposium and a luncheon on the first day of the event. ***Register on the Internet at www.sambahq.org***

Cancellation Policy

Cancellation of the symposium registration must be submitted in writing and will be accepted until two weeks prior to the beginning of the symposium. Your refund, less a 50 percent administrative fee, will be sent after the conclusion of the meeting.

Continuing Medical Education Accreditation

The University of Toronto has been accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The University of Toronto designates this continuing medical education activity for 10.5 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association, and as an accredited group-learning activity (10.5 hours) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada.

Registration Form
Ambulatory Anesthesiology 2000

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Ambulatory Anesthesia 2000 – Preliminary Program

Saturday, June 3, 2000

0730 Registration
0730-0800 Breakfast
0750-0755 Welcome Address

SAMBA President

0755-0800 Opening Remarks
Frances F. Chung, M.D., Canada
Symposium Chair

0800-0930 Preparation for Ambulatory Anesthesia
Moderator: Raafat S. Hannallah, M.D., U.S.A.
Every Patient Can Be an Outpatient
Lydia A. Conlay, M.D., Ph.D., U.S.A.
Pediatric Patient Selection: What Is New?
Raafat S. Hannallah, M.D., U.S.A.
Preoperative Testing: Is There a Need?
J. Lance Lichtor, M.D., U.S.A.
Why Not Tea and Toast for Breakfast?
Sujit K. Pandit, M.D., U.S.A.
Is There a Need for Premedication?
Jan Jakobsson, M.D., Sweden

0930-0945 Interactive Questions and Answers Session with Registrants

0945-1015 Coffee

1015-1145 Optimal Ambulatory Anaesthesia
Moderator: Maria Sol Carrasco-Jimenez, M.D., Spain
Optimal Pain Management: How Do I Do It?
Johan Raeder, Ph.D., Norway
Optimal Antiemetic: What Do I Give?
Mehernoor F. Watcha, M.D., U.S.A.
Achieving Fast Tracking with New Scoring System
Frances F. Chung, M.D., Canada
Anesthetic and Sedation Technique for Office-Based Procedure
Ana Diez, M.D., Spain
Achieving Efficiency with Team Work
Patricia A. Kapur, M.D., U.S.A.

1145-1215 Interactive Questions and Answers Session with Registrants

1215-1315 Lunch

1315-1445 The Ideal Anesthetic Agent and Device
Moderator: Glenda L. Rudkin, M.D., Australia
Sevoflurane Is Ideal for Ambulatory Anesthesia
Beverly K. Philip, M.D., U.S.A.
Desflurane Is Ideal for Ambulatory Anesthesia
Michael H. Nathanson, M.B., U.K.
Target Control Infusion (TCI) Is Ideal for Ambulatory Anesthesia
Gavin N. Kenny, M.B., U.K.
LMA: An Excellent Choice for Ambulatory Anesthesia
Martin S. Bogetz, M.D., U.S.A.
COPA: An Excellent Choice for Ambulatory Anesthesia
Robert S. Greenberg, M.D., U.S.A.

1445-1515 Interactive Questions and Answers Session with Registrants

1515-1545 Coffee

1545-1645 Controversies in Ambulatory Surgery
Moderator: Jean Millar, M.D., U.K.
Every Operation Can Be an Ambulatory Procedure?
Henrik Kehlet, M.D., Denmark
Stop Too Much Ambulatory Surgery!
David Wilkinson, M.D., U.K.
What Are the Surgical Complications?
Paul E.M. Jarret, M.D., U.K.

1645-1700 Interactive Session with Registrants Questions and Answers

Sunday, June 4, 2000

0800-0930 Update in Ambulatory Anesthesia
Moderator: Rebecca S. Twersky, M.D., U.S.A.
Why Is General Anesthesia the Best for Ambulatory Anesthesia?
Rebecca S. Twersky, M.D., U.S.A.
Why is Regional Anesthesia the Best for Ambulatory Anesthesia?
Vincent W. Chan, M.D., Canada
Role of Non-Pharmacologic Therapy in Ambulatory Anesthesia
Paul F. White, M.D., PhD, U.S.A.
What Is New in Muscle Relaxants?
Claude Meistelman, M.D., France
Pediatric Dilemmas in the Outpatient
Hernando De Soto, M.D., U.S.A.

0930-1000 Interactive Questions and Answers Session with Registrants

1000-1030 Coffee

1030-1130 New Horizons in Ambulatory Anesthesia
Moderator: Kari T. Korttila, M.D., Ph.D., Finland
Do We Benefit from Monitoring Depth of Anesthesia in Outpatients?
Charles H. McLeskey, M.D., U.S.A.
Pain Clinic Without Walls
Kenneth Zahl, M.D., U.S.A.
Alternative Medicine and Ambulatory Surgical Anesthesia Practice
Yung-Fong Sung, M.D., U.S.A.

1130-1200 Interactive Questions and Answers Session with Registrants

1200 Closing Remarks
Frances F. Chung, M.D., Canada
Symposium Chair

Contact the SAMBA office for registration information, or register on-line at www.sambahq.org

Say 'Cheese:' President Proud of SAMBA's Success

Continued from page 1

bringing the technical expertise and record of safety in hospital and freestanding facilities into the office setting. The "cheese" is moving yet again, presenting new challenges and opportunities.

Recently there has been widespread publicity on medical errors published by the Institute of Medicine Committee on Quality of Health Care in America: "Anesthesiology is an example of a local, but complex, high-risk, dynamic patient care system in which there has been notably reduced error." Further success for reducing anesthesia mortality lies in the development of "information-based strategies." It is in this area that SAMBA has been most instrumental in ambulatory surgery advancements.

SAMBA is sponsoring a meeting on June 3-4, 2000, in Montreal, Quebec, Canada, prior to the World Congress. Frances F. Chung, M.D., Toronto, Ontario, Canada, has organized an exceptional program. It is a great opportunity to expand your horizons in the international scene. Plans are also being made to co-host a meeting with the Federated Ambulatory Surgery Association for the International Ambulatory Association for Surgery in Boston, Massachusetts, in 2003. There will also be a pre-ASA meeting on the Friday prior to the ASA Annual Meeting. Andrew Herlich, M.D., Philadelphia, Pennsylvania, is busy planning this event.

SAMBA educational activities are acknowledging the challenge and are bringing the technical expertise and record of safety in hospital and freestanding facilities into the office setting. The "cheese" is moving yet again, presenting new challenges and opportunities.

The SAMBA Web site developed by President-elect J. Lance Lichtor, M.D., Chicago, Illinois, is proving to be quite successful. SAMBA has funded a media program for print and radio that has attracted thousands of people to the site seeking information about ambulatory anesthesia.

John B. Leslie, M.D., Scottsdale, Arizona, is currently very busy with the SAMBA Outcomes Research Award. There has been a good response to the January 15 deadline and reviewers are pouring over the submissions. Announcement of the winner is scheduled in May at the annual meeting.

As my term comes to conclusion, I would like to express my gratitude to the many friends I have made, and I'd like to thank you all for the wonderful experiences I have had. I wish to thank our committee chairpersons and Board of Directors for their work. I believe that there are great opportunities for the future of SAMBA in providing programs for our colleagues and patients. I also wish to thank Gary W. Hoormann, whose loyalty and assistance to the Society is appreciated by all.

It's a Nice Place to Visit, But We Wouldn't Want an Operation There: Readers Respond to Latest Online Survey

By J. Lance Lichtor, M.D.
SAMBA Webmaster
Chicago, Illinois

Some patients hate the thought of a hospital admission. Even if an outpatient operation is needed, many people would much prefer having the procedure in the physician's office. Also, hospitals have to maintain more equipment and are tightly regulated, which results in higher patient fees. In a word, surgery in a physician's office costs less. Other patients, although disliking hospital stays, may appreciate the backup that is available in a hospital, even if the costs are a little higher.

For these and other reasons, the last SAMBA online survey asked the question, "Where would you prefer having ambulatory surgery?"

Of 62 votes submitted, 66 percent would prefer having ambulatory surgery in an oupatient area connected to a hospital; 27 percent preferred such surgery in a freestanding clinic with operating rooms and 6 percent preferred the physician's office.

Next quarter's survey:

It is estimated that 44,000 to 98,000 hospital deaths are caused each year by medical mistakes, despite the fact that hospitals are already tightly regulated. Office-based surgery is not regulated to the same extent. Should office-based surgery and hospital-based surgery be governed by the same regulations?

Medical Ethics and Ambulatory Anesthesia: Production Pressure

Mary A. Vann, M.D.
Staff Anesthesiologist
Beth Israel Deaconess
Medical Center Instructor
Harvard Medical School
Boston, Massachusetts

Ambulatory anesthesia attracts practitioners who thrive on activity and efficiency in the operating room and who perform well under time and cost constraints. But the stress placed on anesthesiologists in these situations may have medical and ethical consequences. This article intends to examine the practice pressures in ambulatory anesthesia and to describe their impact on patients and caregivers.

Production pressure refers to the overt or covert incentives and pressures on a person to place production, not safety, as the top priority. These pressures can originate from external or internal sources. Subsequently, the anesthesiologist may also exert similar pressures on coworkers and patients.

External production pressures are placed on the anesthesiologist by surgeons, colleagues, patients and administrators. These external pressures compel us to avoid cancellation of cases, alter our usual anesthetic practices and to work faster. Administrators urge us to reduce costs, limit our use of drugs and supplies and decrease turnover times, all of which may decrease quality of care.

Internal production pressures are those we take upon ourselves. As described by Gaba,[1] these pressures motivate the anesthesiologist to get along with surgeons, avoid delaying cases, avoid appearing overly concerned or a "cry baby," avoid litigation, maximize the number of cases done and work when fatigued. Certainly an anesthesiologist wants to give the impression of cooperation, competence, efficiency and ability in their practice. However, this generates internal pressure to perform when the surgeon or patient is difficult, the case complexity exceeds expectations for the situation or when the anesthesiologist is ill or tired.

These types of pressures are not unique to medicine. They have been blamed for accidents in various occupations. Manufacturers experiencing external pressures may sacrifice quality and safety; disasters due to production pressure have cost lives in transportation and other industries. Examples include the nuclear disaster at Chernobyl, several airline crashes and the hypothetical pizza delivery driver rushing to meet the thirty-minute guarantee.

The only study dealing with the anesthesiologist's experience with production pressure was published in *Anesthesiology* in 1994 by Gaba, et al.[1] In this survey of California anesthesiologists practicing in 1992, the respondents' caseload was approximately 50 percent outpatient. In the study, 54 percent of respondents reported that they felt that they had made an error attributable to fatigue. Sixty-three percent replied that they had made an error in clinical management secondary to the excess workload during a case. Forty-nine percent reported having observed an anesthesiologist pressured to conduct anesthesia in an unsafe fashion given the level of urgency of the situation. The physicians surveyed had also witnessed patients anesthetized for elective surgery with inadequate preoperative evaluations (54 percent), significant contraindications to surgery or anesthesia (31 percent or inadequate monitoring (28 percent). One-third of the respondents also reported observation of a colleague agreeing to administer anesthesia for a patient after procedures were cancelled by another anesthesiologist for safety concerns.

Overt external pressures are often internalized by the anesthesiologist. Thus, the ambulatory practitioner avows that they are more efficient and cost-conscious than other subspecialists. The office-based anesthesiologist may experience additional external and internal pressures, however. To maintain an office contract in a competitive market, the anesthesiologist must strive to please the surgeon and maximize the number of cases done in a given time period while exuding an appropriate level of confidence. Often this needs to be accomplished while altering practice patterns to fit an unfamiliar environment.

Another internal pressure experienced by anesthesiologists is the balance of income and leisure time. In the California survey, fee-for-service anesthesiologists reported more internal production pressure than salaried physicians. Economists have reported that "physicians always will behave so as to maximize the hourly net income that they can extract from the practice of medicine."[2] Indeed, some group practices define productivity only in terms of income, not patient outcomes or satisfaction.

This discussion of production pressure has barely mentioned the needs of the patient. Ethical principles state that the "patient's interests take priority over others' interests."[3] Production pressures conflict with the anesthesiologist's ability to place the patent's interests first. In fact, "health professionals face growing pressure to serve ends that fit awkwardly with the ideal of fidelity to patients."[4] Physicians may be induced to act in haste and to commit violations of their normal practices, which can result in unintentional errors and potential harm to patients.

The ethical principles of *beneficence* (promote good) and *nonmaleficence* (do no harm) may give way under the pressures of ambulatory anesthesia. While the physician does not intend to cause harm, the priorities they set may relinquish these ethical ideals. As an example, patient satisfaction, which is unquestionably an important goal of ambulatory anesthesia, essentially concurs with these principles. Some practitioners may argue that preventing delays and cancellations improves patient satisfaction. However, ignoring nothing-by-mouth status or disregarding poorly controlled medical conditions to please patients

or surgeons may violate the principle of *nonmaleficence* by placing a patient at risk. Fortunately, bad outcomes are relatively infrequent in anesthesia today. The question is whether ambulatory anesthesiologists push the limits of safety in order to appear more efficient, productive and self-assured.

The stress that anesthesiologists may impose on patients will be referred to as "cooperation pressure." So-called cooperation pressure may be exerted on a patient when an anesthesiologist persuades or coerces a patient to accept the most simple or expedient anesthetic. Patients should be informed of all anesthetic options or alternatives. Production pressure may entice practitioners to recommend the technique with the quickest induction or shortest recovery. The technique may also provide the best outcome for that patient, but this may not be the anesthesiologist's motivation for advising the patient to accept it. An anesthetic that permits the patient to be discharged sooner may be recommended since it allows the anesthesiologist to leave the facility earlier. This may be the case when a spinal is not offered to day-surgery patients, especially for cases late in the day.

Anesthesiologists are ethically obligated to involve the patient in decision making and to assure an independent and informed choice. Patient autonomy is the predominant ethical concept today. However, the day-surgery patient may never be able to make a fully autonomous choice. In a study of parents of pediatric patients, many respondents stated that the desire for the surgery itself was more influential in their decision about anesthesia administration than the preoperative discussion of anesthetic risks.[5] Braddock has proposed that "the standard for completeness of informed decision making ought to respond to the complexity of the decision."[6] In his study examining decisions made during a routine office visit, he utilized an ethical model for informed decision making that required discussion of seven elements: 1) The patient's role in decision making, 2) the nature of the decision 3) alternatives, 4) risks and benefits of the alternatives, 5) uncertainties associated with the decision, 6) an assessment of the patients understanding of the decision and 7) an exploration of the patient's preferences. This study found that only 22 percent of decisions met the criteria. Complex decisions met the criteria less frequently than simpler ones. For many operations, the anesthesia may be more complex or risky than the surgical procedure. This study illustrates the challenge that an anesthesiologist faces in attempting to meet this ethical standard in a limited amount of time while speaking to a previously unknown patient.

Ambulatory anesthesiologists operating in a fast-paced, high-efficiency environment may overlook ethical principles as they yield under the stress of their working environment. By recognizing the influence that external and internal production pressures place on them, the physician can work to preserve these ethical ideals in their practices.

References:

1. Gaba DM, Howard SK, Jump B. Production pressure in the work environment. *Anesthesiology*. 1994; 81:488-500.
2. Reinhardt UE. The economist's model of physician behavior. *JAMA*. 1999; 281:462-464.
3. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 4th ed. New York. Oxford University Press, 1994.
4. Bloche, MG. Clinical loyalties and the social purposes of medicine. *JAMA*. 1999; 281:268-274.
5. Waisel DB, Truog RD. The benefits of the explanation of the risks of anesthesia in the day surgery patient. *J Clin Anesth*. 1995; 7:200-204.
6. Braddock CH, Edwards KA, Hasenberg NM, Laidley TL, Levinson W. Informed decision making in outpatient practice. *JAMA*. 1999; 282:2313-2320.

Announcing the… **SAMBA 4th Annual Mid Year Meeting**

Controversies in the New Millenium

October 13, 2000 The Argent Hotel
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GUIDELINES FOR OFFICE-BASED ANESTHESIA

Continued from page 7

state and federal regulations are observed.

All health care practitioners* (*defined herein as physicians, dentists and podiatrists) and nurses should hold a valid license or certificate to perform their assigned duties.

All operating room personnel who provide clinical care in the office should be qualified to perform services commensurate with appropriate levels of education, training and experience.

The anesthesiologist should participate in ongoing continuous quality improvement and risk management activities.

The medical director or governing body should recognize the basic human rights of its patients, and a written document that describes this policy should be available for patients to review.

Facility and Safety

Facilities should comply with all applicable federal, state and local laws, codes and regulations pertaining to fire prevention, building construction and occupancy, accommodations for the disabled, occupational safety and health, and disposal of medical waste and hazardous waste.

Policies and procedures should comply with laws and regulations pertaining to controlled drug supply, storage and administration.

Clinical Care

Patient and Procedure Selection

The anesthesiologist should be satisfied that the procedure to be undertaken is within the scope of practice of the health care practitioners and the capabilities of the facility.

The procedure should be of a duration and degree of complexity that will permit the patient to recover and be discharged from the facility.

Patients who by reason of pre-existing medical or other conditions may be at undue risk for complications should be referred to an appropriate facility for performance of the procedure and the administration of anesthesia.

Perioperative Care

The anesthesiologist should adhere to the "Basic Standards for Preanesthesia Care," "Standards for Basic Anesthetic Monitoring," "Standards for Postanesthesia Care" and "Guidelines for Ambulatory Anesthesia and Surgery" as currently promulgated by the American Society of Anesthesiologists.

The anesthesiologist should be physically present during the intraoperative period and immediately available until the patient has been discharged from anesthesia care.

Discharge of the patient is a physician responsibility. This decision should be documented in the medical record.

Personnel with training in advanced resuscitative techniques (e.g., ACLS, PALS) should be immediately available until all patients are discharged home.

Monitoring and Equipment

At a minimum, all facilities should have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs. Specific reference is made to the ASA "Guidelines for Nonoperating Room Anesthetizing Locations."

There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to the patient, anesthesia machine (when present) and all monitoring equipment.

All equipment should be maintained, tested and inspected according to the manufacturer's specifications.

Back-up power sufficient to ensure patient protection in the event of an emergency should be available.

In any location in which anesthesia is administered, there should be appropriate anesthesia apparatus and equipment which allow monitoring consistent with ASA "Standards for Basic Anesthetic Monitoring" and documentation of regular preventive maintenance as recommended by the manufacturer.

In an office where anesthesia services are to be provided to infants and children, the required equipment, medication and resuscitative capabilities should be appropriately sized for a pediatric population.

Emergencies and Transfers

All facility personnel should be appropriately trained in and regularly review the facility's written emergency protocols.

There should be written protocols for cardiopulmonary emergencies and other internal and external disasters such as fire.

The facility should have medications, equipment and written protocols available to treat malignant hyperthermia when triggering agents are used.

The facility should have a written protocol in place for the safe and timely transfer of patients to a prespecified alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient.

Propofol-Ketamine Update: A Seven-Year Experience

Continued from page 5

demonstration tends to refute the criticism that P-K/RASV/MAC is an uncontrolled (subtext, "unsafe") general anesthetic.[10] The analgesia from the 50 mg dose of ketamine lasts only 10-20 minutes and enables the injection of local anesthetic in a quiet, motionless patient.[11] Avoiding the pain of the local anesthetic injection by means of a dissociative (50 mg) dose of ketamine after propofol hypnosis is an excellent first step in obtaining a near zero PONV rate. Adequate local anesthesia for surgery prevents the cascade of negative cerebral neurohumors that occur when surgeons hurt paralyzed patients. Patients move if the local is inadequate. Movement, as well as a lack of lowered BIS-measured propofol hypnosis with a dissociative dose of ketamine, is why P-K/RASV is a MAC, not a general anesthetic. The routine use of the BIS monitor reduces propofol consumption by an average of 20 percent, or 416 mg per case.[12]

The main areas of criticism of P-K/RASV/MAC have focused on the cost of the propofol, fear of ketamine-induced hallucinations and the inhibition of injecting more than seven mg/kg of epinephrine containing lidocaine, for adequate, nonopioid analgesia.[13] The cost of the propofol has decreased because of the introduction of routine BIS monitoring as well as the availability of the generic formulation. An additional 583 patients beyond the original 1,264 have experienced the same lack of hallucinations reported in references one, four and five. Klein and Ostad have published doses of 35 and 55 mg/kg of lidocaine respectively for tumescent anesthesia when prepared as 500 mg lidocaine (50 cc of 2 percent or 25 cc of 2 percent) and 1 mg epinephrine (1:1,000) diluted in 1,000 NSS.[14,15] Four liters of this solution can safely be used for liposuction in the "typical" 60 kg female. To quote Klein, "It is the inherent slow rate of absorption from the fat that accounts for the safety of liposuction...using high doses of lidocaine."[13] Following a recent death in Irvine, California, involving inappropriate fluid therapy (2 cc in for every 1 cc out) for a large volume liposuction patient (9,000 cc out), the MBC issued a moratorium on >5,000 cc liposuction cases. (The fluid management plan originated with the surgeon who subsequently lost his license for three years.) Traditional thinking has it that a large third space created by liposuction demands aggressive fluid therapy.

With the proper use of compression garments, there is no significant third space. Aggressive (18,000 cc) fluid therapy in this case resulted in a completely avoidable patient demise and attendant "bad press" for caring physicians involved in office surgery. I support the MBC's moratorium.

Oxygen can be a fire hazard in the presence of the anesthesiologist unfamiliar with lasers. It is rare for a patient to not maintain an SpO_2 > 95 percent breathing room air when using my technique. This feature is a testament to the minimally depressant nature of the technique. All of the patients in this series validate "pre-emptive analgesia" as an effective approach to minimizing postoperative problems like PONV and pain. The dissociative dose of ketamine blocks the pain of injection.

An adequate local prevents the pain of surgery (patients move in response to inadequate local, obliging the team to not hurt the patient). The outcome is 0.6 percent PONV and no hospitalizations for PONV or pain. My spreadsheet shows a distribution of 1,528 females to 320 males, totaling 1,848 patients for 53 different surgeons. The majority (81 percent) of the cases were either liposuction (n = 468), breast enlargement, reduction or pexy (n = 279), facelift or rhytidectomy (n = 205), laser facial resurfacing (n = 196), other facial resurfacing by chemical peel of mechanical abrasion (n = 186) or blepharoplasty (n = 155). All of the patients, including the very few who experienced PONV, said they were satisfied with their anesthetic and would choose it again for subsequent procedures. The cost of the propofol is offset by the value of universally happy patients. Every anesthesiologist who has made the leap of faith to try P-K/RASV/MAC has reported the same safe experiences and happy patients I have reported. I encourage anyone seriously contemplating providing office anesthesia to consider the virtues of this approach. It is safety through simplicity.

Editor's Note: *References are available on request from the SAMBA Office or on the SAMBA Web site <www.sambahq.org> — W.G.M.*

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Committee on Awards Seeks Nominees for Distinguished Service Award

Louis A. Freeman, M.D., Fresno, California, chair of the Committee on Awards, advises that the committee is seeking nominations for the SAMBA 2001 Distinguished Service Award. The Award will be presented during the SAMBA 16th Annual Meeting on May 3-6, 2001, at the Renaissance Esmeralda Resort in Indian Wells, California.

The award, which represents the highest honor SAMBA can bestow upon an individual, is presented in recognition of outstanding service to ambulatory anesthesia. Past Distinguished Service Award Recipients are Mary-Louise Levy, M.D., Chevy Chase, Maryland (1994); Bernard V. Wetchler, M.D., Chicago, Illinois (1995); Stanley Bresticker, M.D., Somerset, New Jersey (1996); Harry C. Wong, M.D., Salt Lake City, Utah (1997); Burton S. Epstein, M.D., Bethesda, Maryland (1998); and Surinder K. Kallar, Richmond, Virginia (1999). Wallace A. Reed, M.D., Phoenix, Arizona, founder of the Phoenix Surgicenter, is the 2000 recipient.

Members interested in submitting a nomination for the SAMBA 2001 Distinguished Service Award should contact the SAMBA office for a nominating form. You may request a form by e-mail at <samba@ASAhq.org> or by telephone at (847) 825-5586. The nominating form requests the name of the nominee, a brief curriculum vitae and a short description of the person's accomplishments. References are requested as well as the name and telephone number of the person submitting the nomination.

The deadline for nominations for the 2001 Distinguished Service Award is **August 1, 2001**.