



Society for Ambulatory Anesthesia

# Ambulatory Anesthesia<sup>SM</sup>

## PRESIDENT'S MESSAGE

### Incoming President Declares SAMBA to Be on Right Track

By J. Lance Lichtor, M.D.  
SAMBA President

*The following is Dr. Lichtor's inauguration speech that was presented at the Society's Annual Meeting on May 7, 2000, at the J.W. Marriott Hotel in Washington, D.C.*

Ten months ago, I realized that if we were to lead ourselves to a productive and meaningful year in 2000, there was a need to recommit ourselves to our collective vision: the education of physicians as well as our work in providing information for our patients. My sense then was that we needed to expand and enhance that vision and commitment.

I decided to go on a personal retreat. I needed to quietly commune with myself, and, to be genuinely fruitful, I decided to take SAMBA with me. There would be two minds, but one to work through a vision. I imagined that SAMBA was a wise but sleeping giant, a powerful force.

Just before I left, I was reading the *New York Times*, and an article caught my attention. It was about the completion of the transcontinental railroad of 1869. The article spoke of the drama of the completion of this event that united the country. It spoke of this event as a force — after all, it had cost so much in terms of human effort, vast sums of money and singular coordination of an economy that had not yet awoken to the industrial revolution.

What caught my attention about the driving of the final spike into the

rail line to span the country was this...I had not known that the final spike and the silver hammer used were electrically wired to a telegraph line which made an electrical signal that was sent to the entire nation.

And the electrical signal was "felt," if you will, as a proclamation to the country — *as it was happening*. It was a shared event. Perhaps the first such national shared event in our history.

What is relevant for us here is that this simultaneous celebration electrically "woke up" the sleeping giant that was our country until that moment. It was the metaphor of "connection." In our modern vernacular, it was a "wake-up call." It was in this mood and sense that I went on my retreat, with my companion, SAMBA.

Because I had given myself a "national" orientation, the first thought I had was that we are American physicians in the most medically advanced country in the world. When I contrast that in my mind with the rest of the world — and I begin to "think internationally" — I realize that we are more powerful, have more potential for care and healing than any other country, that there are many countries throughout the world who could benefit from what we have taught ourselves in the past 20 years. *And perhaps there are many things that we also might learn from our international colleagues.*

Because I have taken SAMBA with me, it is an easy step to make to realize that within the specialty of anesthesia, ambulatory surgery has carved a wide path as a subspecialty, ranging from a beginning when we could do only 14 procedures with care, and



J. Lance Lichtor, M.D.

dared not to do more, until now when we can do, well, I won't say how many, like McDonald's who doesn't count how many billions sold. The members of SAMBA provide anesthesia for more than 65 percent of all of the surgery done each day in the United States. What we can't know for certain is how far the rest of the world must go to reach this accomplishment in anesthesia.

It was at that moment when the vision took me. I suddenly connected SAMBA and its power with that of the sleeping country suddenly connected by an electrical impulse that told us it was time to wake up. I realized SAMBA could do the same. It could become the waking giant for the art and science of outpatient surgery within the whole world.

Our Society is about education and research, of becoming a community of physicians sharing their knowledge. We do that here at our annual meeting,

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## The True Seat of Power

Sometimes I have felt that the job of editing *Ambulatory Anesthesia* was just like my one-year job as chief resident. A chief resident has the only job where there is no particular job description written down, no one is exactly certain what all one is supposed to be responsible for, plus one actually "learns on the job." And after a year they let you go, hire someone else, and it starts all over again.

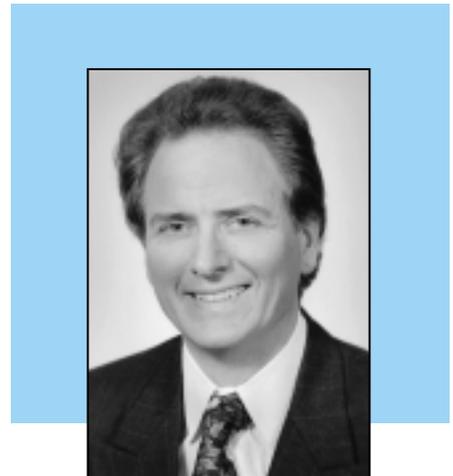
Likewise, my one-year stint as editor has been a real education, especially the last issue with the challenges of a new computer publishing system. Now I get to pass all that on to Girish P. Joshi, M.D., who has been our Committee on Publications Vice-Chair for the past year. I am certain that Dr. Joshi is just waiting to get his on-the-job training started.

But, of course, my efforts with the newsletter did not go unnoticed or unrewarded. I have been asked to chair the Committee on Annual Meeting for our next meeting May 2-6, 2001, in Indian Wells, Palm Springs, California. The SAMBA Annual Meeting is indeed a chal-

lenge — a challenge to deliver a meeting that will satisfy a wide range of members and their widely different needs and practices. And, of course, we want to do it at a reasonable cost. All of you should have received by now the mass e-mail asking for your comments and suggestions relative to the Annual Meeting. It is a pleasure to say that we have received many great ideas. I wish I could have responded personally to every one. You can all be assured that they will be thoughtfully considered for inclusion in the program.

The evaluations from the recent SAMBA Annual Meeting in Washington D.C., direct us toward more audience question-and-answer time being made available. Also, our membership wants practical information that they can apply easily and immediately to their ambulatory anesthesia practices. The Committee on Annual Meeting is committed to satisfying these two primary suggestions.

Lastly, I want to thank all the members of the SAMBA Committee on Publications for their constant sup-



Walter G. Maurer, M.D.

port this past year. They were always available when called upon. Additionally, many members of SAMBA have come forward with their own ideas for changes in *Ambulatory Anesthesia*. I trust that these pages will always remain an open forum for any and all ideas relating to the field of ambulatory anesthesia.

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# Immediate Past President Proud of SAMBA's World Influence

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

*This speech was presented by Dr. Kemp, SAMBA 1999-2000 President, at a luncheon held on May 5, 2000, during the SAMBA 15th Annual Meeting at the J.W. Marriott Hotel in Washington, D.C.*

Last year, those of you who were present heard a presidential address that highlighted a technical proficiency of PowerPoint® never experienced before in 14 previous SAMBA meetings. The background music was a bit loud, but overall the presentation was, well, spectacular. As your President for this past year, I must confess that I am not an expert with PowerPoint. In fact, I remain puzzled that Microsoft demands that I point and click "start" in order to turn my computer off.

So, I am not the PowerPoint sensation that Ricky Twersky is so skillful at, nor am I Jay Leno. I've been a medical director at a freestanding surgery center for 20 years. I recently came across a couple of friends separately in one week who are retired physicians, and they extolled the virtues of retirement. At the breakfast table a few days later, I started to tell my wife of these chance meetings. She abruptly cut me off and said, "Dick, you have got to stop hanging around the bus station."

This past year has been very busy for SAMBA with confronting new opportunities and challenges. In addition to our spring annual meeting, Frances F. Chung, M.D., has organized an international group of speakers for what promises to be an interesting meeting in Montreal, Canada, on June 3 and 4 prior to the World Congress of Anaesthesiologists. In May 2003, SAMBA will jointly host, with the Federated Ambulatory Surgery Association and the International Association of Ambulatory Surgery, an international meeting in

Boston, Massachusetts. SAMBA's meeting will be folded into this meeting, and a more "European" format will be developed, with surgeons and nurses having programs simultaneously and some together. Last October, I attended a meeting in Spain in which over 700 anesthesiologists, surgeons and nurses participated in a meeting on ambulatory surgery and anesthesia.

I would like to acknowledge the participation of some of our members who have given their time and energy to the Society. Walter G. Maurer, M.D., from Cleveland, Ohio, has been our newsletter editor and has upgraded with some new formats. J. Lance Lichtor, M.D., has been the principal behind the SAMBA Web site. The American Society of Anesthesiologists (ASA) recently appropriated \$132,000 to create an improved Web site. Lance has developed the SAMBA Web site for, would you believe it, a couple thousand dollars. Our outreach program with newspaper and radio stories has brought hundreds of individuals from the public to our site on a weekly basis. There is no question that the Internet will become a positive educational and resource site for ambulatory anesthesia — not only for physicians and nurses but also for the public at large. SAMBA will continue to be influential on the international scene through this medium.

Thanks should be given to Melinda L. Mingus, M.D., New York, New York, who was the program chair for last December's very successful Mid Year meeting in Dallas, Texas. Andy Herlich, M.D., of Philadelphia, Pennsylvania, is already well along in organizing next October's meeting in San Francisco prior to the ASA meeting. I'd like to thank Louis A. Freeman, M.D., from Fresno, California, for chairing the Distinguished Service Award Committee, which will be presented tomorrow. Lucy Everett, M.D., from Seattle, Washington, has been most helpful with the Practice Management Committee. SAMBA receives numerous requests for infor-



Richard A. Kemp, M.D.

mation ranging from clinical questions to those of an administrative request for help or information.

I would like to personally thank Charles H. McLeskey, M.D., Gurnee, Illinois, for organizing this meeting as the chair for the Annual Meeting. Charley decided to make a career change from academia to industry in the middle of this year. Charley, please stand and acknowledge our heartfelt thanks for your work this year, and all of those fine presentations which you have given us over the years. We all hope that Charley will continue with his participation with SAMBA. Barbara S. Gold, M.D., who began the year as Vice-Chair of the Annual Meeting, graciously stepped forward and has put the final touches on this meeting. She has also been our Treasurer and a big help this year. Barbara, thank you.

Tomorrow we are looking forward to the announcement and presentation of our Outcome Research Study Award. John B. Leslie, M.D., from Phoenix, Arizona, has done an outstanding job in developing the format and organizing a distinguished panel. This Society owes a tremendous thanks to Gary W. Hoormann for his loyalty, friendship, attention to detail and kindness. This Society and meeting could not possibly be as successful

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# Incoming President Declares SAMBA to Be on Right Track

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but we have an opportunity to expand that to a year-round, everyday event. So we have a mandate and we have the power to reach out to educate, inform and mentor the world by taking the knowledge, the skills, the techniques we have and forming them on an electrical impulse we already have, the Internet, that will allow a world force to provide the finest of outpatient services.

You all may not be aware of the work SAMBA has been doing on the Internet for the past five years. I don't want to bore you with all the details, but the net of it is that members can access e-mail addresses and phone numbers of other members of the Society; for residents and fellows in our subspecialty, we have made a database of teaching programs; we were the first to provide electronic registration for meetings; we have provided Medline services for our membership; we have made available online summaries of speeches by leading practitioners.

And that is not to speak of the small success of our Patient Information Service and its feedback loop that allows patients to ask us questions online for immediate response.

It seems to me that all this, however

progressive, is only the clock that has the potential to ring and wake the giant.

I hope it will not be too much to say that we wish not to replay the electrical impulses on an international basis; the transcontinental railroad may now become the SAMBA "international highway."

And, like the analogy of the railway, a plan has been developed that will need two things to be done concurrently, much like laying the track, and building the engines and seating cars to roll on it when completed. I am assuming here that there are good ideas in other places than the United States. Therefore, we need to collect and compile best practices. I am going to charge the International Relations Committee to begin this process of polling the world of outpatient physicians and centers to learn what are, in fact, the best of the best practices in our subspecialty. Then, when "The Plan" is completed, we will have the information to put on our Web site for international information/education:

## **The Plan**

1) Develop a SAMBA discussion list where physicians in the United States exchange information daily with their international colleagues.

2) Committees within SAMBA

moderate discussions.

3) Clinical committees can be sharpened to provide information on subjects such as:

Office anesthesia, pediatric anesthesia, communications and pain.

4) Patient information area needs to be expanded for the United States as well as established for the world.

5) Reference and study materials need to be prepared for an international audience of physicians (i.e., summarized articles on ambulatory anesthesia).

6) Have the education committee offer CME programs on our Web site.

7) And we have to be willing as an organization to fund and support this effort broadly.

I am sincere when I say that I think of us as a giant. I don't think it is just a metaphor for a speech to say that we are a sleeping giant in terms of realizing our potential as a national and international force in ambulatory surgery. In the tritest of statements, I think we can make a difference in an area of learning and education and information that is now a void. I believe we can fill that void, and in so doing create for ourselves and our international colleagues a dialogue that will stun and surprise us all. We have the power; now we need the will to use it.

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# Immediate Past President Proud of SAMBA's World Influence

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without Gary. Let us give Gary a round of applause.

The founders of SAMBA declared that the mission of SAMBA is education and research. For 15 years, this has been emphasized over and over. Any organization which has a focus on its internal affairs is doomed for failure. This past year, SAMBA has been confronted by outside forces which might well have taken our concentration away from our mission.

Members of SAMBA and the ASA Committee on Ambulatory Surgical Care developed guidelines for office anesthesia, which were passed by the ASA House of Delegates last October. A number of us have become very involved with legislation and the state regulatory process. National publications have asked for SAMBA's position on the Health Care Financing Administration's proposal to allow nurse anesthetists to practice independently.

SAMBA and its members have

achieved national and international respect and acclaim. Still, we must respond to the fact that the political process will decide important patient issues, most assuredly for office surgery and anesthesia. I would urge, however, that SAMBA continue to focus on its mission of education and research and that we each as individuals continue on a daily basis to work at preserving the doctor-patient relationship.

## Bylaws: Not a Dry Subject

By Grover R. Mims, M.D.  
Winston-Salem, North Carolina

When our editor, Walter G. Maurer, M.D., asked me to write an article on the SAMBA bylaws, I immediately thought of an old friend. My friend was an expert on humidity when it was a hot topic in anesthesiology. I enjoyed teasing him by stating that humidity was a “dry subject.” I hope I can make this discussion of our bylaws interesting and not too dry!

The SAMBA bylaws have recently undergone extensive revision in response to the need to involve more SAMBA members in the activities of the organization. The “birth” of SAMBA and its early growth were in the capable hands of the founding mothers and fathers. By necessity, this group divided up the duties and wore many different hats in order to operate SAMBA. As SAMBA grew and became more complex, it became obvious that the existing system was not involving enough of the membership in SAMBA’s activities.

Basically, SAMBA was being run exclusively at the executive level. The Board had grown into a relatively large group, but the committee structure was relatively small. With SAMBA’s rapid growth in membership, changes were needed. A need existed to preserve experience and a sense of history in the leadership of SAMBA while opening up avenues for new people to participate in leadership.

Richard A. Kemp, M.D., became chair of the Bylaws Committee in 1993. Under his leadership, the committee began to work on revising the bylaws. His committee’s work was continued under the guidance Lydia A. Conlay, M.D., Ph.D., who succeeded Dr. Kemp as chair. Her committee finalized the bylaws in its current form, as discussed below.

The Board of Directors, which consists of SAMBA’s elected officers, was streamlined with the offices of first and second vice-presidents combined to create one vice-president office. The at-

large directors, who are elected by the membership, were increased to six. The delegate to the American Society of Anesthesiologists (ASA) House of Delegates and the editor of SAMBA’s *Ambulatory Anesthesia* serve as ex-officio (nonvoting) members.

Term limits and preservation of experienced leadership may seem like contradictory terms; however, the bylaws allow for both. The president-elect and vice-president are to be elected annually. The treasurer and secretary are elected biennially. Three, or one-half, of the directors are elected annually. The directors serve a two-year term. Elected directors are eligible for re-election to one additional two-year term. By comparison, the ASA delegate is elected triennially and the alternate delegate annually.

A candidate for the office of president-elect must be a present officer. A candidate for vice-president must be a present director or the current secretary or treasurer. No other officer needs to be a present or former director.

A candidate for director must be: 1) a current director (eligible for re-election to a full first or second two-year term) or 2) the chair of a current committee, subcommittee or an ad hoc committee.

The committees of SAMBA have also seen change. In 1989, we had nine committees and three subcommittees. The bylaws stated that “each standing committee and subcommittee shall consist of at least three members and a chairperson.” The current bylaws list 15 standing committees and three subcommittees. Each committee and subcommittee consists of six members and a chair, unless otherwise specified in the bylaws. Adjunct members do not count toward satisfying the minimal membership requirements. Membership appointment on a committee or subcommittee is for two years, but all members shall be eligible for reappointment for one additional two-year term.

Committee chairs serve for one year but may be eligible for reappointment for one additional year as chair of the same committee.

The bylaws are constantly being re-



Grover R. Mims, M.D.

vised and expanded to make sure that SAMBA is doing what it is saying and saying what it wants to do. The members of the Committee on Bylaws are: Raymond D. Adams III, M.D.; Adam F. Dorin, M.D.; Elie Fried, M.D.; Joseph F. Johnston, M.D.; Richard A. Kemp, M.D., Advisor.; Ashok K. R. Krishnaney, M.D.; Grover R. Mims, M.D., Chair; Ramesh I. Patel, M.B.; James E. Redford, M.D.; and Jasvantsinh J. Zala, M.B.

The Committee on Bylaws reviews the bylaws annually or more often if needed and recommends amendments when necessary. The committee receives and reviews all proposals for amendments or additions to the bylaws from the secretary in order to ascertain their desirability as a matter of policy, their legality and their consistency or conflict with existing bylaws. Any proposed amendment must be reviewed and approved by the Board of Directors and then voted on by the membership of SAMBA. To pass, the amendment must be approved by two-thirds of the active members present and voting at the annual membership meeting.

I hope that this has not been a dry discussion for you, the readers, for it is through progressive, up-to-date bylaws that SAMBA can continue to be the inclusive, active organization that it is today. ☺

# Optimizing Practice Patterns in Ambulatory Anesthesia

By Melinda L. Mingus, M.D.  
New York, New York

On October 8, 1999, SAMBA held its Mid Year Meeting at the Adams Mark Hotel in Dallas, Texas. The topic for the meeting was "Optimizing Practice Patterns in Ambulatory Anesthesia." This was an appropriate topic for the Mid Year Meeting as the practice of ambulatory anesthesia is faced with forces affecting competition in our industry and impacting our specialty. These forces are:

**Clinical Practice:** Ambulatory anesthesia has done well in this area and has a low rate of complications and a wide array of new drugs and techniques.

**Patient Information and Education:** The subspecialty of ambulatory anesthesia can improve in this area since it has yet to explore many of the opportunities that the Internet offers. Perioperative education can positively impact patient outcome.

**Government Regulations:** Restrictions are getting tighter and tighter, reducing physician reimbursement and ability to practice.

**Business Management:** Ambulatory anesthesiologists need to become involved in cost management and employee relations.

SAMBA Mid Year Meeting 1999 presentations are summarized below:

*Patient Evaluation and Education* — Beverly K. Philip, M.D.

Preoperative clinical assessment prior to anesthesia is time well spent. Medical evaluation criteria should be based on a combination of patient physiological and procedure factors, not chronological age. Metabolic equivalents of activity help to predict cardiac reserve. Equally important were psychosocial factors, such as ability to follow instructions and adequate home situation. Since patients and their families vary according to their coping styles, the anesthesiolo-

gist needs to be sensitive to how much the patient really wants to know. Relaxation techniques and reassurance to decrease anxiety over even minor side effects may be very important. Different teaching strategies (brochures, videos and lectures) in a variety of teaching locations (ambulatory surgical unit, preanesthesia clinic, surgeon's office, and patient's home) provide the best means to impart information to patients.

*How Do We Measure the Benefits and Outcomes of Preoperative Assessment for the Ambulatory Patient?* — Stephen P. Fisher, M.D.

The preoperative evaluation clinic improves operating room efficiency, reduces cost and improves outcome. A centralized location can better allocate resources to perform necessary preoperative testing, better organize necessary medical documents and better provide general information, all of which can avoid operating delays. A separate fee for anesthesia consultation and/or a facility fee for services rendered may help to support the preoperative clinic.

Operating room delays and cancellations on the day of surgery are a significant cost to the hospital. An anesthesiologist-led preoperative clinic commits the anesthesiology department to making sure the case goes well and increases the exposure of the anesthesiologist to the lay public. It also provides opportunities for the anesthesiologist to become business managers active in cost-reducing, quality-enhancing strategies.

Elimination of unnecessary preoperative tests could significantly reduce hospital costs as well as reduce unnecessary delays. In the same way, eliminating unnecessary routine preoperative medical specialty consultations could improve efficiency and reduce expense.

A preoperative clinic managed by anesthesiologists can decrease delays, reduce costs, increase patient and surgeon satisfaction and establish standards of efficient service to im-



Melinda L. Mingus, M.D.

prove quality and add value to patient care.

*Use of the Internet to Facilitate Preoperative Evaluation in the Ambulatory Patient* — Walter G. Maurer, M.D.

A wide variety of patient locations spaced widely apart point to the use of the Internet as a very useful preoperative tool. A computer-based history can be created and automatically added to a growing database as more information is available about the patient. The computer format allows for a "decision-tree" questioning to be built in, preventing errors and facilitating treatment plans. The Cleveland Clinic Foundation uses a computer-based system called HealthQuest. HealthQuest is an interactive patient history-taking tool, originally developed by Michael Roizen, M.D., for Nellcor Corporation. A patient risk classification based on medical history and surgical procedure is also built in, the result of work by L. Reuven Pasternak, M.D. HealthQuest results permit some patients to avoid a visit to the preoperative clinic and to avoid unnecessary tests. Use of this tool frees up anesthesia resources to better concentrate on sicker patients. The Cleveland Clinic's cost per patient cleared is approximately \$24.28. Their cancellation rate has remained around 0.3 percent.

Boston's Beth Israel Deaconess

Medical Center directs its patients to its Web site to view both preoperative and postoperative instructions. A recent study to evaluate postoperative pain indicated that patients would prefer to access the Web for preoperative information.

*Human Resource Challenges for the Anesthesiologist: Hiring in a "Sellers" Market* — Lydia A. Conlay, M.D., Ph.D.

Hiring and retaining talented anesthesiologists is challenging in today's environment. The anesthesia workplace has changed into a "virtual" market where flex-time and part-time workers are becoming the norm. Attracting staff and maintaining their optimal productivity requires applying the following characteristics: employment security, selective hiring of new personnel, self-managed teams and decentralized decision-making, reduced status distinctions and barriers and comparatively high compensation contingent upon group performance. Staff may fear that their increased productivity could put them out of a job. Because the anesthesia market is so mobile, it is very important to maintain a large applicant pool. The recruitment process must be selective enough to weed out applicants who would not fit into the department. Recruiting should be an ongoing process because of turnover (10-15 percent/year in academic departments) and because of the long time (six months) it usually takes to get staff on board. Applicants' expectations must match the expectations and realities of the department to avoid bad hires. Job posting via the Internet has created a "virtual" market, making it easier to hire and get hired.

*An Economic Approach to Analyzing Operating Rooms* — L. Reuven Pasternak, M.D.

Operating rooms can be profitable if revenues exceed costs. Costs and revenues must be clearly identified to effectively manage an operating

room system. Fixed costs can be divided into long-term (contractual obligations of at least six months) and short-term (subject to monthly review and change). Staff is a significant part of short-term costs. Variable costs can be facility-wide or confined to room and procedure. Revenues can be based on procedure (fixed charge so that variable costs cannot be passed on), bundled (conflict between professional fees and facility costs), market consolidated (small variations per procedures can result in wide swings in volume) and regulated (subject to local, state and federal control). Each operating room requires two non-physician personnel for staffing. Each operating room must be assessed fixed overhead distribution and incremental costs. Utilization rates in the upper 70s allow flexibility without a loss.

*What Is the Best Way to Market an Ambulatory Surgery Facility?* — Adam F. Dorin, M.D.

The best ambulatory surgical units are to have the following necessary ingredients: experienced outpatient surgical management, well-conceived design and sufficient capital. Efficiently run operating rooms with short turnover times attract and retain quality physicians. The clinical, paid hours per case (the number of paid hours for clinical staff divided by the number of cases) should not be greater than 8-11 hours per case. Staff should be multitasking, capable of handling a diversity of cases. Compensation should be competitive and have built-in incentives to reward both employees and facilities. Fees should be appropriate to the region. Top procedures should be reviewed monthly to make sure that costs are not exceeding revenues. Public relations and marketing efforts are a top priority. Professional packets and brochures can be given to surgeons, office schedulers and the community (under promise, but over deliver). How well you will perform in a particular community can be estimated

with a simple market penetration that compares the zip codes from your patient population to the total number of people living in the area. Accreditation (the Accreditation Association for Ambulatory Health Care, Inc., Joint Commission on Accreditation of Healthcare Organizations) and Medicare and state certification are important for the success of the ambulatory surgical unit.

*How Do We Measure and Prevent Morbidity in Ambulatory Surgery?* — Lee A. Fleisher, M.D.

While the morbidity and mortality following ambulatory surgery may be low, the complexity of patients and procedures is increasing. In addition, surveillance measures are limited in the usual outpatient setting. Readmission to the hospital after 24 hours is a frequently used indicator for quality control. However, readmissions within one week may reflect perioperative care. Outpatient readmission rates should be compared to inpatient rates for determination of national rates to better define safe anesthesia. Large national studies are under way to determine absolute rates of readmission and mortality.

*Does Anesthetic Technique Influence Outcome in Ambulatory Surgery?* — Meg A. Rosenblatt, M.D.

Patient satisfaction is inversely related to the number of symptoms 24 hours after surgery. Confusing this picture is the fact that measuring patient satisfaction is subjective and more a function of surveys than actual events. General anesthesia (GA) contributed more postoperative symptoms than did regional anesthesia (RA). In addition to a more rapid return to normal baseline function, RA provided postoperative pain relief. More complicated orthopedic procedures are able to be performed as outpatient procedures because of newer RA techniques. Anterior cruciate ligament reconstruction can be

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# SAMBA Travel Award Recipients

The following individuals were presented \$1,000 Travel Awards during the recently convened SAMBA 15th Annual Meeting in Washington, DC. The awards, which were made possible by a grant from AstraZeneca Pharmaceuticals, were presented to the residents whose abstracts received the highest grades. The recipients were invited to be poster presenters at the meeting.

Since its inception, SAMBA has provided close to \$20,000 in travel awards to defer the cost of residents' travel to the SAMBA Annual Meeting, where many make their first presentation at a national convention. The Travel Awards program is another means SAMBA uses to further its mission to promote research in ambulatory anesthesia.

**Tino Chen, M.D.**, Orange, California  
*Evaluation of the Connell Airway (CA) Tube: A Feasibility Study*

**Margarita Coloma, M.D.**, Dallas, Texas  
*Fast-Tracking After Propofol-, Sevoflurane- or Desflurane-Based Ambulatory Anesthesia: Use of Rapacuronium*

**Rebecca Denson, M.D.**, Gainesville, Florida  
*Decreasing the Amount of Environmental Medical Waste*

**Patrick P. Higgins, M.D.**, Toronto, Ontario, Canada  
*Postural Stability Following Low Dose of Droperidol in Outpatients Undergoing Dilatation and Curettage Procedure*

**M.A. Khan, M.D.**, Chicago, Illinois  
*Brachial Plexus Block With Buprenorphine for Postoperative Pain Relief*

**Michelle S. Kim, M.D.**, Redlands, California  
*The Effect of Intranasal Fentanyl on the Emergence Characteristics Following Sevoflurane Anesthesia in Children Undergoing Surgery for Bilateral Myringotomy Tubes (BMT) Placement*

**Shitong Li, M.D.**, Dallas, Texas  
*A Comparison of the Costs and Recovery Profiles of Three Anesthetic Techniques for Ambulatory Anorectal Surgery*

**Robert H. Overbaugh, M.D.**, Fort Sam Houston, Texas  
*Preoperative Sedation Using Intranasal Fentanyl in Hon-duran Children Undergoing Outpatient Ophthalmologic Surgery*

**Francis Salinas, M.D.**, Seattle, Washington  
*Do Ambulatory Surgery Patients Need to Void After a Short-Acting Spinal or Epidural Anesthetic?*

**Xinli Shao, M.D., Ph.D.**, Dallas, Texas  
*Comparison of Bisulfate-Containing Propofol and Diprivan for Induction of Anesthesia in the Ambulatory Setting*

**Dajun Song, M.D., Ph.D.**, Toronto, Ontario, Canada  
*Assessment of Balance Function Using Computerized Force Platform Following Ambulatory Anesthesia in Outpatients Undergoing Gynecological Laparoscopic Procedures*

**Jun Tang, M.D.**, Los Angeles, California  
*Recovery After Neuromuscular Block With Rapacuronium: Spontaneous vs. Edrophonium-Assisted*

**T.J. Zhou, M.D.**, Dallas Texas  
*Recovery Profile of Rapacuronium During Desflurane, Sevoflurane or Propofol Anesthesia for Outpatient Laparoscopy*

## AMBULATORY ANESTHESIA RESEARCH FOUNDATION AWARDS

The following individuals received cash awards for submitting the five highest graded abstracts to the SAMBA 15th Annual Meeting. The awards are made possible through a grant from the Ambulatory Anesthesia Research Foundation.

1st Place  
**M.A. Khan, M.D.**, Chicago, Illinois  
*Brachial Plexus Block With Buprenorphine for Postoperative Pain Relief*

2nd Place  
**Jun Tang, M.D.**, Los Angeles, California  
*Recovery After Neuromuscular Block With Rapacuronium: Spontaneous vs. Edrophonium-Assisted*

3rd Place  
**Shitong Li, M.D.**, Dallas, Texas  
*A Comparison of the Costs and Recovery Profiles of Three Anesthetic Techniques for Ambulatory Anorectal Surgery*

4th Place  
**Dajun Song, M.D., Ph.D.**, Toronto, Ontario, Canada  
*Assessment of Balance Function Using Computerized Force Platform Following Ambulatory Anesthesia in Outpatients Undergoing Gynecological Laparoscopic Procedures*

5th Place  
**T.J. Zhou, M.D.**, Dallas Texas  
*Recovery Profile of Rapacuronium During Desflurane, Sevoflurane or Propofol Anesthesia for Outpatient Laparoscopy*

Continued from page 7

safely and comfortably performed under femoral nerve block, femoral sciatic nerve block or epidural anesthesia. Compared to GA, these RA techniques had fewer postoperative complications, fewer unplanned admissions and significant cost savings.

*How Will Changes in Medicare Regulations Affect Ambulatory Anesthesiologists?* — Karin Bierstein, J.D.

Anesthesiology care in ambulatory surgical centers will follow economics and reimbursement schedules as dictated by the Health Care Financing Administration. High on the hit list are pain block procedures. Reduced reimbursement for neurolytic injections will likely mean that fewer will be performed. The Hospital Outpatient Department (HOPD) proposed rule would also limit payment for pain management. HOPD has also proposed expenditure ceilings for spending targets established in advance. Both the HCEA reduced reimbursement for ASC pain procedures and the HOPD spending limits would shift many procedures back to the hospital setting. The proposed 8-percent reduction in physician anesthesiology services would not affect current reimbursement for similar

procedures performed as office-based or consultation services.

*Measuring Patient Satisfaction in Ambulatory Surgery* — Alex Macario, M.D.

Patient satisfaction is considered an index of quality of care. However, surveys to measure patient satisfaction are unstandardized and confusing to interpret. Patients generally measure satisfaction based on previous experiences. If their previous anesthetic experience was bad, then their expectations are not high, and they are usually very satisfied. Because expectations and perceptions vary among patients, measuring satisfaction may not be valid.

Another way of measuring quality is by measuring outcomes. But measuring individual patient preferences may be a better way to assess outcome than by *a priori* concerns. In addition, setting standards for optimal practice could reduce variation in physician care for patients with similar conditions. This combination may be the best approach to patient satisfaction.

*Where Are We Today? Where Are We Going?* — Charles H. McLeskey, M.D.

Perioperative medicine is where anesthesiologists should be because

33 percent of hospital costs occur in the operating room, while only 5.6 percent of costs are related to anesthesia. To this end, anesthesiologists must meet the challenge to manage the processes, costs, complications, patients, information, technology, training and therapy. Data must be analyzed to dispel myths and to determine which processes work best. A broader scope needs to be taken to examine overall costs and efficiencies rather than myopically focusing solely on anesthesia-related items. It is with this broad scope that new treatment modalities will emerge, such as combination treatment regimens for PONV.

Who is better positioned than the anesthesiologist to customize a patient's perioperative regimen so as to maximize a return to normal daily activity? We are also best positioned to manage information that patients search for and receive. We have done a good job educating ourselves; what about reaching out to our consumer? Our patients should rest assured that the anesthesiologist of today is cognizant of the latest technology, all aspects of current treatments and the delivery of such treatments. 

## Final Call for Distinguished Service Award Nominations

The Committee on Awards, chaired by Louis A. Freeman, M.D., Fresno, California, has issued a final call for nominations for the SAMBA 2001 Distinguished Service Award to be presented at the Society's 16th Annual Meeting on May 3-6, 2001, at the Renaissance Esmeralda Resort in Indian Wells, California. The Distinguished Service Award is the highest honor SAMBA can bestow on an individual.

Members can make nominations

by forwarding to the SAMBA office the name on 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, 2000**. Nominations may also be e-mailed to the SAMBA office at [samba@asahq.org](mailto:samba@asahq.org).

Previous recipients of the SAMBA Distinguished Service Award 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); Surrinder K. Kallar, Richmond, Virginia (1999); and Wallace A. Reed, M.D., Phoenix, Arizona (2000). 

## Toast and Tea for Breakfast Before Elective Outpatient Surgery?

By *Sujit K. Pandit, M.D.*  
 Department of Anesthesiology  
 University of Michigan School  
 of Medicine, Ann Arbor, Michigan

Until very recently, most anesthesiologists and surgeons throughout the world followed the traditional NPO midnight policy (nothing by mouth after midnight) without questioning its validity. However, as outpatient surgery gained popularity throughout the 1980s, investigators recommended liberalization of preoperative fasting guidelines, specifically regarding clear liquids.<sup>1</sup> The results of a national survey conducted in 1993 showed that 68 percent of practicing anesthesiologists allowed clear liquid 2-4 hours before an elective surgery in children, and about 41 percent would allow the same in adults.<sup>2</sup> More recently, in 1996, the American Society of Anesthesiologists (ASA) appointed a task force to recommend a practice guideline for fasting before elective surgery. The resulting report was published in the journal *Anesthesiology* in 1999.<sup>3</sup>

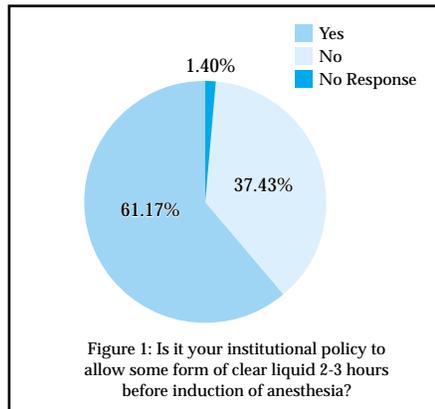
**Table 1**

ASA Practice Guidelines for Preoperative Fasting time Before Elective Surgery	
Clear Liquid . . . . .	2 hours
Human Breast Milk . . . . .	4 hours
Light Breakfast . . . . .	6 hours
Solid Food . . . . .	8 hours

Are anesthesiologists in the United States following, among other recommendations, the ASA task force's recommendations of six hours fasting after a light breakfast? A paper presented at the International Anesthesia Research Society (IARS) in Honolulu, Hawaii, last March answers that question.<sup>4</sup> The investigators conducted a national survey among active SAMBA members who practice in the United States. The time of the survey

was from June to December 1999. These investigators stratified 1,869 eligible SAMBA members by geographical location of practice by state and drew a random sample of one of

**Figure 1**

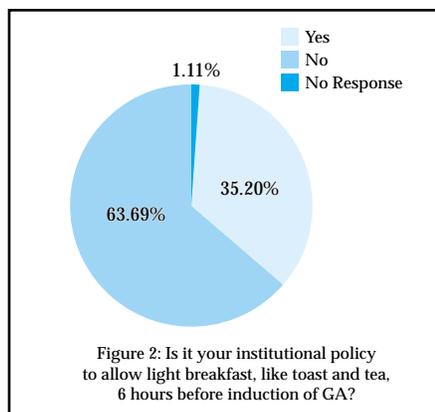


every three consecutive names using systematic selection, which yielded 623 potential respondents. They sent a questionnaire with 17 simple questions to this randomly selected sample. Of 623 questionnaires sent, 378 members responded.

**Results**

The response rate for this survey was between 60-63 percent, depending on how we calculated the rate. This gives a margin of error of less than 0.05. Sixty-four percent of re-

**Figure 2**



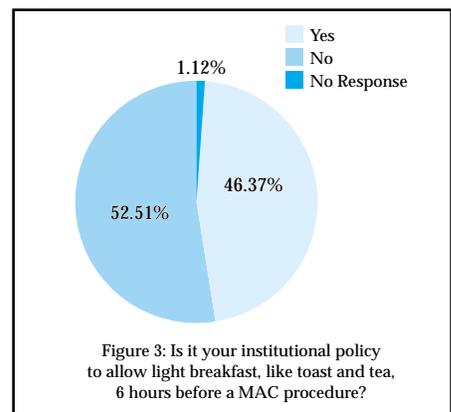
sponders were primarily hospital-based, 34 percent were surgical center-based and 2 percent were



*Sujit K. Pandit, M.D.*

primarily office-based. While 15 years of practice was the mode, with a median of 17 years, respondents' years in practice ranged from three

**Figure 3**



years to 50 years.

Important results are shown in pie charts (Figures 1-5). In addition, 68 percent of the respondents said they would allow human breast milk four hours prior to the operation.

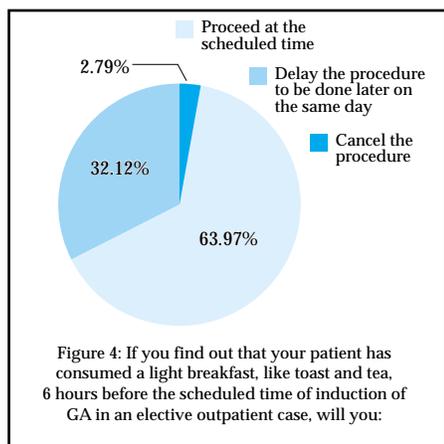
Toast and tea or coffee was by far the most commonly allowed breakfast. Other acceptable foods included bread, sugar cookies, soup, crackers, gelatin, cereal, low-fat milk, and fruit. Many respondents noted that the toast should be only lightly buttered or not buttered at all. Items not allowable were fatty or greasy food, any solid meat product (sausage,

bacon, steak or chicken), whole milk, eggs, cheese, fried foods or a heavy breakfast.

### Comments

The results of this national survey demonstrated that the majority of SAMBA members practicing anesthesia in the United States have already

**Figure 4**

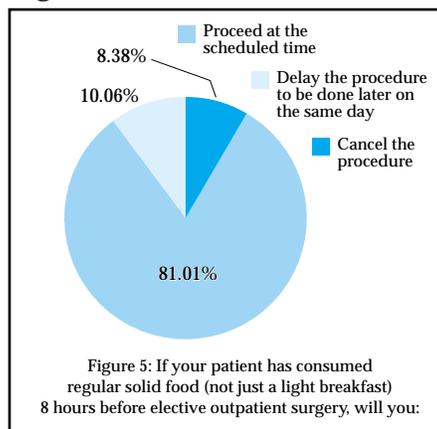


changed their practice and allow a light breakfast such as tea and toast six hours prior to elective surgery. The mechanism of emptying the stomach after intake of solid food is complex. The factors that influence the gastric emptying time for solid

food include the type of food (i.e., proportion of carbohydrate, protein and fat), body posture after food, exercise, meal weight, caloric density, size of the food particles swallowed and total amount of food. Gastric emptying is slowest with lipids, intermediate with carbohydrates and fastest with protein rich food.<sup>5</sup>

There are two reports that address the issue of a light breakfast before elective surgery. Miller and colleagues gave patients a light breakfast consisting of a slice of buttered toast and a cup of tea or coffee with milk 2-4 hours before surgery and measured gastric contents after induction of anesthesia by inserting a gastric tube.<sup>6</sup> They concluded that there was no significant difference in gastric volume or pH between the control group (fasting) and the study group. Soreide, et al., gave healthy female volunteers a standard hospital breakfast consisting of one slice of white bread with butter and jam, one cup (150 ml) of coffee without milk or sugar and one glass (150 ml) of pulp-free orange juice.<sup>7</sup> Gastric contents were measured by repeated ultrasonography and paracetamol absorption techniques. No solid food could be detected in the stomach in any subject 240 minutes after ingestion of breakfast. They concluded that

**Figure 5**



at least four hours is needed for solid food to empty from the stomach before an operation.

In conclusion, the survey results show that a vast majority of SAMBA members have already changed their practice and are following the recently published ASA practice guidelines for preoperative fasting time in patients undergoing elective operations. The majority would allow a light breakfast such as toast and tea six hours before elective surgery.

References available on the SAMBA Web site <[www.SAMBAhq.org](http://www.SAMBAhq.org)>.

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## **Mid Year Meeting 2000: Controversies in Anesthesia**

**October 13, 2000  
(One day before the ASA Annual Meeting)  
The Argent Hotel San Francisco  
San Francisco, California**

A conference jointly sponsored by  
the American Society of Anesthesiologists (ASA)

The Society for Ambulatory Anesthesia is proud to introduce "Controversies in Anesthesia" as the topic for the SAMBA Mid Year Meeting 2000. We invite you to join your friends and colleagues at the SAMBA Mid Year Meeting 2000 on October 13, one day prior to the ASA Annual Meeting in San Francisco.

### **Registration Information**

Registration for the SAMBA Mid Year Meeting 2000 is \$125 for SAMBA members, \$175 for non-SAMBA members and \$50 for residents. This registration fee includes the course syllabus, all educational presentations, a continental breakfast, a luncheon and coffee breaks. Early registration is recommended as seating may be limited. **The preregistration deadline is September 22, 2000.** Registrations received after that date will not be processed and will be returned so that the individuals can register on site.

Cancellation of registration must be submitted in writing and will be accepted until one week prior to the beginning of the conference. Please include your home address to expedite the processing of your check. Your refund, less a \$50 administrative fee, will be sent after the conclusion of the meeting.

### **Hotel Reservations**

Hotel reservations must be made through the ASA Annual Meeting housing bureau at (800) 974-7916. Members residing outside the United States and Canada should telephone (847) 940-2155.

### **CME Credits**

The American Society of Anesthesiologists (ASA) is approved by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. The American Society of Anesthesiologists designates this continuing medical education for 6 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

**SAMBA**  
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Park Ridge, IL 60068-2573  
(847) 825-5586  
samba@asahq.org  
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## Lecturers

---

### Program Chair

**Andrew Herlich, M.D.**

*Associate Professor of Anesthesiology  
Director, Head and Neck Anesthesia  
Temple University School of Medicine  
Philadelphia, Pennsylvania*

### Faculty

**Stephen F. Dierdorf, M.D.**

*Professor of Anesthesiology  
Indiana University School of Medicine  
Indianapolis, Indiana*

**Peter S.A. Glass, M.D., Ch.B.**

*Professor and Chair  
Department of Anesthesiology  
SUNY Health Science Center at Stony Brook  
Stony Brook, New York*

**Tom C. Krejcie, M.D.**

*Associate Professor of Anesthesiology  
Northwestern University School of Medicine  
Chicago, Illinois*

**J. Lance Lichtor, M.D.**

*Professor  
Department of Anesthesiology  
and Critical Care  
Department of Pediatrics  
University of Chicago  
Chicago, Illinois*

**Ronald S. Litman, D.O.**

*Associate Professor of Anesthesiology,  
Pediatrics and Dentistry  
University of Rochester  
School of Medicine and Dentistry  
Strong Memorial Hospital  
Rochester, New York*

**Lee A. Fleisher, M.D.**

*Associate Professor of Anesthesiology  
Chief, Division of Perioperative Health Services Research  
Department of Anesthesiology  
Johns Hopkins University  
School of Medicine  
Baltimore, Maryland*

**Walter G. Maurer, M.D.**

*Medical Director, Ambulatory Anesthesia  
The Cleveland Clinic Foundation  
Cleveland, Ohio*

**David B. Mayer, M.D.**

*President  
Esurg Corporation  
Seattle, Washington*

**Gail I. Randel, M.D.**

*Assistant Professor of Anesthesiology  
Northwestern University  
School of Medicine  
Chicago, Illinois*

**Phillip E. Scuderi, M.D.**

*Associate Professor of Anesthesiology  
Wake Forest University  
School of Medicine  
Winston-Salem, North Carolina*

**Mehernoor F. Watcha, M.D.**

*Professor of Anesthesiology  
Department of Anesthesia and  
Critical Care Medicine  
Children's Hospital of Philadelphia  
Philadelphia, Pennsylvania*

## Meeting Agenda

---

7:30 a.m. — 8:30 a.m.  
CONTINENTAL BREAKFAST AND REGISTRATION

8:25 a.m.  
Welcome  
**Moderator: Andrew Herlich, M.D.**

8:30 a.m. — 10 a.m.  
SESSION 1

8:30 a.m. — 8:50 a.m.  
Ambulatory Procedures: Have We Gone Too Far or Not Far Enough?

**J. Lance Lichtor, M.D.**  
**Objective:** Each day, many of us feel that we are pushing the envelope of patient safety in terms of which patients and which procedures are suitable for the ambulatory environment. At the conclusion of this talk, the attendee will be able to assess their own practice in relation to local and national trends.

9 a.m. — 9:20 a.m.  
Pediatric Procedures Out of the Operating Room: Are We Safe Enough?  
**Ronald S. Litman, D.O.**  
**Objective:** As the ambulatory pediatric patient population is

subjected to more procedures outside of the operating room, they are also subjected to increasing risks of sedation and anesthesia. After this talk, the attendees will be able to make more informed choices in their pediatric sedation and anesthesia techniques as well as in patient selection.

9:30 a.m. — 9:50 a.m.

Difficult Airways in the Ambulatory Setting: Is Safety Being Compromised?

**Martin S. Bogetz, M.D.**

**Objective:** The difficult airway is not commonly a prime consideration in the ambulatory practice. The attendees will be able to assess their patients and make more informed choices after Dr. Bogetz's discussion/talk.

9:50 a.m. — 10 a.m.

Questions and Answers

10 a.m. — 10:30 am

BREAK

10:30 a.m. — 12 noon

SESSION 2

10:30 a.m. — 11:30 a.m.

Prophylactic Antiemesis: Pro and Con

10:30 a.m. — 10:50 a.m.

Pro Comments

**Mehernoor F. Watcha, M.D.**

11 a.m. — 11:20 a.m.

Con Comments

**Phillip E. Scuderi, M.D.**

**Objective:** The attendees will be able to assess the benefits and drawbacks to administration of prophylactic or rescue antiemetics and incorporate them into their own practice.

11:20 a.m. — 11:30 a.m.

Questions and Answers

11:30 a.m. — 11:50 a.m.

Has the Preoperative Evaluation Process/Clinic Saved Us Time and Money?

**Walter G. Maurer, M.D.**

**Objective:** Much emphasis has been placed upon the economics of preadmission testing and consultation. The attendee will be able to assess the pros and cons of their own preoperative assessment practice at the conclusion of this talk.

11:50 a.m. — 12 noon

Questions and Answers

12 noon — 1:15 p.m.

LUNCHEON

1:30 p.m. — 2:30 p.m.

SESSION 3

1:30 p.m. — 2:30 p.m.

Succinylcholine in the Ambulatory Environment Is Dead

1:30 p.m. — 1:50 p.m.

Pro Comments

**Tom C. Krejcie, M.D.**

2 p.m. — 2:20 p.m.

Con Comments

**Stephen F. Dierdorf, M.D.**

**Objective:** The attendees will be able to rationally choose the use of succinylcholine or a nondepolarizing neuromuscular blocker in the ambulatory practice.

2:20 p.m. — 2:30 p.m.

Questions and Answers

2:30 p.m. — 2:50 p.m.

Generic Medications: Tempest in a Syringe?

**Peter S. A. Glass, M.D.**

**Objective:** Generic medications have become a prominent issue as the cost of medical care rises. At the conclusion of this talk, the attendee should be able to make informed decisions about the use of such medications in their practice.

2:50 p.m. — 3 p.m.

Questions and Answers

3 p.m. — 3:30 p.m.

BREAK

3:30 p.m. — 4:30 p.m.

SESSION 4

Threats to Our Well-Being

3:30 p.m. — 3:50 p.m.

Hey Doc, Are You Okay?

**Gail I. Randel, M.D.**

**Objective:** Ambulatory anesthesiologists are facing increasing threats to their health and safety, especially with reference to work stress and latex allergy. The attendees should be sufficiently informed at the conclusion of this talk so that they may modify their own risks.

3:50 p.m. — 4 p.m.

Questions and Answers

4 p.m. — 4:20 p.m.

Frustrated With Clinical or Academic Medicine? New Horizons Await You

**David B. Mayer, M.D.**

**Objective:** The transition from clinical medicine to medical related business may be smooth or rough depending upon the business choices that are made. Dr. Mayer has made a successful transition and will advise the attendees as to how they may successfully make the transition.

4:20 p.m. — 4:30 p.m.

Questions and Answers



Mid Year Meeting 2000:
Controversies in Anesthesia

October 13, 2000
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The Argent Hotel San Francisco
San Francisco, California

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- SAMBA Member \$125
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## SAMBA to Co-host Fifth International Congress of Ambulatory Anesthesia

The International Association of Ambulatory Surgery (IAAS) has selected SAMBA, together with the Federated Ambulatory Surgery Association (FASA), as co-sponsors of the Fifth International Congress of Ambulatory Surgery. This international event, devoted exclusively to ambulatory surgery, will be held May 8-11, 2003, in Boston, Massachusetts. The co-sponsoring organizations will incorporate their annual meetings into what promises to be the premiere international ambulatory surgery event of the early new century.

A joint planning committee comprised of members from SAMBA, FASA and IAAS will develop a three-track educational program focusing on ambulatory anesthesia, ambulatory surgery and management and support staff. The program will be designed so that attendees can attend either a single track of instruction or a track consisting of selected presentations of their choice from the concurrent sessions. The joint planning committee will be assembling a faculty of internationally renowned experts to present a highly informative program. Complementing the program will be an international technical exhibit and scientific poster presentations featuring presenters from around the world.

Day trips to ambulatory surgical centers will be scheduled during the congress. These trips will be designed to provide interested attendees with a firsthand look at everyday operations of a freestanding

facility. A post-congress trip to a Sunbelt destination will be provided to present a similar look at the daily operations of a surgery center located in a different region of the country.

An exciting social program featuring tours to interesting local destinations will round out the program. A specially planned social evening for all congress attendees will conclude this part of the program.

Arrangements will be made with major air carriers to provide discounted fares for all congress attendees, whether they are traveling within the United States or from overseas. Discounted car rentals will also be available for those who wish to make sightseeing trips before or after the congress.

Hotel accommodations will be available at the Sheraton Boston, the Boston Marriott at Copley Place and the Midland Hotel. The Hynes Convention Center will be the site of the educational program, poster presentations and technical exhibits. The Sheraton and Marriott Hotels are connected to the Hynes Convention Center through the Copley Place Mall, while the Midland Hotel is located a short walk from the convention center and mall.

Although registration information for the international congress is not available at this time, SAMBA encourages its members to reserve these dates today and to tell their colleagues in ambulatory surgery to do the same. [See us](#)