



Wisconsin Society of Anesthesiologists Newsletter

Winter 2011

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Welcome!

By Lois A. Connolly, M.D.



The 2011 annual meeting of the WSA took place at the Abbey Resort, Fontana, Wisconsin. The fall weekend meeting was a tremendous success and drew the leadership of the ASA to join us during the meeting. The annual meeting (free to WSA members) provides a good forum to meet and network with anes-

thesiologists throughout the state and discuss topics to enhance patient care. One member stated regarding the regional anesthesia hands-on workshop, "I was impressed, excellent faculty, I paid \$1000 for the ASRA course in Chicago, this free workshop was as good, with the advantage of less participants. Thank you so much." In this newsletter you will find a brief overview from Liz Yun, MD.

Next year the annual fall WSA meeting is being held at the American Club, Kohler, Wisconsin. The American Club is the Midwest's only AAA Five Diamond Resort Hotel. In addition to the luxury accommodations the resort offers inspired dining to world-class golf and spa services. Please make plans to join us September 8-9, 2012.

This year the WSA hosted a luncheon on Saturday Oct. 15th at the ASA. This was very well received and gave the WSA leadership a chance to discuss concerns with the anesthesiologists from Wisconsin. Most anesthesiologists are concerned about the impact of healthcare reform, both Medicare and Medicaid, on their practices. Eric Jensen, WSA lobbyist, has his hands on the pulse and addresses these issues in this newsletter.

If you wish to be become more involved in the WSA, please consider attending the second annual Legislative Advocacy Day on January 11, 2012. Also, the Alternate Delegates to the ASA hold one-year terms so any interested WSA member may apply for these positions as well as any other position that has term limits. The state of Wisconsin is divided into 5 districts based on the density of anesthesiologists within those counties. The division is included in the newsletter. Get to know your district director. They represent you on the WSA board.

The board members of the WSA constantly seek to maximize the value that the WSA membership brings to the anesthesiologists in the state of Wisconsin. You will shortly receive a membership survey so we can assess the climate of practice and tailor the WSA to our members. Please take thoughtful time to complete this survey.

I look forward to working for you over the next two years. Please feel free to contact me with any concerns.

Lois A. Connolly, M.D.
President, WSA

Board of Directors By Lois A. Connolly, M.D.

I wish to introduce you to the WSA Board of Directors.

Your Officers (2 year terms ending 2013):

President: Lois A. Connolly, MD
 President-Elect: Carolyn Farrell, MD
 Immediate Past President: Robert Koebert, MD
 Secretary/Treasurer: Jennifer (Braunschweig) Habelwitz, MD
 Asst. Secretary/Treasurer: Brian Schreiber, MD

District Directors: (Three Year Terms)

District Director, Region I William Campbell, MD (2013)
 District Director, Region II Rachel Budithi, MD (2012)
 District Director, Region III Elizabeth Yun, MD (2012)
 District Director, Region IV Edmund Fangman, MD (2012)
 District Director, Region V Jim Lodahl, MD (2014)

One Year Terms:

WMS Delegate Rose Campise-Luther, MD
 WMS Alternate Delegate Carolyn Farrell, MD

Three Year Terms:

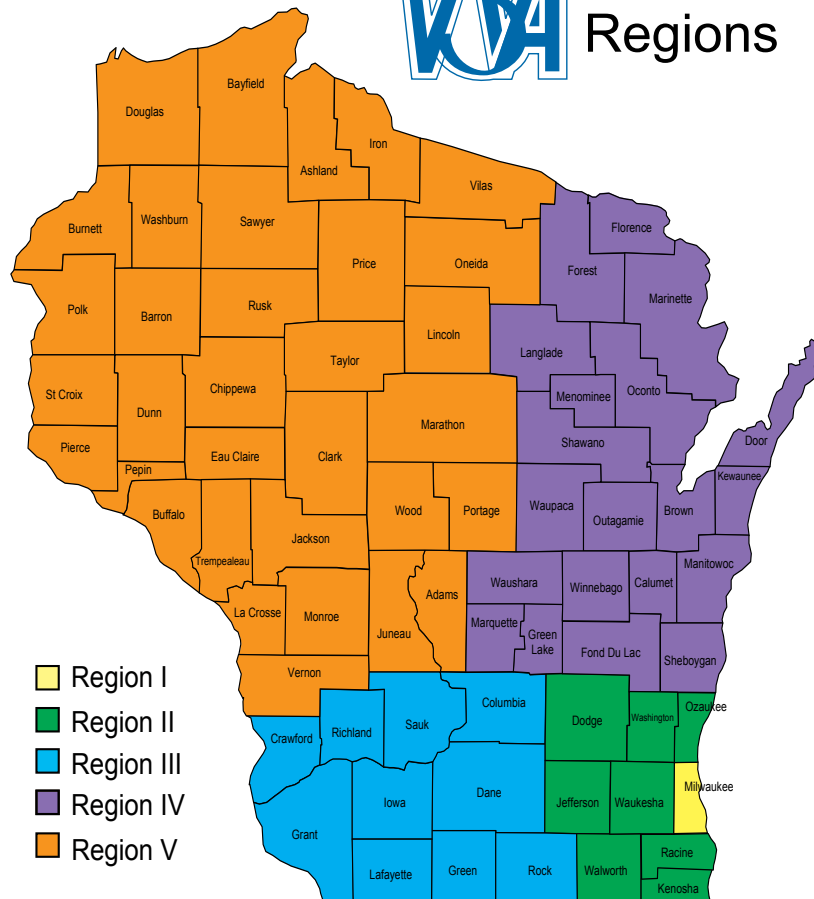
ASA Delegate Deb Rusy, MD (2012)
 ASA Delegate Elizabeth Yun, MD (2014)

One Year Terms:

Alternate ASA Delegate A. Nisar Akbar, MD
 Alternate ASA Delegate Robin Goldsmith, MD
 Alternate ASA Delegate Rose Campise-Luther, MD
 Alternate ASA Delegate Devinder Sidhu, MD
 Alternate ASA Delegate Dermot O’Neill, MD

Three Year Terms

ASA District Director Robert Kettler, MD (2014)
 ASA Alternate District Director James Mesrobian, MD (2014)



- Region I
- Region II
- Region III
- Region IV
- Region V

Outgoing President's Message

By Robert F. Koebert, M.D. WSA Immediate Past President



It has been my honor to serve as President of the Wisconsin Society of Anesthesiologists for the past two years. My charge, as I have seen it, has been to continue to make the society ever more meaningful to our membership. This has been a process that had been initiated by my predecessors and has been propelled forward through our affiliation with the management team from Svinicki Association Management, Inc.

The WSA has become professionally run and organized which has allowed us to do many things that were difficult to accomplish in the past. This newsletter is but one of the projects that we are able to do much more efficiently than we had ever done in the past. The WSA website (www.wsaonline.org) is constantly being improved.

Last year, we held the first WSA Legislative Day in Madison. Little did anyone know of the political fireworks that were to unfold in our state in the ensuing months. The political quagmire in Wisconsin prevented much business being done and some of our objectives remain unmet. I am optimistic that we might still accomplish some of our goals before the current

legislative session concludes early in 2012. We are looking forward to our second WSA Legislative Day which is scheduled for Wednesday, January 11, 2012. Please make plans to join us.

I enjoyed having the opportunity to meet with some of the anesthesiology groups around the state. I would encourage any group that would like to have representatives of the WSA attend a department or corporate meeting to contact us to arrange for that to occur.

I am pleased by the composition of the WSA Board of Directors. We have made a concerted effort to recruit anesthesiologists from around the state to represent the membership. The WSA is in great hands with Lois Connolly as our new president. I am sure you will see continued value in our WSA membership as the future unfolds before us.

Respectfully submitted;



Robert F. Koebert, M.D.
Immediate Past President, WSA

2012 Annual Meeting
The American Club • Kohler, Wisconsin
September 8-9, 2012

The
American
club®

2013 Annual Meeting
Pfister Hotel • Milwaukee, Wisconsin
September 7-8, 2013

The
Pfister®

Executive Director's Report

By Jane Svinicki, C.A.E.



In Too Deep? Saying yes to Adventure, then having second thoughts

Did you ever notice that a year before you go somewhere, it is a lot easier to say, "Yeah, I will travel to Africa - cool."

When you are a couple days from leaving only then do you ask yourself – "How crazy am I?" Especially when you learn there are half a million refugees on the Kenya border, starving and desperate, and you are going to Kenya too, only to be driven around like some grand poobah in an air-conditioned jeep to look at animals.

When I told people I was going to Africa on vacation last August, they looked concerned and told me to be careful and bring the phone number of the American Embassy. Sometimes they would say, "you are really adventurous." No one said, "wish I was going with you."

It's a long, long way from here to there. The Atlanta to Johannesburg, South Africa flight alone is almost 16 hours. I was on three overnight flights during my three week trip. Lots of opportunities to develop deep vein thrombosis.

I had to get four shots (including yellow fever for which they give you the live virus to develop immunity), malaria pills and Cipro, for that inevitable stomach upset, just to be allowed onto the continent. As the doctor was giving me the yellow fever shot she told me, "about one in ten people go to bed for a day or two from this shot." I wasn't even in Africa yet and I was potentially getting sick.

As the last week passed before I left, I learned about the African's relaxed attitude about time. If you cannot get the flight back from Victoria Falls one day...just go the next day! It will work out.

My travel mantra was, as always, "Be flexible, be polite and be generous." I was on vacation, time to relax and enjoy. Sometimes I had to spend some money to get out of a problem, I spent it and kept quiet. People in the third world deserve better than petty complaints about a \$50 entry visa to a country where that is a month's wage.

When I originally said yes to going to Africa, I knew it would be a trip outside my comfort zone, way outside. And because of that, it would help me grow as a person. I would meet some new people, see some great stuff and learn more about the world.

What does this have to do with being an Executive Director of an association? It is exposure to the new and different that changes perspective, changes lives and brings about innovation. Innovation is an overused buzzword right now, but new experiences get the mind working in different ways out of the routine you may have been stuck in, to reach your goals.

So you don't have to go to Africa to change your world, but you will have to go outside your comfort zone. Trust me, it will be thrilling.

A handwritten signature in black ink that reads "Jane A. Svinicki". The signature is fluid and cursive.

Jane A. Svinicki, CAE
Executive Director



Annual Meeting Recap

By Elizabeth Yun, M.D.

On September 17 and 18, 2011, the Wisconsin Society of Anesthesiologists held its annual meeting at the Abbey Resort in Lake Geneva Wisconsin. This meeting covered a wide variety of clinical and practice management topics. This article provides a brief synopsis of the lectures.

On Saturday, after a welcome from Dr. Robert Koeber, the outgoing WSA president, the program started with the lecture: Introducing a Regional Anesthesia Program to your Hospital/Surgicenter by Dr. James Conterato of Marshfield Clinic. In his lecture, Dr. Conterato noted that over the past 15 years the demand for regional anesthesia in ambulatory surgery centers has increased. Ultrasound guided placement of peripheral nerve blocks as single injections and as postoperative continuous catheters are especially popular. He then reviewed his experiences and challenges setting up an acute regional pain service at Marshfield Clinic.

The next speaker, Dr. William McIvor of the University of Pittsburgh presented MOCA Simulation Requirements: What Will This Mean to You? He described how the University of Pittsburgh simulation center provides opportunities for practitioners to assess their clinical and teamwork skills, thus improving their ability to cope with difficult clinical situations. As Dr. McIvor explained, the American Board of Anesthesiologists plans on incorporating simulation as part of the recertification program. For further information on this topic, he provided these links: http://www.theaba.org/Home/anesthesiology_maintenance, <http://www.asahq.org/For-Members/Education-and-Events/Simulation-Education.aspx>, <http://www.wiser.pitt.edu>.

The next lecture was Obstetrical Anesthesia Update presented by Dr. Nicole Higgins of Northwestern University. She reviewed patient safety issues in obstetrics including, new strategies for prevention of infections, prophylactic antibiotics, antithrombotic guidelines and local anesthetics toxicity treatment. She then described changes in obstetric management topics such as the use of MgSO₄ for preterm labor and new thinking in VBAC management. Finally, Dr. Higgins discussed issues in obstetrical anesthesia management such as bolus versus infusion administration for epidurals, management of the obese pregnant patient, new considerations for post dural puncture headache management and the use of low dose phenylephrine infusions to prevent hypotension in c sections.

After the lunchtime ASA update from Dr. Mark Warner, President of the ASA, the next presentation was Dealing with the Rising Need to Provide Anesthesia Care Outside the Operating Room by Dr. Mary Warner of the Mayo Clinic, Rochester MN. She discussed how the rise in demand for sedation in outside locations has led to the development of new practice models with non anesthesia personnel providing moderate to deep sedation. For these models to work, she stated that anesthesiologists need to be actively involved in an oversight capacity. For example, they must credential non anesthesia providers, train these providers in airway rescue skills, set the standards of care in equipment, drugs, monitoring, documen-

tation and patient assessment. By participating, anesthesiologists can ensure patients receive safe care in these remote locations

Dr. Mark Warner of the Mayo Clinic presented Future Technologies and Their Impact on Perioperative Patient Safety. He reviewed new technological advances in nanocrystals, radiation therapy, minimally invasive and noninvasive procedures and new ways of utilizing electronic medical records such as trend identification and early recognition of complications. He noted that anesthesia as a specialty needs to evolve by expanding in to other areas of perioperative care like preoperative patient evaluations, intensive care, and chronic postoperative care.

The WSA Distinguished Service Award was then awarded posthumously to Dr. Ralph Waters, who established the first academic anesthesia residency program in the United States at the University of Wisconsin. Dr. Mark Schroeder of the University of Wisconsin and the Secretary-treasurer of the Wood Museum and Library accepted the award on behalf of Dr. Waters. Dr. Schroeder also gave a talk, The Ralph Waters Lecture about Dr. Waters' life and many accomplishments, the most significant being the establishment of the first academic anesthesia program. Dr. Waters' vision for this program was to train physicians to provide excellent clinical anesthesia and to enhance the growth of the specialty through research. Many prominent anesthesiologists of the time graduated from this program and established similar academic anesthesia programs throughout the country and the world.

On Sunday September 18, there were two morning lectures. The first lecture was Introducing Electronic Medical Records into Your Anesthesia Practice by Dr. Scott Springman of the University of Wisconsin. He noted that with the Affordable Health Care, the government is now giving money for hospitals to implement electronic medical records. Dr. Springman then described the myriad trials and tribulations of setting up an electronic medical record system. He also addressed the concern of how the data collected from these records might be used in monitoring compliance and in medical legal situations.

The final speaker was Dr. Josh Sebranek of the University of Wisconsin who presented Perioperative Care of the Patient with Coronary Stents. He discussed medical concerns with bare metal and drug eluting stents. In particular, Dr. Sebranek addressed the perioperative risks of these stents, which include rethrombosis and bleeding. He reviewed current recommendations for the perioperative care of stents including the different preoperative antiplatelet therapies needed for each type of stent, what to do when these patients present for emergency surgeries and the use of bridging therapies for these patient who are scheduled for surgery.

Please join us at next year's annual meeting which will take place on September 8-9, 2012 at the American Club, Kohler Wisconsin.

Annual Meeting Photos [next page](#)

Annual Meeting Recap Photos



WSA Board of Directors welcomed ASA President, Mark Warner, MD to the WSA Annual Meeting held September 17-18, 2011 at the Abbey Resort.



Outgoing President Dr. Rob Koebert (Left) receives a plaque from Dr. James Mesrobian (Right), the Immediate Past President of the WSA at the Annual Business Meeting.



Outgoing President, Dr. Rob Koebert (Left) with Immediate Past President Dr. James Mesrobian (Center) and Dr. Mark Warner (Right)



Dr. Jay Mesrobian (Left) with Dr. Rose Campise-Luther (Center) and Dr. Robin Goldsmith (Right) enjoying the outdoor reception held at the WSA Annual Meeting



Attendees to the WSA Annual Meeting enjoy cocktails at the Saturday evening reception on the shores of Lake Geneva

Annual Meeting Recap Photos



Attendees to the WSA Annual Meeting enjoyed a sunset dinner cruise on the "Lady of the Lake"



WSA Staff Annette Schott (Left) and Jane Svinicki Right) enjoy the dinner cruise



WSA President, Dr. Rob Koebert presents a plaque to Dr. Mark Schroeder



Attendees to the WSA Annual Meeting enjoyed a sunset dinner cruise on the "Lady of the Lake"



Wisconsin Medicaid Reforms Taking Shape

By Erin Jensen, J.D.

Facing a deficit of \$1.8 billion in Wisconsin's Medicaid and associated health insurance programs, Governor Walker's 2011-13 Budget infused \$1.2 billion in new dollars, while directing the Department of Health Services (DHS) to find more than \$500 million in savings to close the deficit gap. While DHS has been working for months to come up with new initiatives, changes and cuts to achieve the ordered savings, details have begun to emerge only in the last few weeks.

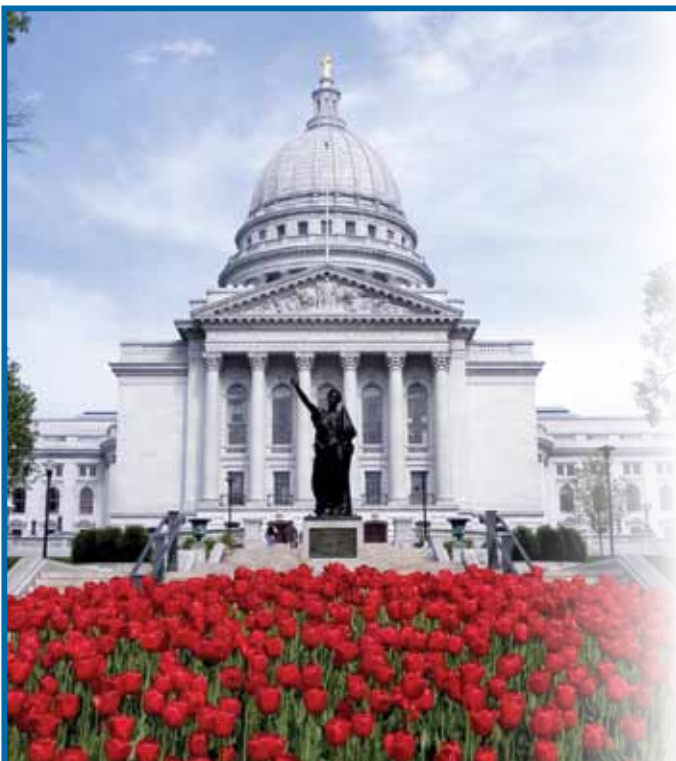
At the end of September, DHS published a series of Medicaid Efficiencies proposals, describing in very general terms many of their reform ideas. (Link to the publication: <http://www.dhs.wisconsin.gov/mareform/PackageJFC9.30.11.pdf>) The list included thirty-nine items in four topic areas: payment reform, service delivery reform, benefit reform and eligibility reform. Plans include transitioning more than 150,000 recipients to lower-benefit plans, increasing participant financial obligations (co-pays and premiums), creation of medical homes, and reductions in payments to some providers.

A key proposal among the 39 items is one entitled, "Physician Rate Change for Certain Services Provided in a Hospital." The detail-light proposal summary indicated DHS will reduce rates paid to physicians "for services typically provided in an office setting when those services are instead provided in a hospital setting," instead paying 80% of the office rate when

the service is provided in a hospital. Projected savings = \$1.5 million. WSA began communicating with DHS and other administration officials in an effort to determine which in-hospital services will be affected. We have received confirmation that anesthesia codes will not, and various WSA members are now reviewing the remainder of the lengthy draft list.

A second proposal of interest, entitled "Reimbursement Modification for Consultation Services," will result in a straight 20% reduction from current payments for consultation services. Projected savings = \$1.6 million. At the time of writing, a list spelling out the affected services was not available.

Many of the proposed changes require a "waiver" from the Federal Centers for Medicare & Medicaid Services (CMS). At the end of October a proposed "waiver request" was released (Link: <http://www.dhs.wisconsin.gov/mareform/FinalJFC-Submission10.31.11.pdf>), and pursuant to Wisconsin law was submitted to the Legislature's Joint Finance Committee (JFC) for approval. The request contained many of the proposals released in September, and received party-line JFC approval on November 10th. It will be immediately submitted to CMS, and absent approval by year-end, another solution to close the budget gap will have to be found.



Save the Date

— Legislative Action Day —

Wednesday, January 11, 2012

8-9:30 am Issues Meeting

9:30-11:45 am Capital Visits

12-1:30 pm Lunch

**To Register Fill out enclosed form
or online at www.thewsa.org**

Preregistration Required

For more information please visit www.thewsa.org



January 11, 2012

Legislative Advocacy Day

TIME	7:30am – 8:00am	Registration & Continental Breakfast at the Madison Club
	8:00am – 9:30am	Issues Meeting
	9:30am – 11:45am	Capital Visits
	12:00pm – 1:30pm	Debrief & Lunch at the Madison Club

WHERE The Madison Club, Capitol Room, 5 East Wilson Street
(parking underneath the Hilton or city parking across the street)

LEARN

- How to be part of the legislative process.
- How to communicate effectively with State legislators on issues that affect you and your patients.
- What issues affect your medical practice and your patients.

WSA Legislative Advocacy Day PRE-REGISTRATION REQUIRED

Name: _____

Home Address: _____

City, State, Zip: _____

Office Phone: _____

Cell Phone: _____

*Email: _____

Employer or Affiliation: _____

**IMPORTANT – YOU WILL RECEIVE AN EMAIL CONFIRMATION OF YOUR
REGISTRATION**

WSA:
6737 West Washington St. Suite 1300, Milwaukee, WI 53214
FAX 414-276-7704
EMAIL info@thewsa.org

Getting Involved in Politics - A Newcomer's View

By Rose Campise-Luther, M.D.

In April of this year, I had the privilege to attend the ASA legislative conference in Washington, D.C. as delegate member of the Wisconsin Society of Anesthesiology. The motto was "All politics are local" and after my experience, I would add "All politics affect you". Like many of us, I had been in D.C. to visit the monuments and the museums but never actually got an inside view into how our country is governed. I have always strongly felt that if one does not participate in the process, one can't complain about the end result. It is this belief, which encouraged me to get involved with the legislative work of our state and national societies.

I got my first preview into politics attending the Wisconsin Society of Anesthesiologists own legislative day in Madison in January of this year and was astonished by the intricacy of how political decisions are made, bills passed and how one critical voice can change the outcome of a vote on an important issue at the last minute. I had the chance to talk with my representatives and present issues that affect anesthesiologists in Wisconsin. Experiencing firsthand the lack of knowledge

about the practice of anesthesia by our senators and assembly members demonstrated to me how important it is to be politically involved and educate them. Nevertheless, it was a very cordial, personal meeting and I left with a feeling of accomplishment.

My experience in Washington, D.C. was very different, almost overwhelming. Anesthesiologists from all over the country traveled to our capital to get informed and involved. The conference opened with a very informative state issues forum that highlighted challenges other component societies are facing and may become issues in our State as well. It included scope of practice challenges in the field of interventional pain medicine as well as issues with truth in advertising. Shifting from a state to a federal focus, the attendees were then given an introduction into how capitol hill works by the ASA Director of Congressional and Political Affairs Manuel Bonilla. In summary, although there are some similarities to local government, things are very different in Washington, D.C. especially in the way decisions are reached and enacted.

The WSA joins SmartTots

By Rose Campise-Luther, M.D.

Earlier this year I had written about the increasing body of evidence that suggests potential adverse effects of virtually all of the agents currently used in routine pediatric anesthesia practice on the developing brains of young animals. The International Anesthesia Research Society (IARS) and the Food and Drug Administration (FDA) formed a public-private partnership called SmartTots (Strategies for Mitigating Anesthesia-Related neuro-Toxicity in Tots), which is dedicated to raising the funds to support the needed research and to enlist researchers in answering whether or not the animal data is applicable to humans.

The SmartTots governance structure is comprised of a Steering Committee, a Scientific Advisory Board, an Executive Board, an Industrial Advisory Board and an Affiliate Advisory Council. The Scientific Advisory Board has been appointed with representation from a wide range of stakeholders, including anesthesiology, neuroscience, neuroimaging, pediatric neurology and development, epidemiology, developmental biology and behavioral psychology. Its responsibility is to evaluate the scientific merit and potential impact of research proposals submitted and to oversee the implementation and progress of funded projects. The Affiliate Advisory Council, which is comprised of multiple specialty organizations, will give the Scientific Advisory Board broad and direct input as well as help with fund raising efforts for SmartTots. Members of this council include the American Society of Anesthesiologists, the Society of Pediatric Anesthesia and the American Academy of Pediatrics, among others.



The WSA is the first component society of the ASA to join SmartTots as a member of the Affiliate Advisory Council and as such will do its part to find answers to these important questions and ensure the safety of our patients.

As Anesthesiologists we all have a long track record of making patient safety our priority. Although very few of us will be able to do the actual research to determine if our anesthetic agents cause neurodevelopmental problems in children, each of us can indirectly support the research effort. The WSA has taken an important first step on behalf of all anesthesiologists in Wisconsin and I hope we all can continue on this path by supporting Smart Tots with donations. 100% of donations will go into research and in August of this year the first call for research proposals was issued. If you are interested in donating to SmartTots you can do so by either going online to www.smarttots.org/support.html or mail a check to SmartTots, 100 Pine St. #230, San Francisco, CA 94111.

ASA Director's Report

By Bob Kettler, M.D.

One of the responsibilities of a District Director of the American Society of Anesthesiologists (ASA) is to provide a report to the component society membership of the meetings of the House of Delegates (HOD) and Board of Directors of the ASA. The HOD met during the recent Annual Meeting of the ASA; on adjournment of the HOD the Board of Directors held the October Interim Board of Directors meeting (OI BOD). This is my report to you of these meetings.

HOD

The HOD met on 16 and 19 October 2011 in Chicago, Illinois. The WSA was represented by Drs. Nisar Akbar, Rose Campise-Luther, Susan Goelzer, Robin Goldsmith, Bob Kettler, Robb Koebert, Jay Mesrobian, and Deb Rusy. The resident representatives were Drs. Richard Beddingfield (MCW), Rebecca Broecker (UW), and Andrew Schroeder (MCW). There were 16,598 registrants for the meeting (a 6% increase from 2010), and this number included 3343 international registrants (an increase of 9% from 2010). During the annual meeting about \$250,000.00 was contributed to the ASAPAC (the political action committee of the ASA), including over \$4000.00 from WSA members.

The HOD considered an agenda of 144 items of business. I'm not going to report on all of them; instead I'll concentrate on a few that were controversial or that I think are important to the general membership of the WSA. Please feel free to contact me with any questions you may have.



The Committee on Bylaws recommended a modification of the Bylaws that would have read, "The Chief Executive Officer shall be selected and evaluated by the Administrative Council of the Board of Directors and shall be under the direction and supervision of the President." This is a continuation of an effort to reorganize the administrative functioning of the ASA that began with the Organizational Improvement Initiative (OII). Proponents of this measure felt that a President who may not have managerial training and serves only a one-year term cannot properly manage the personnel of a large organization like the ASA. (The ASA President has served as the CEO of the ASA.) Opponents felt the Board should have more of a role in selection and oversight of the CEO. In the end the House approved language giving the Board a role in the evaluation of the CEO.

The Committee on Quality Management and Departmental Administration recommended the allocation of \$200,000.00 to develop a "Deep Sedation for Non-Anesthesiologists Physician Education Program." Proponents of the program felt that deep sedation by non-anesthesiologist physicians is an established

and growing practice. Anesthesia chiefs who are responsible for all anesthetic practice in their hospitals need a means of assuring that other practitioners are properly trained to be credentialed for that procedure. Opponents felt that the ASA should show leadership by not appearing to endorse a practice that is inappropriate. The HOD referred this matter to a committee of the President's choice.

The HOD also approved the Administrative Council's approval of the addition of about 3400 square feet to the Washington office. This will lead to an increase of \$128,000.00 in operating expenses and \$17,500.00 in capital expenditures for 2012.

Immediately prior to adjournment of the HOD President Mark Warner turned the gavel over to incoming President Jerry Cohen. (Dr. Cohen has accepted our invitation to attend the WSA's annual meeting in September 2012.)

OI BOD

For the most part the OI BOD concerned administrative matters related to ASA management that I felt were unlikely to be of interest to the general membership of the WSA. However, there was an informational item that I thought may be of general interest.

The District of Columbia Society of Anesthesiologists (DCSA) announced an Anesthesiologist Assistant (AA) school opening in June 2012. Howard University, National Children's Medical Center, and Georgetown University have expressed interest in a clinical affiliation. The school has been developed "by the leadership of Case Western Reserve in Cleveland, Ohio."

If anyone has any questions about specifics of the agenda of the HOD or the OI BOD, feel free to contact me at rkettler@wi.rr.com.

Finally, this year the WSA did something new at the ASA's annual meeting. The WSA hosted a luncheon on Saturday, 15 October 2011, for any WSA member attending the meeting. About 60 people, roughly 25% of WSA members attending the annual meeting, took part in the luncheon. This event provided a nice break from the meeting's often hectic schedule and a welcome opportunity to socialize. Jay Mesrobian, M.D., our Alternate Director, came up with the idea and made the arrangements—a job well done.



WSA President Provides Services to Children of Zimbabwe

By Robert F. Koebert, M.D. WSA Immediate Past President

This past June I took advantage of an opportunity to travel to Chitungwiza, Zimbabwe with a team of plastic surgeons, nurses and anesthesiologists from around North America to provide services to children with cleft lip and palate deformities. It was a challenging trip but proved to be a tremendously rewarding experience.

There are quite a few organizations that deliver such services. Alliance for Smiles (AFS) sponsored this particular mission. I have traveled with AFS several times in the past. AFS is a non-profit organization based in San Francisco, CA and organizes about 8-10 trips to locations around the world each year. Local Rotary Clubs partner with AFS for sponsorship and funding.

On June 11, 2011 I traveled to Atlanta, GA to rendezvous with others who had volunteered their services for this mission. The delegation included two plastic surgeons, two anesthesiologists, OR and PACU nurses as well as several other support positions. From Atlanta we boarded a plane to make the 14 hour flight to Johannesburg, South Africa and, from there, a short flight to Hurare, Zimbabwe.

We arrived in Zimbabwe late the following evening. The process of clearing customs with our 24 large boxes of equipment in addition to our personal luggage proved to be time consuming and it was past midnight by the time we finally arrived at the hotel.

The hotel was conveniently situated a mere 3 km from the Chitungwiza Central Hospital just outside of the large city of Hurare, Zimbabwe. The hotel staff was very accommodating but the facilities were not quite what we might expect in North America. Insects are ubiquitous and cockroach sightings were common. Power was a bit sporadic and hot water a luxury. The swimming pool contained water so murky that no one would even consider using it and internet access was unheard of. It was the first time in many years that I went two weeks without the ability to check e-mails (my apologies if any of you were trying to contact me during that time).



Early the next morning I was awakened by a knock on my door (the wake up call as there were no phones in the rooms)



and we had breakfast and headed to the hospital to set up our equipment and triage the more than 100 patients who had arrived hoping to have cleft lip and/or palate repairs. Many of these patients had traveled more than 10 hours in hopes of receiving our care. At the end of the day, we had examined every potential patient and determined that about 75 of them were appropriate for our mission. We had identified a number of patients who had cardiac or respiratory disease that made them unacceptable surgical risks and were given recommendations for follow up. Future trips are being planned and many of these patients might prove to be satisfactory surgical candidates at that time. A preliminary schedule was created and we were to begin operating the following morning.

AFS has portable anesthesia machines that we bring with us (DRE) and two Sevoflurane vaporizers. We had a single wall source of oxygen and had to modify our oxygen hoses to be able to provide oxygen to each of our two machines from that single source. We had made the decision to set up two OR tables in a single OR suite. This proved useful as we had but two anesthesiologists and we were able to assist one another since we were working side by side.

Once we were satisfied that we had our equipment in working order, we began the business of caring for our patients. The first morning of surgery tends to be harrowing as we inevitably find glitches in our equipment or processes that need to be addressed. The hospital experienced frequent power outages and water was not always available in the scrub sinks. Flexibility and ingenuity are tremendous attributes for success under these circumstances.

The local hospital employees are extremely helpful in our work. Nurse anesthetists do the majority of the work at the Chitungwiza Central Hospital. There is one anesthesiologist on staff but she is generally in the hospital only one or two days per week. The anesthetists were very anxious to help us and learn from us as our work progressed. The local surgical techs were indispensable for the work we performed. There is a definite sense of teamwork that develops over the course of two weeks. We bring our own sterilization equipment and the volunteer who runs it (a farmer from Nebraska) does a tremendous job of organizing the local workers to help him.

The monitors that we bring with us have end tidal CO2 monitoring capability that works as long as we have electrical power. This is a bit of a luxury during such missions but during the frequent power outages we had no ETCO2 monitoring.



Over the 10 days of surgery, our two surgical teams performed a total of 69 procedures. Cleft lip and palate repairs comprised all of the surgeries except for one patient who underwent repair of a severe burn contracture with Z-plasty to his neck. We had several patients who had some respiratory issues post operatively and my anesthesiologist colleague (a German citizen from Massachusetts General Hospital) spent two nights in the hospital tending to patients that required a bit more care than is normally available in this hospital. Our pediatrician, also, went above and beyond to ensure the safe peri-operative care of our charges. With these resources, all of our patients ended up doing reasonably well during their hospital stays.

Unfortunately, we learned of the death of one child who had undergone primary cleft palate repair and was discharged to the care of his parents the next day. He expired the following day when he experienced respiratory distress and could not be reached by emergency personnel due to the remote location of their home. This loss dampened all of our spirits but a critical review of the case gave no indication of any impending complications.

Our one day off (Sunday) provided an opportunity to visit a game preserve near Chitungwiza accompanied by our Rotary Club hosts. There we sited zebras, warthogs, waterbucks, ostriches, monkeys and even a rhinoceros. Shortly after leaving the preserve, we observed about 40 baboons feasting in a farmer's field of winter wheat. The day wrapped up with a feast of barbecued meats at The Spillway along with a bit of dancing with our hosts.



Sadza is the staple food of the Zimbabwe people. It is made of corn meal and reminded me of polenta. Though, I suspect, many Zimbabweans do not get to eat meat very frequently, our delegation was served generous portions of meats. Chicken was most common followed by beef, pork and various fish. I found the local beers (predominantly lagers) to be quite refreshing and the wines (from South Africa) were excellent quality. (We did find time at the end of each day to enjoy some refreshments.)



We begin to wind down our operations over the final two days. No cleft palates are repaired on our final surgical day. We limit the procedures on that day to cleft lips only as they tend to require less post operative care. Once the last surgery has been completed, we begin the task of packing our equipment for the return trip to the States. We do, however, keep one machine set up until the final morning for the unlikely need to bring any patient back to the OR for bleeding complications.

We encourage all of our patients to return for a final clinic visit on the final morning of our stay. Despite the long distances traveled by many of the patients, the vast majority do, indeed, return for final checks and instructions. The smiling faces on the children and parents are our just rewards for the grueling work involved in the mission.

Finally, it is time to head to the airport for the long trip home. Invariably, we encounter some logistical hassles in getting our durable equipment through customs without paying huge fees. We say goodbye to our hosts and to the colleagues that have become close friends during the trip. It is good to finally return to Wisconsin and appreciate all of the advantages we enjoy. Not long afterwards, however, I begin to think about the next trip that will allow me to help children around the world. It is important and rewarding work. I would encourage all of you to give serious consideration to such volunteer work.

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