



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

SAMBA on Cutting Edge as President's Term Ends

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

This is my last note to you as President of SAMBA. In my initial address in May 2000, I spoke about making our Society an integral part of the global community and spreading SAMBA's goal to teach about ambulatory anesthesia throughout my year as President.

At last fall's Mid Year Meeting, we recorded the speakers who made slide presentations and made this material (audio and slides) available on the Web. We plan to record the speakers at the spring Annual Meeting, too.

In the spirit of a global community, our Web site's patient information page has been translated into Spanish, German and Chinese. If you feel that translation into other languages is appropriate, please let us know. Our Spanish version, for example, is not just for patients in the United States who speak Spanish but also for Spanish-speaking individuals throughout the world. The goal, ultimately, is to include professional information in different languages and then to have an exchange of information within the United States and all over the world. At the beginning of my term, the translation project seemed simple and straightforward, but I am amazed at how long a project can take.

Our Society's affiliation with the International Anesthesia Research Society (IARS) continues to bear fruit. IARS also is using the Internet to expand its print offerings. These expanded services are available to members of our Society.

Thanks to new online technology, former static images with degraded image quality — owing to the photographic process — have been replaced by high-quality digital loops that transmit dynamic images, e.g., echocardiographic findings, with minimal degradation of image quality. A new subject/keyword tagging mechanism that assigns articles to more than one section "tag" (not possible with the print journal) also will be implemented soon. For example, an article on ambulatory anesthesia in children can be tagged for both the ambulatory and pediatric sections.

With the new system, the ability of SAMBA members to track the topics and articles relevant to their practices will be enhanced. This feature augments the capability of online subscribers to track the topics, authors and articles important to them with the online CiteTrack service provided by *Anesthesia & Analgesia*. CiteTrack alerts subscribers by e-mail whenever new content in *Anesthesia & Analgesia* or another participating journal is published that matches the criteria of topics, authors and articles specified by the subscriber. The e-mail alerts include citations (authors, title, journal name, volume and page) and URLs for articles.

Information on this useful service is available on the journal Web site <www.anesthesia-analgesia.org>.

SAMBA members can also sign up for e-mail alerts that announce the availability of new issues online and the posting of tables of contents in future issues. These online services are provided to any SAMBA member



J. Lance Lichtor, M.D.

who is a subscriber to *Anesthesia & Analgesia*. SAMBA members with questions or suggestions about the benefits available to online subscribers of *Anesthesia & Analgesia* can contact the *Anesthesia & Analgesia* editorial office at <sleepers@lmi.net>.

SAMBA is a wonderful organization. I thank all of you who serve on its Board of Directors, who are committee chairs and committee members or members who participate to make it one of the preeminent subspecialty organizations. Thank you for giving me the honor of being your President. I hope that we can continue to work together to foster research, education, scientific progress and the growth of ambulatory anesthesia. 

Lots of Issues in This Issue of *Ambulatory Anesthesia*

The number of surgical procedures performed in offices increases yearly. There is growing concern, however, of increased morbidity and mortality in this setting. It is feared that patient safety may be at risk because safety standards followed by hospitals and ambulatory surgical centers might be bypassed in offices.

A number of organizations and agencies have published standards for office-based surgery and anesthesia. The American Society of Anesthesiologists (ASA) has provided detailed guidelines for administration of anesthesia in the office setting (see <www.ASAhq.org/ProfInfo/offbasedguide.htm>).

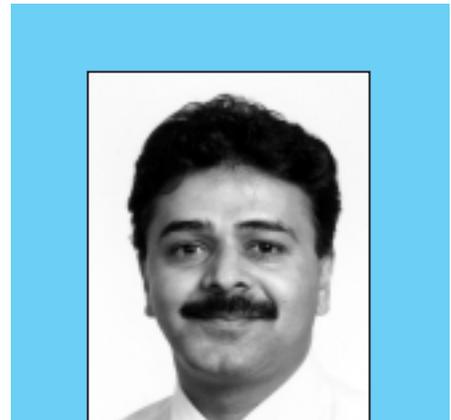
While hospitals and their affiliated ambulatory surgical centers are certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), freestanding ambulatory surgical centers and offices are certified by agencies such as the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), on which SAMBA has two Board of Directors representatives. In this issue, William Beeson, M.D., outlines the role of the AAAHC in improving delivery of care and maintaining patient safety in offices.

Patient safety also can be improved by early identification and treatment of complications. Although rare, malignant hyperthermia (MH) still remains a major concern for anesthesiologists. The Malignant Hyperthermia Association of the United States (MHAUS) advises and prepares medical facilities for prompt diagnosis and treatment of MH episodes. In an effort to prepare

In addition to quality of care issues, it is also important that we take care of our personal health.

all the members of the operating room staff to manage an MH crisis, MHAUS has proposed guidelines directed to the ambulatory surgical facility. MHAUS President Henry Rosenberg, M.D., provides us with a synopsis of these proposed guidelines.

Due to an increasing number of elderly patients presenting for ambulatory surgery, there needs to be height-



Girish P. Joshi, M.D.

ened awareness of the various challenges posed by this rapidly expanding surgical population. Mary Ann Vann, M.D., Boston, Massachusetts, summarizes the discussion of a panel on ambulatory anesthesia for the geriatric patient presented during the ASA Annual Meeting last October in San Francisco, California.

In addition to quality-of-care issues, it is also important that we take care of our personal health. Since our

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AAAHC to Study Ambulatory Practices

By William Beeson, M.D., President
Accreditation Association for
Ambulatory Health Care, Inc.

In recent months, there has been significant concern over the quality of ambulatory care delivered outside the hospital setting. Calls for increased regulation have come from a variety of sectors. Medical errors and quality of medical care have been a frequent topic in various national publications over the past six months.

Recently, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) was notified by the U.S. Department of Health and Human Services that the Inspector General is conducting a study of quality oversight of ambulatory surgery. According to the study design, the purpose of the study is to "assess the quality oversight of ambulatory surgery in the Medicare program performed in hospital outpatient departments, ambulatory surgery centers and physician offices." This study will be ongoing for the next 12 months and will take place in a number of venues. It will be an important study; previous reports from the Office of Inspector General have led to congressional hearings and regulatory changes.

The American Society of Anesthesiologists (ASA) and SAMBA each have two representatives serving on the AAAHC Board of Directors.

Considerable national attention has been focused on the medical community following the November 1999 release of the Institute of Medicine's report dealing with medical errors. Once again, public attention is focused on the medical community and the ambulatory care setting in particular. Numerous states are looking at medical errors in the ambulatory setting and are contemplating increased regulations and/or accreditation as a prerequisite for performing procedures outside of the hospital setting. AAAHC governmental affairs staff has reported that no less than nine states currently require or accept accreditation for ambulatory surgical centers (California,

Delaware, Florida, Montana, Nevada, New Jersey, New York, Pennsylvania and Utah). For office-based surgical procedures requiring certain levels of anesthesia, Pennsylvania and Rhode Island require accreditation; California and Florida require state certification or accreditation; Texas exempts accredited outpatient facilities from anesthesia standards; and New Jersey has adopted anesthesia standards. Other state licensing boards and health departments are contemplating such regulations. A recent moratorium on office-based surgery imposed by the Florida Board of Medicine in response to an increased number of deaths associated with office-based surgical proce-

...within a relatively short time period, many states will implement rules and regulations affecting ambulatory surgery.

dures serves to highlight the gravity of this issue.

Risk management and continuous quality improvement are two particularly important areas drawing attention from outside groups that may benefit from mandatory accreditation. Risk management is extremely important to medical liability insurers. Insurers realize that accredited organizations have developed effective risk management programs which significantly reduce the likelihood of litigation or increase the likelihood that the entity will prevail should litigation take place. The accreditation requirements dealing with oversight might also serve to decrease medical errors as well as provide excellent documentation to reflect the high quality of care delivered. Such documentation is recognized to be potentially valuable in litigious circumstances.

Third-party carriers also realize that



William Beeson, M.D.

continuous quality improvement is important in any organization. They realize that accredited organizations have implemented ongoing programs and systems that help identify problem areas which require continuously monitored, corrective-action plans. In a cost-conscious environment, insurance companies are concerned that budget cuts do not result in decreased quality of care. As a result, it is anticipated that various health care networks may require accreditation as a condition for participation within their network in the near future. This action would help persuade the general public of the network's interest in quality of care and would demonstrate that a nationally recognized accrediting organization is providing oversight in this area. It could also mean that large third-party payers would be able to reduce overhead by eliminating or significantly reducing their in-house physician quality care monitoring programs. At the present time, AAAHC has had several discussions with high-ranking officials in various insurance plans regarding these activities.

For these and other reasons, it is expected that within a relatively short time period, many states will implement rules and regulations affecting ambulatory surgery. AAAHC has had multiple discussions with representatives of the American Medical Association

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MHAUS Offers Surgery Procedure Manual and Videotape

By Henry Rosenberg, M.D., President
Malignant Hyperthermia Association
of the United States

The Malignant Hyperthermia Association of the United States (MHAUS) has developed a malignant hyperthermia (MH) Ambulatory Surgery Procedure Manual and Training Videotape to help all members of the ambulatory surgery staff effectively manage MH. MH is an uncommon, genetically determined and potentially lethal syndrome that is triggered in susceptible individuals by commonly used general anesthetics. Unfortunately, MH is still claiming several lives every year in the United States — MHAUS's goal is to completely eliminate the incidence of MH deaths. Darlene Mashman, M.D., Assistant Professor of Anesthesiology at Emory University School of Medicine, Atlanta, Georgia, initially developed the concept of this program for hospital settings. Carolyn P. Greenberg, M.D., Professor of Clinical Anesthesiology at the Cornell Weill College of Medicine, New York, New York, revised it for ambulatory surgical settings.

Dr. Mashman explains: "I first used a multitask approach of procedures to manage critically ill patients while working in our Level I trauma center. This is an effective approach when many procedures must be accomplished at the same time. I felt this approach could be adapted to the treatment of MH. I analyzed and prioritized the tasks that needed to be done and divided them among the medical staff. This system, which incorporates the MHAUS MH protocol, flowchart and worksheets, was then found to be efficient and effective in reducing response time to mock MH events in our institution. I have also found that periodic mock drills for the medical staff reinforce a smooth implementation of the MH response plan."

Dr. Greenberg adds: "In adapting the manual, we identified the roles and responsibilities that different individuals have in the ambulatory surgery center and assigned specific tasks to

each category of individual. Everyone on the ambulatory surgery team needs to be fully prepared to treat an MH crisis in any surgical setting: Standard guidelines for managing MH should be consistent. The MHAUS MH protocol should be followed, and all equipment and medications that are necessary to manage an MH crisis need to be readily available."

The manual contains a flowchart, staff worksheets, recommended MH cart/kit supplies and checklist, event drill form, MHAUS poster, various MHAUS brochures and an adverse metabolic reaction to anesthesia (AMRA) report to be filed with the North American MH Registry (Direc-

Unfortunately, MH is still claiming several lives every year in the United States — MHAUS's goal is to completely eliminate the incidence of MH deaths.

tor, Barbara Brandom, M.D., Children's Hospital of Pittsburgh, 3705 Fifth Avenue at DeSota Street, Room 7449, Pittsburgh, PA 15213-2583). The accompanying instructional video enacts the MH response plan. The MH response plan should be reviewed, customized by each site and practiced before it is used for an actual MH event.

The successful treatment of a patient with MH depends on several key factors, including early recognition of the signs and symptoms. This can be accomplished by educating and updating staff about the syndrome and its treatment. In the MH response plan, tasks are outlined and assigned to each team member in a checklist format on a worksheet. This response tool ensures that multiple therapies are insti-



Henry Rosenberg, M.D.

tuted simultaneously and efficiently during the MH crisis so that the anesthesia care provider can focus on patient treatment and minimize the risk of complications associated with MH. As outlined in the manual, basic supplies, emergency drugs and 36 vials of dantrolene should be in an MH cart/kit and centrally located in the operating room area. Medical staff should all be aware of the location of the MH cart/kit.

There are several key points worth mentioning when using the response plan included in the manual.

1. The anesthesia care provider must recognize the early warning signs of MH: hypercarbia, tachycardia, tachypnea, cardiac arrhythmia, unstable blood pressure, rigidity, mottling, mixed respiratory and metabolic acidosis, myoglobinuria and fever (often late).

2. A method of alerting staff to initiate the plan and getting the MH cart/kit to the room must be determined and tested before an MH emergency arises.

3. Multiple tasks need to be performed simultaneously, quickly and efficiently.

4. Used supplies and dantrolene must be restocked.

5. The patient and family should receive counseling, a letter describing the

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Grandma Enters New Age: A Report from the ASA Annual Meeting

By Mary Ann Vann, M.D.

Staff Anesthesiologist

Beth Israel Deaconess Medical Center

Instructor, Harvard Medical School

Boston, Massachusetts

The American Society of Anesthesiologists (ASA) Committee on Geriatric Anesthesia presented the panel "Ambulatory Anesthesia for the Elderly Patient: Grandma on the Move" at the ASA Annual Meeting last October in San Francisco, California.

The committee's panel focused attention on a rapidly expanding surgical population. **Jeffrey H. Silverstein, M.D.**, West Nyack, New York, covered the "Preoperative Evaluation and Preparation of the Elderly Patient." He remarked that age is not a disease, and that if no disease state is present, the patient will have the same risk profile regardless of age. He emphasized that preoperative identification and management of pre-existing conditions and medications is vital. He orders testing based on physiologic age, not chronological age. Anesthesiologists need to be cognizant of elderly patients' hearing loss and social issues. Specifically, the elderly have decreased sound sensitivity, derangement of loudness perception, impaired sound localization and slower processing of information. He advised the audience to address the patient face-to-face at a distance of three to six feet, speak slowly and deliberately and avoid shouting. Written instructions should be simple and explicit, and the font size should be greater than 12 point. Social issues should be considered, such as the existence of living wills or do-not-resuscitate orders, the patient's home environment, nutrition and independence.

Sheila R. Barnett M.D., Newton, Massachusetts, addressed "Perioperative Adverse Events and Discharge Criteria for the Elderly." She cited the Warner study in the *Journal of the American Medical Association* (1993; 270(12):1437-1441), which determined that elderly patients undergoing out-

patient surgery had no higher morbidity or mortality than nonsurgical patients. Older patients suffer more cardiovascular and central nervous system (CNS) events perioperatively than young patients but experience less postanesthesia care unit (PACU) events such as nausea, shivering, drowsiness or dizziness. The incidence of postoperative CNS dysfunction or delirium is high. Early CNS dysfunction occurs more frequently in patients with greater age or lower levels of education, those undergoing repeat operations or those suffering from infectious or respiratory complications. Advanced age is the only risk factor associated with late CNS dys-

There is a decreased response to beta-receptor stimulation and connective tissue changes associated with aging.

function, which can occur in 10 percent of elderly patients.

Unanticipated admission of the elderly after ambulatory procedures is primarily due to medical events in the PACU rather than nausea and vomiting or pain. Dr. Barnett mentioned that there are few studies that specifically looked at adverse outcomes in elderly patients after ambulatory anesthesia. Age predicted the location of return visits for the elderly, but there was no greater rate in the frequency of return. She also remarked on the significance of social issues in the care of elderly patients. They may suffer greater disability after minor procedures and cognitive and sensory problems. The lack of a spouse may require the commitment of several family members for assistance with transportation and recovery.

G. Alec Rooke, M.D., explained "Why Hemodynamic Stability Is Difficult in the Elderly Patient." There is a



Mary Ann Vann, M.D.

decreased response to beta-receptor stimulation and connective tissue changes associated with aging. The stiffening of arteries leads to systolic hypertension, and rigid veins limit the buffering of changes in blood volume. Stiff ventricles predispose the patient to diastolic dysfunction. Cardiac output depends on late filling, atrial kick and adequate preload. The basal output of the sympathetic nervous system increases with age, and patients display an exaggerated response to stimuli. Sympathetic blockade is advisable to prevent swings in blood pressure. Dr. Rooke added that since volume loading may be ineffective prophylaxis or treatment of hypotension during spinal anesthesia, more aggressive vasopressor therapy should be used. Larger doses of ephedrine or phenylephrine infusions may be required; however, alpha agonists may compromise cardiac output.

Talmage D. Egan M.D., Salt Lake City, Utah, outlined the "Clinical Pharmacology of Opioids and Sedative-Hypnotics — Does Age Matter?" He described alterations in remifentanyl dosage for the elderly. The pharmacokinetic differs secondary to decreased central clearance and distribution volume. Equilibration is slowed, which alters its pharmacodynamics. The clinical implication is a markedly

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Grandma Enters New Age: A Report from the ASA Annual Meeting

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lower effective concentration and a 50- to 70-percent lower dosage requirement. Propofol requires a similar substantial dosage reduction. Other intravenous (I.V.) agents should be administered in decreased dosages, but the pharmacologic bases for the reduction is variable. Diminished cardiac output is a mechanism to explain observations of higher peak levels.

Raymond C. Roy M.D., discussed "Postoperative Analgesia for the Elderly Outpatient." He advocated alterna-

tive methods of pain control. He recommends the pre-emptive use of N-methyl-D-aspartate (NMDA) antagonists to prevent spinal cord wind-up and acute opioid tolerance and to decrease postoperative analgesic requirements. The drugs he utilizes are: magnesium dosed at 30 mg/kg, ketamine dosed at 15 mg/kg, a combination of magnesium and ketamine, methadone and dextromethorphan. Dr. Roy stated that intraoperative use of aggressive beta blockade lowers the need for postoperative analgesics, but the use of opioids for intraoperative cardiac stability

may lead to acute opioid tolerance. Systemic local anesthetics, administered by I.V. or topical anesthetic cream may provide postoperative analgesia.

He warned that prophylactic use of nonsteroidal anti-inflammatory drugs might result in unforeseen responses or cause greater antiplatelet effects. Ketorolac doses should not exceed 15 mg in the elderly. Also, pro-drugs, which need to be converted to an active form, may not be as effective in the elderly. These drugs include codeine, hydrocodone and the COX-2 inhibitor parecoxib. 

MHAUS Offers Surgery Procedure Manual and Videotape

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event, information on the MHAUS Medical Identification Tag Program, and a referral should be made to MHAUS by calling (800) 98-MHAUS (800-986-4287) or through the Web site at <www.mhaus.org>. The chart should be clearly marked "avoid succinylcholine and volatile anesthetic gases," and an AMRA report should be filled out.

6. A member of the anesthesia staff should be assigned to keep the team updated on MH. That person should also maintain the MH response plan, periodically check it for accuracy, make changes as appropriate and conduct periodic drills.

The MH Ambulatory Surgery Procedure Manual and Training Videotape was produced in cooperation with Organon, Inc.

MHAUS also would like to acknowledge and thank SAMBA representatives for reviewing the materials and releasing this statement: "SAMBA supports the activities of MHAUS and commends the Association on its efforts to develop a Malignant Hyperthermia Procedural Manual."

MHAUS is a nonprofit organization

dedicated to reducing the morbidity and mortality of MH by: 1) improving medical care related to MH, 2) providing support and information for patients and 3) improving the scientific

understanding and research related to MH and other kinds of heat-related disorders.

number of Hotline calls has grown from approximately 170 calls per year to 2,500 calls in 2000. Calls ranged from questions about acute and suspected cases of MH, drug safety and follow-up care of MH patients to what advice should be given to MH-susceptibles and their families. MHAUS advocates that body temperature should be monitored in all surgical patients undergoing general anesthesia, adequate supplies of dantrolene be stocked nearby and thorough family histories be obtained prior to surgery.

MHAUS operates solely by voluntary tax-deductible contributions. These contributions come from individuals, corporations and professional societies.

The MH Ambulatory Surgery Procedure Manual and Training Videotape is available for \$175. Contact MHAUS, Box 1069, Sherburne, NY 13460, (800) 98-MHAUS (800-986-4287) or visit the MHAUS Web site at <www.mhaus.org>. Also from the Web site, you can obtain information about the entire spectrum of MHAUS educational materials, research, programs, MHAUS membership and to make tax-deductible contributions.



The advertisement features a background image of a medical professional in a white coat. Overlaid on this is a dark rectangular box containing the text: "About Us", "For more information on MHAUS, visit:", and the website address "www.mhaus.org" in a large, stylized font. Below the website address, there is a list of bullet points: "• knowledge and support resources", "• advice medical facilities", "• help with difficult patients", "• reliable medical professionals", and "• fast & free to identify services at risk". At the bottom of the box, it says "What is MHAUS? Services, Educational Materials, Scientific Research and Funding" and "Find out what makes MHAUS a commitment to your professional responsibility to patients."

Since its inception in 1982, the num-

ber of Hotline calls has grown from approximately 170 calls per year to 2,500 calls in 2000. Calls ranged from questions about acute and suspected cases of MH, drug safety and follow-up care of MH patients to what advice should be given to MH-susceptibles and their families. MHAUS advocates that body temperature should be monitored in all surgical patients undergoing general anesthesia, adequate supplies of dantrolene be stocked nearby and thorough family histories be obtained prior to surgery.

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Stress: What You Don't Know Can Hurt You

By Michael A.E. Ramsay, M.D.
Chief of Anesthesiology
Baylor University Medical Center
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Professor of Anesthesiology
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Dallas, Texas

Stress occurs on a regular basis, and when it is under control, it can be a good motivator that mobilizes adrenaline and improves performance. It can mobilize us into action and can be a positive force that drives us to succeed. Many people with too little stress in their lives will actively seek risk in such activities as skydiving, or simply going to Imax® movies, to bring excitement into their lives. It is when our coping mechanisms become overloaded that stress becomes *distress*, reduces efficiency and becomes harmful to our well-being. This may occur acutely from a single traumatic event or, as is common in the physician's practice, it occurs insidiously over a longer period of time. The accumulation of stressors eventually results in impairment and burnout. The key to surviving or even thriving on stress is to control it.

Stress Factors for Physicians

There are many stress factors in a physician's life. Type A behavior (tense, aggressive, action-oriented) is prevalent among physicians, both male and female, and this may lead to self-induced stress. The demands of the hospital or practice may conflict with the demands of the home. In the workplace, constant demands from a changing practice and reimbursement issues are increasingly prevalent. Quality patient care and malpractice litigation are being focused upon more intensely. The physician must cope with life-and-death decisions and deal with bad outcomes when they occur.

The drive to increase performance and efficiency results in an increased workload and often in a less-than-ideal work environment. The anesthesiologist is often under increasing

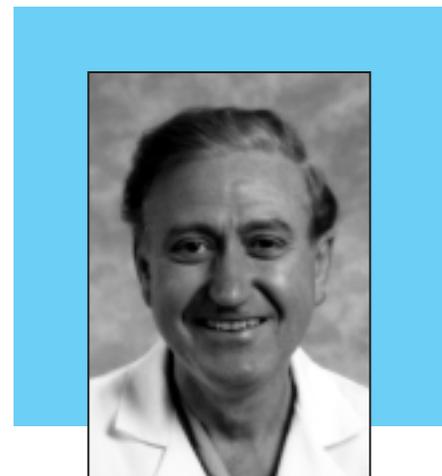
pressure to move cases along even though all the appropriate information may not be available or has only just become available minutes before induction. Therefore, a rapid decision-making process has to be entertained without the luxury of a discussion with a colleague — often, life-and-death consequences are based on your thought process. This results in an increased stress level that may be compounded by fatigue. In addition, anesthesiologists must attempt to keep pace with changing financial factors. One strategy for combating adverse health care economics is a growth policy, but increasing volume to make up for reduced reimbursement usually results in longer working hours. The

Learn to manage your emotions. Emotional intelligence is far more important for a successful life than a high IQ.

outcome of this modern-day anesthesia practice has caused an increase in both stress and fatigue. If we are not vigilant, a decrease in performance will occur.

Consequences of Stress

The human being is a complicated physiological machine that is prone to error, and the incidence of these human errors is increased by stress. As performance decreases, errors of omission appear with increasing frequency. This may be demonstrated by minor errors, or "slips." These slips may be exhibited in recording errors or recent memory loss and rarely lead to a major event. As performance further deteriorates, however, errors of commission occur: these are "mistakes" where the planning process itself is flawed. This may lead to technical or judgmental errors such as



Michael A.E. Ramsay, M.D.

selecting a wrong or inappropriate technique that results in an adverse outcome (e.g., administering succinylcholine to a paraplegic). These mistakes, of course, can have devastating results.

The results of unchecked stress will eventually lead to poor performance, an increase in human error or medical mistakes, dysfunctional behavior and then to failure, either on the homefront or in the workplace. Sexual dysfunction and marriage problems leading to separation and divorce may result at home. Reliance on alcohol or drugs may result in catastrophic events in the home and workplace. Dysfunctional behavior in the workplace may result in actions taken by partners, peers or administration. Tolerance for this type of behavior is now vanishing due to courts recognizing the vicarious liability of the employer when a hostile work environment is not addressed. The impaired physician is a major loss to society but is also a threat. Clearly, the result of uncontrolled stress is a dysfunctional physician who is a risk to patients, colleagues and family.

Signs of Stress

The key to stress management is to recognize it and the insidious way that it can creep up on you. The acute

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Stress: What You Don't Know Can Hurt You

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stressful event may be obvious, such as the death of a spouse, but there are many other triggers that, though we are exposed to them, we may not recognize. The acute response to stress is that of an alarm or arousal reaction. This may result in an excess of catecholamines, with symptoms of palpitations, headache, tension, anxiety, irritability, insomnia, lack of concentration, phobias, fatigue, eating disorders and eventually a potential for reliance on medication or alcohol.

If the stress continues, and if we are to survive, we enter a stage of resistance or energy conservation. This may present as social withdrawal, tardiness, apathy, cynicism, decreased sexual desire and resentment of the workplace. If a coping mechanism is not instituted, a stage of exhaustion or burnout is eventually reached. Symptoms may include depression, mental and physical fatigue, the desire to "quit" (whether it be work or family) and most ominously, suicidal and addictive tendencies.

Managing Stress

It is impossible, and probably unhealthy, to avoid stress. The key is to cope with stress so that negative consequences are avoided. The first step

is to take care of yourself, both physically and mentally. Take the time to exercise regularly, get enough sleep and eat right. Exercise is a great way to dissipate stress, relieve anxiety, elevate mood and clear the mind. Pamper yourself. Take time to play: "All work and no play" is a recipe for disaster.

Learn to manage your emotions. Emotional intelligence is far more important for a successful life than a high IQ. This will lend itself to conflict resolution skills and will improve communication at home and in the workplace. Interpersonal conflict is a very potent stress producer, whether it is family- or colleague-related. Learning to communicate effectively, understanding the other point of view and being empathetic even in disagreement are skills that need to be learned.

Learn to listen. It will also help with the second step in managing stress: controlling your reactions to stressors. An important step in handling stress is to ignore those factors out of your control and only attempt to control those factors that you can realistically control. Try to avoid overreacting; do not fret over things that you cannot control. Become realistic about your goals and what you can reasonably accomplish. Take "time out," whether it is a week off or just a deep breath. Look for some humor in unpleasant situa-

tions, and discuss events with a confidant. Do not avoid the truth; if you are in the wrong, deal with it. Do not use avoidance tactics. Utilize emotional intelligence skills to understand and subsequently defuse your emotions.

Control the amount of stress that you are exposed to by being realistic about work assignments. Learn to say "no." Develop a group, practice or department policy that provides ground rules on work hours, behavior patterns and conflict resolution so that fatigue is reduced and dysfunctional behavior is dealt with, early on, by peer intervention.

Finally, take care of each other. If you see a buddy demonstrating the signs of stress, help out. Often simple talking can bring issues back down to manageable levels. The impaired physician is not only a great waste of investment but is also a significant risk to him/herself and others. 

Suggested Reading:

- Hanson PG. *The Joy of Stress*. Kansas City: Andrews and Mcmeel; 1986.
- Powell T. *Stress Free Living*. New York: DK Publishing; 2000.
- Goleman D. *Working With Emotional Intelligence*. New York: Bantam Books; 1998.

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Bylaws Amendments Proposed for Membership, Research

By Grover R. Mims, M.D., Chair
Committee on Bylaws

At its October 2000 meeting, the SAMBA Board of Directors approved proposed Bylaws amendments to the Society's Bylaws that will better state the functions of the Committee on Membership and the Committee on Research. The amendments also formally add the function of committee appointments to the responsibilities of the President-Elect.

In accordance with the procedures to amend the Bylaws, the proposed amendments must be distributed to

every member of the Society at least two weeks prior to the SAMBA Annual Membership Meeting to be held on May 6, 2001, at the Renaissance Esmeralda Resort in Indian Wells (Palm Springs), California. At the Annual Membership Meeting, the proposed amendments will be read a second time followed by a vote. A two-thirds affirmative vote of the active voting members present is necessary for the proposed amendment to become effective.

The proposed amendments to the Bylaws are as follows (additions are noted by underlining; deletions are noted by strikethroughs):



Grover R. Mims, M.D.

ARTICLE III

MEMBERSHIP

Section 3.1. MEMBERSHIP.

a. Membership in the Society is a privilege and not a right and is contingent upon compliance with the requirements specified in these Bylaws. No person shall be accepted or continued as a member unless he/she is of good moral character and adheres to the ethical standards of the medical profession and is practicing in accordance with the principles of this Society as set forth in these Bylaws.

b. An application for membership shall be made upon an official membership application form.

Section 3.3. RESIGNATION. Any member in good standing may resign from the Society by submitting a written communication addressed to the Secretary. ~~Such resignation shall be accepted by the Board of Directors at the next regular meeting following the one at which the communication is first read.~~ There shall be no prorated reimbursement of dues for the remaining period of the paid-up year of resignation.

~~**Section 3.4. ELECTION OF MEMBERS.**~~

~~a. An application for membership shall be made upon the official membership application form.~~

b. ~~The Committee on Membership shall investigate all proposals for membership. The Committee shall forward the name and membership classification of any candidate it approves for membership to the Board of Directors for consideration. If approved by a two thirds (2/3) vote of the Board of Directors, such membership shall be granted.~~

Section 3.4. DURATION OF MEMBERSHIP.

Section 3.5. MEETINGS.

ARTICLE IV

ASSESSMENTS

Section 4.1. ANNUAL ASSESSMENT (DUES).

a. By the first day of December in each year, each member shall be sent a notice of the per capita dues levied by the Board of Directors after approval of the membership at the Annual Membership Meeting.

b. Payment of these annual dues for each calendar year shall be forwarded

to the Treasurer of the Society not later than five (5) days before the 31st of December. ~~of the preceding year.~~

c. Such per capita dues shall apply in the same manner immediately upon the admission or reinstatement of members. ~~For a new member admitted after June 30 of any calendar year, only one half (1/2) of the regular per capita dues shall be levied. Every member for whom the per capita dues are paid shall be entitled to receive such publications as may be issued by this Society for its members. Dues for new members admitted after September 1 of any calendar year shall be applied to the upcoming year; membership will become effective immediately.~~

Section 7.8. COMMITTEE ON BYLAWS.

a. Composition. The Committee on Bylaws shall consist of six (6) members and a Chair. The Vice-President shall serve as the Board advisor to the Committee.

Section 7.9. COMMITTEE ON FINANCE AND BUDGET.

a. Composition. The Committee shall

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consist of six (6) members and a Chair. The Treasurer shall serve as the Board advisor to the Committee.

Section 7.15. COMMITTEE ON MEMBERSHIP.

- a. Composition. The Committee on Membership shall consist of a chair and six (6) members. The Secretary shall serve as the Board advisor to the Committee.
- b. Functions. The Committee on Membership shall make every effort consistent with required standards to increase the numerical strength of the Society. The Committee shall investigate why former members fail to renew membership in the Society, investigate the ethical, personal and professional qualifications of each applicant and shall submit its findings and recommendations to the Board of Directors for consideration in accordance with Section 3.5.b. of these Bylaws. The Committee also shall review and make recommendations concerning applications for change in membership status. The

Committee shall have access to accurate records of ~~past and present the~~ Society membership. ~~The Committee shall make every effort, consistent with the required standards, to increase the numerical strength of the Society.~~

Section 7.16. COMMITTEE ON RESEARCH.

- a. Composition. The Committee on Research shall consist of a chair, six (6) members and a board advisor.
- b. Functions. The Committee on Research shall establish guidelines for research grants presented by the Society, send notification of grant applications to anesthesiology residency training program chairs, announce availability of grant applications to the SAMBA membership either in the form of a letter to the membership or as an announcement in the Society's newsletter, receive applications for research grants, grade all applications for research grants and determine whether or not research grants should be awarded. The Committee on Research shall not be bound to present research grants at

the end of each grading period should the Committee concur that no application worthy of funding was received. ~~by the committee.~~ The Committee shall submit any grant to be funded to the Board of Directors for its approval prior to the awarding of the grant.

Section 8.5. PRESIDENT-ELECT.

The President-Elect shall perform the duties of the President during absence or disability and shall be an ex-officio member of all committees but shall serve on the Nominating Committee as a consultant member. The President-Elect shall select those members of the Society for appointment to committees at the beginning of their term. The President-Elect shall serve as Chair of the Judicial Committee and as the Vice-Chair of the Committee on Affiliations. The President-Elect shall oversee the operations of the Society's administrative committees and subcommittees and shall have purpose to maintain contact with the Board advisors to these committees. The President-Elect shall advance to the office of President without the process of nomination and election.

WANTED: Distinguished Service Award Nominees 2002

Louis A. Freeman, M.D., Fresno, California, Chair of the Committee on Awards, advises that the committee is seeking nominations for the SAMBA 2002 Distinguished Service Award. The award will be presented during the SAMBA 16th Annual Meeting on May 2-5, 2002, at the Hilton Hotel, Walt Disney World Village.

The award, which represents the highest honor SAMBA can bestow upon an individual, is presented in recognition of outstanding achievement in ambulatory anesthesia.

Past Distinguished Service Award Recipients are: Mary-Louise Levy, M.D., (1994) Chevy Chase, Maryland;

Bernard V. Wetchler, M.D., (1995) Chicago, Illinois; Stanley Bresticker, M.D., (1996) Somerset, New Jersey; Harry C. Wong, M.D., (1997) Salt Lake City, Utah; Burton S. Epstein, M.D., (1998) Bethesda, Maryland; Surinder K. Kallar, M.D., (1999) Richmond, Virginia; and Wallace A. Reed, M.D., (2000) Phoenix, Arizona. Paul F. White, M.D., Ph.D., Dallas, Texas, is the 2001 recipient.

Members interested in submitting a nomination for the SAMBA 2002 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. A form also appears on the following page. The nominating form requires, in addition to 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 2002 Distinguished Service Award is **August 1, 2001.** 

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AAAHC to Study Ambulatory Practices

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tion, various state medical licensing boards and other accrediting bodies regarding these implications. SAMBA leaders agree with AAAHC and other groups that voluntary, peer-reviewed accreditation is preferable to mandated accreditation. Rather than attempting to "reinvent the wheel," several states have incorporated many of the AAAHC standards into their rules and regulations dealing with ambulatory care.

In anticipation of the resulting increased demand for accreditation in the office-based setting, AAAHC is taking several steps. At the present time, planning has begun for the formation of a special task force to review anesthesia standards, including those for conscious sedation that would be used in an office-based setting. It is noted that anesthesia is an area of concern for many state regulatory bodies as it pertains to office surgery, and it has been the stimulus for many states to seek regulation of office-based procedures. This task force will ensure that AAAHC has appropriate, up-to-date,

clinically based anesthesia standards that are not only practical but appropriate. AAAHC Past President Margaret Bridwell, M.D., is currently chairing another task force charged with reviewing the entire AAAHC accreditation process with an eye on streamlining accreditation and making it more "user friendly," while still ensuring its integrity.

Finally, AAAHC's two subsidiaries, the Institute for Quality Improvement (IQI) and Healthcare Consultants International, Inc. (HCI), are poised to provide support services to organizations interested in accreditation. HCI is currently developing tools for organizations that desire guidance with the accreditation process. The tools will serve as educational aids, assisting organizations in complying with accreditation standards. In addition, the IQI is working with a number of specialty societies to develop monitoring and assessment programs pertaining to medical errors in the office setting. The IQI is also engaged in several clinical quality improvement studies in various specialty areas. 

Lots of Issues in This Issue of *Ambulatory Anesthesia*

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specialty can be extremely stressful, it is important to pay particular attention to our mental and emotional health. Therefore, in this issue, we discuss stress management. Michael A.E. Ramsay, M.D., Dallas, Texas, discusses the various aspects of stress management, including recognition of stress and the steps we can take to minimize and cope with stress.

Of note, the Discussion Board on the SAMBA Web site has been very active; a number of practitioners are using this forum to present their questions and concerns. Some of the topics of discussions will be summarized in future issues of this newsletter.

Finally, I would like to remind you to attend the SAMBA 16th Annual Meeting to be held at the Esmeralda Resort in Indian Wells (Palm Springs), California, on May 3-6, 2001. 