

# AnesthesiaNews

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Newsletter of the Department of Anesthesia and Perioperative Care | University of California, San Francisco



## Value-Based, Patient-Centered Outcomes

### COMMENTARY

BY MERVYN MAZE, MB ChB

Chair of the UCSF  
Department of Anesthesia  
and Perioperative Care

**Contrary to popular perception, healthcare providers, patients, payers, and policy-makers do agree on something: we are united around enhancing healthcare's value proposition by improving patient outcomes as efficiently as possible.**

Unfortunately, several factors conspire to thwart these good intentions, most notably inadequate measurements. After all, in order to manage and improve, one needs to measure and most provider organizations struggle to capture data on two key pieces of the equation: the actual costs for delivering an episode of care and patient-centered outcomes.

In many other industries, organizations enhance value by eliminating activities and resources that fail to add to the customer's satisfaction. However, under the fee-for-service payment system, healthcare stakeholders function as separate business units driven by competing incentives and are more inclined to protect their revenue than adopt a culture where teamwork, including shared accountability, is the norm.

To deliver excellent outcomes as efficiently as possible, we need to change our culture. The starting point is finding an alternative to a system that incentivizes volume, rather than patient-centered value. Amongst the value-based payment systems some are studying is the aptly named "episode of care" payment, also called "bundled payment." In operational

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DEPARTMENT CHAIR  
EDITOR-IN-CHIEF  
Mervyn Maze, MB ChB

EDITOR:  
Morgen Ahearn

DESIGNER:  
Laura Myers Design

PRINCIPAL WRITER:  
Andrew Schwartz

PHOTOGRAPHERS:  
Christine Jegan  
Michael T. Lee  
Marco Sanchez  
Brant Ward

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and Perioperative Care

521 Parnassus Avenue  
Room C 450, Box 0648  
San Francisco, CA 94143-0648  
415/476-2131

<http://anesthesia.ucsf.edu>

Send all inquiries to  
[ahearnm@anesthesia.ucsf.edu](mailto:ahearnm@anesthesia.ucsf.edu)

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## FROM THE CHAIR

While the Department's anesthesia providers all strive to provide our surgical patients the highest quality of care possible, we need to ask: What parameters reflect this? Should we examine only those for which we are "directly" responsible? Or should we assume a collective responsibility together with the other members of the team of health providers that are involved in the patient's surgical episode of care?

I would vote for the latter. I see it much like any team activity. In baseball, for example, when a team loses it matters naught whether a pitcher strikes out 15 batters if the fielders do not get outs on routine groundballs and the batters do not advance runners in scoring positions.

For anesthesia providers, the current measures only look at individual performance – and even at that, they are terribly flawed. Consider that among the data reported to



NSQIP, only provision of the appropriate antibiotic within 60 minutes of incision is somewhat under our control. Even then, there may be a delay in the time from administration to cut time – and the choice of antibiotic is more in the surgeon's realm. Holding us individually accountable in those circumstances is questionable at best.

More importantly, in the surgical context, it is to the patient that we need to be held accountable. And it is

unlikely that the patient will remember to commend the anesthesia provider for delivering the antibiotic in the appropriate manner were the patient to subsequently develop a septic complication requiring a prolonged hospital stay.

Michael Porter encapsulated best what the important outcomes are for the patient in a landmark commentary on Value in Healthcare.<sup>1</sup> At the top of the hierarchy he suggests Health Status Retained or Regained and includes both survival as well as the degree of health recovered. Tier 2 is the Process of Recovery and includes the timeliness of the care and its arduous nature (eg., being subjected to a succession of painful procedures). Finally, Tier 3 is Sustainability of Health, which includes whether there are relapses or iatrogenic diseases created by the treatment.

If anesthesia providers only measure our contribution to surgical care in terms of, say, prompt discharge from the PACU following a general anesthetic, we run the risk of being marginalized in the surgical care team and remaining anonymous to the patient. As experts in perioperative management and as coordinators of care, we can bring more value to our surgical patients by embracing a holistic view that includes us in measures based on improving outcomes that are important from a patient's perspective.

A handwritten signature in black ink, appearing to read 'Mervyn Maze', written in a cursive style.

Mervyn Maze, MB ChB  
Professor and Chair

### Reference:

1. Porter, ME. What is value in Health Care? *New England Journal of Medicine* 363 (26): 2477-2481, 2010.

# Expansion of Anesthesia Services

In December 2009, the Centers for Medicare and Medicaid Services (CMS) published a revision to its Conditions of Participation for anesthesia services.

“CMS changed some important requirements,” says Maurice Zwass, MD, who represents the UCSF Department of Anesthesia and Perioperative Care on UCSF’s Sedation Committee. “The big one requires that a ‘qualified practitioner’ – who is not performing the procedure – be at the bedside administering the procedural sedation/anesthesia, including in non-operating room settings. The intent is to have someone solely focused on and fully prepared to rescue the patient if necessary.”

The endoscopy suite, the catheterization lab, interventional and diagnostic radiology, electrophysiology, and a variety of cardiology-related procedures are among those affected. In these settings, hospitals now needed to ensure the presence of both the specialist performing the procedure and a highly qualified practitioner to administer procedural sedation/anesthesia.

## Meeting the Increased Demand

To meet this demand, UCSF Medical Center turned to the Department of Anesthesia and Perioperative Care. “Our training is the most focused and, presumably, we would be the most efficient for providing deep sedation or general anesthesia, including monitoring and rescue,” says Zwass. The need to cover more sites has required more hours from existing staff – and the hiring of more practitioners who meet the Department’s exacting standards.

This came on the heels of generally expanding volumes, linked to other factors such as longer imaging sequences and more sophisticated procedures, says Claire Brett, who coordinates the department’s pediatric non-operating room anesthesia (NORA) program. “A Gamma Knife procedure can require an all day general anesthetic for the patient,” she says.

She notes, however, that the changes have been less dramatic in pediatric anesthesiology, which has had more of a presence

in NORA due to fundamental requirements for deep sedation/general anesthesia for infants and children during diagnostic procedures – and to guidelines that go back over 25 years.

In part, the guidelines for pediatric patients emerged from fatal complications involving sedated children in dentists’ offices and other sites, which, says Brett, “clearly showed the critical role of a skilled practitioner intervening immediately to manage an unexpected airway or cardiac complication.”

## Educating and Qualifying Other Physicians

In addition to ensuring that more anesthesiologists and nurse anesthetists are available for NORA, the department is creating systems to credential non-anesthesia providers to administer sedation. Chair Mervyn Maze, MB ChB, chose a robust approach to ensure patient safety and meet both the letter and spirit of the revision, while respecting existing practice patterns.

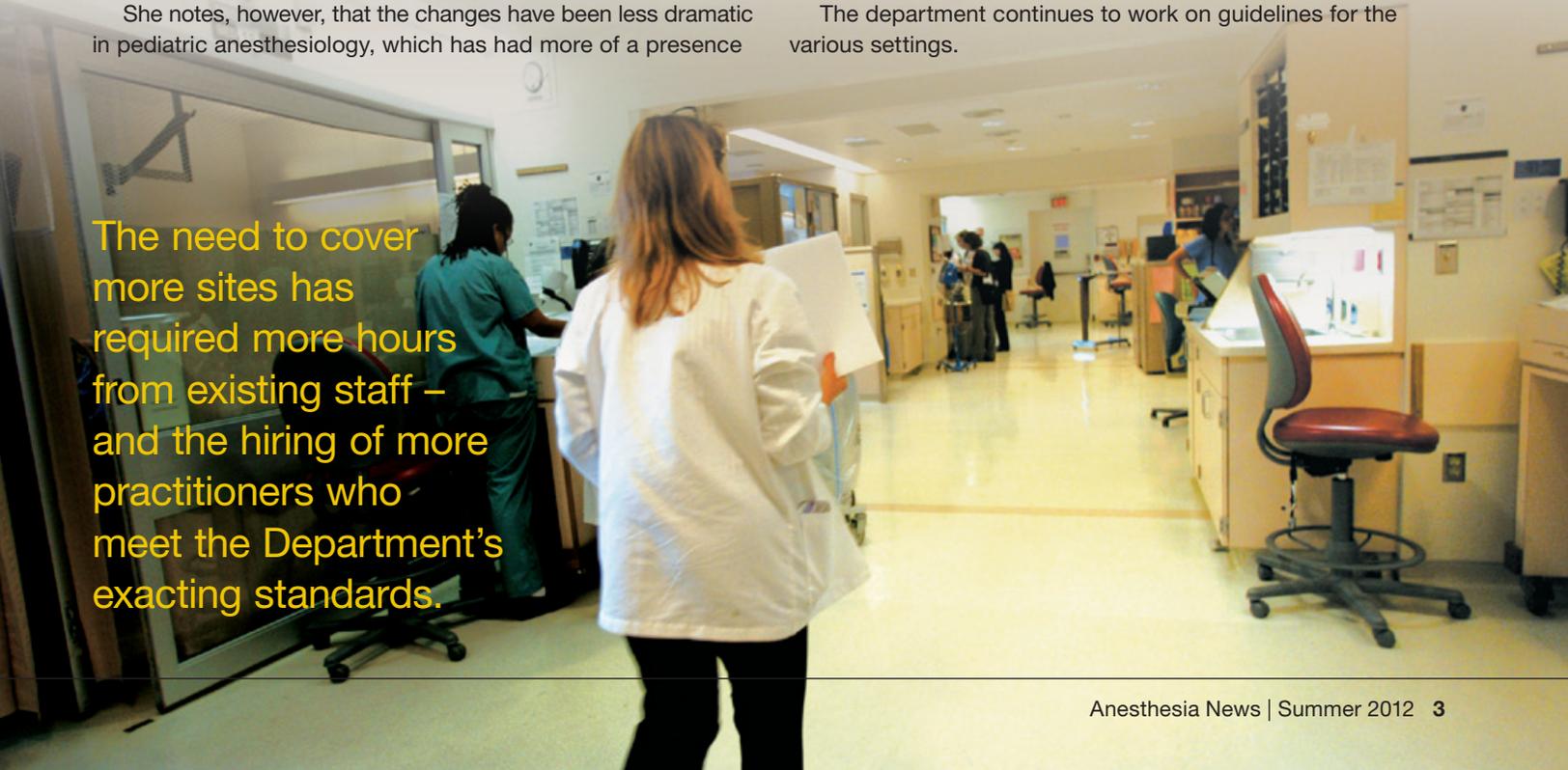
“For example, pediatric hospitalists at UCSF Benioff Children’s Hospital have delivered moderate and deep sedation for select patients and their practice has a good record, so we felt we should develop an appropriate educational and privileging mechanism that would allow them to continue,” says Zwass.

The resulting program requires the hospitalists to spend 10 days in the OR, complete at least 10 intubations, place at least 10 laryngeal mask airways, and participate in four simulations. A long standing screening mechanism to assign an appropriate practitioner remains in place.

“Rescue is rare, but when an unexpected event occurs, immediately intervening is critical,” says Zwass, in explaining the rigor. “In the OR, you’re surrounded by other trained clinicians, but in non-OR settings, you have to be able to initiate ventilation and other measures until additional hands arrive.” That takes training for both the qualifying practitioner and ancillary staff.

The department continues to work on guidelines for the various settings.

The need to cover more sites has required more hours from existing staff – and the hiring of more practitioners who meet the Department’s exacting standards.



## ASK THE EXPERT

# Ravi V. Joshi, MD



## How do advances in transesophageal echocardiography (TEE) and transthoracic echocardiography (TTE) change patient care and the role of cardiothoracic anesthesiologists?

**T**he advent of 3D echocardiography for TEE and TTE have vastly improved perioperative cardiac imaging and advanced the role of anesthesiologists as diagnosticians in the perioperative setting. In many cases, a complementary approach using both modalities is the most valuable.

Since 1982, when Drs. Nelson Schiller and Michael Cahalan first started placing 2D TEE probes in surgical patients at UCSF, TEE has developed into an immensely powerful tool for monitoring surgical patients with cardiovascular disease. Over time, TEE has added, not just real-time cardiac monitoring, but diagnostic capability for the anesthesiologist. This has become a vital part of cardiovascular and thoracic surgery, and the cardiothoracic (CT) anesthesiologist has become an essential member of the cardiac team. The CT anesthesiologist provides anesthesia and life support, but in addition, now provides critical imaging, guidance, and evaluation of surgical cardiac procedures. CT anesthesiologists have also expanded that role from the operating room into other settings such as the intensive care unit (ICU).

For example, say a patient is undergoing aortic surgery, and a problem occurs. It could be a drop in blood pressure, low urine output, or subtle changes on the EKG. A TEE is capable of revealing a possible rupture of the aorta, or whether the heart is pumping properly, or even detecting an intra-operative heart attack. We can evaluate the proper placement of prosthetic heart valves, and let the surgeon know if there is a problem with the heart before coming off the heart-lung bypass machine. These issues directly affect patient care and the success of surgery. We are integral to that success.

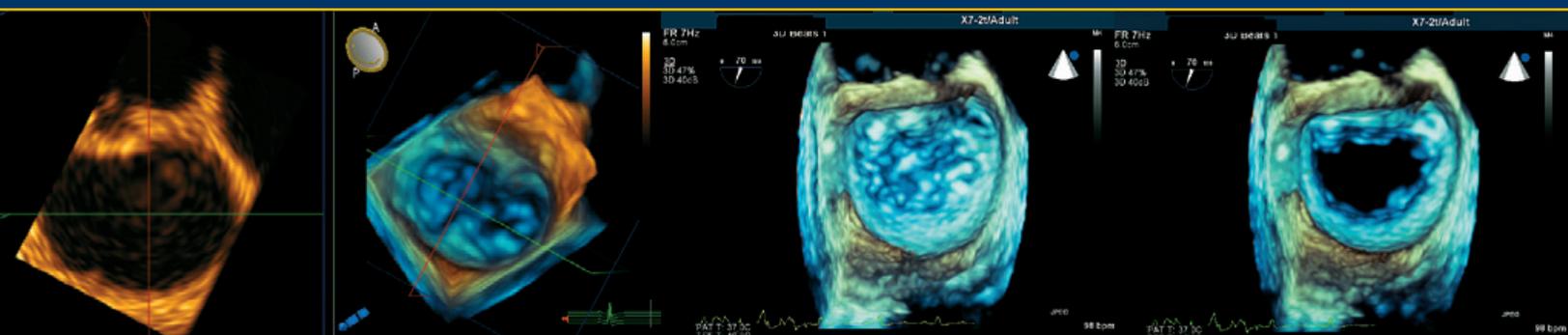
### 3D Echocardiography

This use of TEE in the operating room has been possible for a while, but with the introduction of 3D echocardiography, we get even more information to better evaluate intra-operative cardiac function and the surgical procedure. This is especially important in cases of mitral valve surgery and in new catheter-based percutaneous cardiac procedures. TEE has become a major modality for guiding the interventional cardiologist to correctly deploy catheter-delivered intra-

cardiac devices. The 3D images help us better determine where to deploy such devices and if these devices are seated properly; it's almost vital for these procedures – and the cardiologist can't manipulate the TEE during the procedure, so it has to be our role.

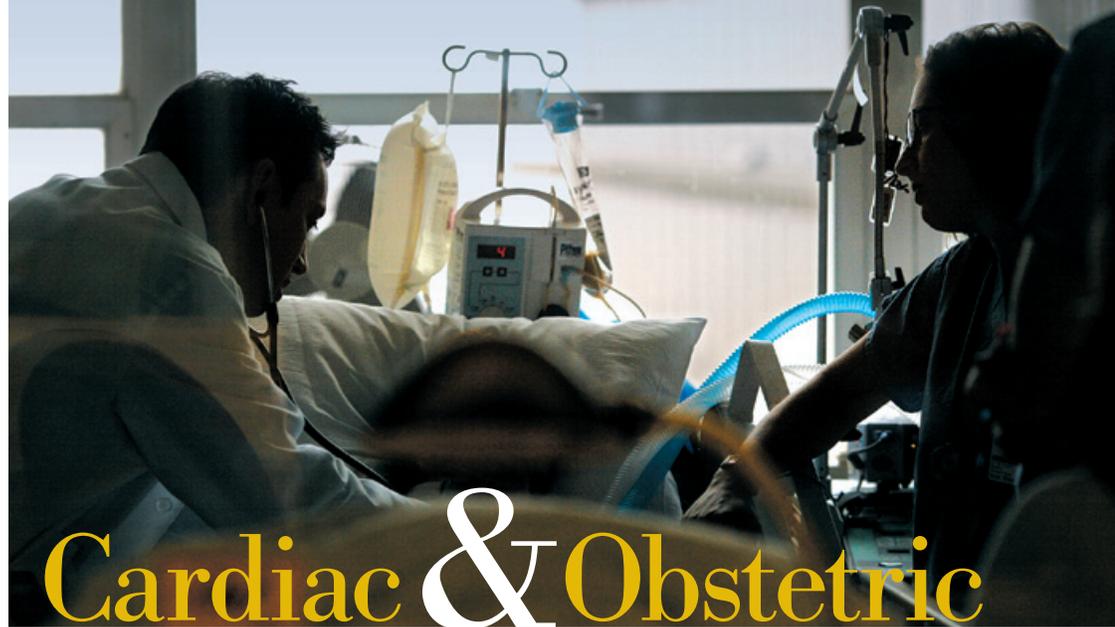
By adding Color-flow Doppler to 3D images for TEE (4D TEE), you can look at blood flow in three dimensions and gain the added benefit for assessing diseased heart valves. It's an indication of how the modality seems to be expanding in many ways.

Advances in transthoracic echocardiography (TTE), with 3D transducers, are further enhancing the importance of echocardiography for perioperative care. TTE or surface echocardiography is less invasive, as the images are acquired on the chest instead of in the esophagus. A TTE can scan the entire heart by multiple viewing planes that TEE cannot reach, so a TTE can gather important information that TEE may not be able to. With TTE, cardiothoracic anesthesiologists can quickly gather important diagnostic information before surgery in the pre-op area or at the ICU bedside.



# ACGME Approval Fortifies Two Fellowship Programs

A rigorous program with exciting clinical and research options is the key to continuing to attract the finest anesthesia fellows in the country. With those thoughts top of mind, the UCSF Department of Anesthesia and Perioperative Care has won accreditation from the Accreditation Council for Graduate Medical Education (ACGME) for two of its longstanding fellowship programs: cardiac and obstetric anesthesia.



## Cardiac & Obstetric

### ANESTHESIA FELLOWSHIP PROGRAMS

Isobel Russell, MD, who, until her recent retirement, directed the **CARDIAC FELLOWSHIP PROGRAM** for the Department, notes that it was the ACGME accreditation process that led to an agreement with Kaiser Permanente, San Francisco Medical Center, whereby Kaiser would take on the UCSF cardiac anesthesia fellows for a portion of their 12-month fellowship. The addition of Kaiser takes some of the pressure off the fellows sharing cardiac cases with UCSF residents.

“The program is designed to expose the trainee to all aspects of cardiothoracic anesthesiology and is a great avenue for faculty recruitment,” says Russell. “Most of our current faculty have done their fellowships here.”

The new ACGME version of the fellowship will include:

- Three months of cardiac anesthesia at UCSF Medical Center at Parnassus (Moffitt-Long Hospital)
- Three months of cardiac anesthesia at Kaiser Permanente, San Francisco Medical Center
- One month in the cardiovascular intensive care unit at Moffitt-Long
- One month of thoracic anesthesia at Moffitt-Long
- Two months of dedicated echocardiography training in the echo lab at Moffitt-Long, working alongside the cardiology faculty and residents
- Two months of elective time

Beginning May 1, 2012, Kevin Thornton was appointed as the new director of this fellowship program.

In the case of **OBSTETRIC ANESTHESIA**, UCSF has a long history of being a leader, beginning with Sol Shnider, MD, and on through Sam Hughes, MD, and Mark Rosen, MD.

“I’m very excited, because ACGME approval adds to this tradition, by giving a certain structure and consistency to the fellowships,” says Pamela Flood, MD, who directs the program. “We’re very happy to have been one of the first approved applicants.”

The ACGME version of the obstetric anesthesia fellowship will continue the tradition of a clinical and research-based fellowship.

For the clinical piece, fellows will rotate through the labor rooms at both Moffitt-Long and San Francisco General Hospitals. “At Moffitt-Long, there is a high volume of particularly complex, challenging cases, while the underserved population at SF General has other needs,” says Flood.

She notes as well, that the fellows will do rotations in neonatology and maternal fetal medicine – and have the opportunity to work closely with the other specialists who are present in the labor and delivery room.

In addition, 30 percent of the fellowship is dedicated to research, including a scholarly project and the expectation that fellows will present at a national meeting. Lectures and journal clubs will focus on key competencies and fellows will be able to take advantage of the unusually rich opportunities at UCSF for both clinical and basic research.

“ACGME accreditation for OB anesthesia has been a work in progress for 15 years,” says Flood. “It’s exciting to see it come to pass.”

## Seven Retirees Exemplify Clinical, Research, and Teaching Excellence

In 2012, seven valued members of the UCSF Department of Anesthesia and Perioperative Care – Martin Bogetz, James Caldwell, Lydia Cassorla, Ken Drasner, Kathryn Rouine-Rapp, Isobel Russell and William Shapiro – are retiring. As a group, they represent nearly 200 years of exemplary service to their patients, the Department, and the larger institution. Individually, they have each made a unique mark.

Below, they offer some parting thoughts on their time here, the profession, and what they'll do next. Their first year on the faculty is in parentheses below their name.



**Martin Bogetz**  
(1982)

It's time for me to step aside. For almost 25 years I've been the sole medical director of the UCSF Ambulatory Surgery Center. For over 11, I've had primary responsibility for our medical student programs. It's time for new ideas and new energy.

As I reflect, what stays with me most is the patients I've had the privilege of taking care of – the poignancy of illness and the grace people have in dealing with adversity.

I'll miss the professionals I worked with – faculty colleagues, nurses, technicians, administrative staff and those that keep the place clean and functioning. Most cherished are the learners. I am proud of the small role I played in helping others appreciate our noble specialty; the residents and medical students make me feel that the specialty and medicine in general are in good hands.

I admit I'm stepping aside in part because I am neither as flexible nor as tolerant as I once was. I've seen multiple iterations of the electronic medical record. The regulatory and compliance burden has become a profound

distraction from patient care. The "one size fits all" mentality has stifled the ability of professionals to make their unique contribution to patient care or education. But what pushed me over the retirement edge is that I became a grandfather this June!

I'm looking forward to more time with [my wife] Karen, my children, my grandchild and other family; to things I've been putting off – golf, gardening, cleaning the garage; and to being more spontaneous. I've been graciously offered an opportunity to continue clinically and with the medical students so I plan to be back part time.



**William Shapiro**  
(1982)

For thirty years, William Shapiro, MD, has served as a clinician, teacher, mentor, and researcher.

He was a cardiac anesthesiologist at

Moffitt/Long for both adult and pediatric patients, and then at Mount Zion where he served as Chief of Cardiac Anesthesia and, later, Chief of Anesthesia. His special clinical interest is in the management of anesthesia for vascular, thoracic, and major cancer

surgery. His teaching has focused on perioperative cardiac rhythm disturbances, pacemakers, ICD devices, and ECG interpretation, which complemented his postgraduate training as a Cardiovascular Research Institute fellow in the cardiac electrophysiology lab.

As Vice Chair and Department Director for Clinical Services, he has worked with the Anesthesia Department service chiefs to ensure high quality patient care, and efficient daily operations of all operating room and procedure locations where anesthesia services are provided.



**Ken Drasner**  
(1985)

The short answer is that I'm retiring now because I can. I'll be 64 years old...and this last year we finally managed to get the last of our kids

off the payroll. The longer version is that I had questions I wanted to go after concerning the toxicity of local anesthetics and how they might be used safely – and I think we've answered them adequately.

I truly enjoyed working in the OR at SF General, but one of the great things about being an academic anesthesiologist is that you have a diversified week. It also allowed me the satisfaction of working on things that last beyond the day, with a timeline that can go on for years. You get to decide what problems and questions you want to solve and go after them. A fabulous experience.

I'll miss a lot of people – cherished friends – but I'll keep in contact after I leave.

My wife is retiring as well – and we'll spend the next year of our life in France, in a town called Menton, on the Mediterranean. After, I don't know. Who knows? Life is mostly about tactics, far more than strategy.



**James Caldwell**  
(1986)

It's the right time for me to retire. I'm 60, in good health and am fortunate that I can afford to do it now.

I'll miss the people I work with. I can't overstate the pleasure of working with great, motivated,

intelligent people. But I won't miss getting up early in the morning!

I'm particularly proud of teaching awards from residents, because they're such a bright bunch. If I impress them, that's a real compliment.

I won't be coming back part-time. Charlotte and I sold our house and moved onto our boat in the Richmond Bay Marina – a long range trawler – and some time in November, we'll head out under the Golden Gate, turn South and see what happens.

I'd particularly like to say thank you to Dr. Miller, who was Chair when I was hired and took a chance on this guy from Scotland. He gave me a lot of support over the years.



**Lydia Cassorla**  
(1989)

After 13 years caring nearly exclusively for pediatric and adult cardiac surgery patients, the Wharton School

opened its program in San Francisco, and I decided, at 50, to learn about something completely different – business. However, soon after graduation I inherited family responsibilities in Miami that kept me from devoting the energy it takes to develop a new professional life. Now, turning 60, it's time to open new opportunities.

Being part of our Department has been one of my most significant privileges. From early residency I sensed that I was walking among giants. I left UCSF for fellowship and 5 years in private practice, and was thrilled when Dr. Miller and Dr. Hickey asked me to return.

I will miss most the people I admire and enjoy. It is not just the anesthesia, surgery and nursing teams – the entire staff contributes immeasurably. The academic environment has been a wonderful stimulation with the opportunity to learn something every day from our amazing colleagues, residents, and now nurse anesthetists. Deciding together what is best for each patient is a healthy process.... I won't miss the E-1 phone when on call at Moffitt.

First I plan to take a deep breath, but I'll continue to work as an anesthesiologist part time and hope to contribute to a foundation or NGO with health care involvement. There are also friends and family around the world who I have not seen in years. And, of course, one never really knows what is next!



**Isobel Russell**  
(1990)

I started at UCSF in 1985 as an intern in Medicine, and went on to become a member of the Department of

Anesthesia as a resident, then a fellow and, finally, a faculty member. Working alongside the cardiac OR team as they developed into an outstanding group has been among my proudest accomplishments. I have also treasured the rich academic environment at UCSF and will truly miss all my colleagues who have made my life at UCSF so fulfilling.

My next adventures include developing the Bel Russell Foundation (a not-for-profit to support children with congenital heart disease in Malaysia), working in private practice and enjoying my family.



**Kathryn Rouine-Rapp**  
(1991)

I view my retirement as the commencement of my next career. I plan to create a professional life that

provides practice diversity, service, teaching, learning, and recognition of expertise. I will accomplish this by working in multiple settings, including UCSF Medical Center at Mount Zion.

My 29-year association with UCSF began during a medical student rotation in 1983. I have no regrets, and especially recognize professional support during my mid-level career as crucial for my success.

I will miss many people but not the work during nights, weekends and holidays. I'm looking forward to a schedule that promotes travel, devotion of time to professional organizations, and more time with family.

## COMMENTARY:

### Value-Based, Patient-Centered Outcomes

*continued from front page*

terms this involves combining Part A (facility fees) and Part B (professional fees) of Medicare payments into a single payment that is distributed according to who did what and whether what was done contributed to a good outcome.

Together with Kevin Bozic, MD, Vice-Chair in the Department of Orthopaedics at UCSF, we are now engaged in research designed to establish whether bundled payments will improve the value of the services we deliver. Using lower limb arthroplasty as the service provided, we intend to re-engineer the care pathway using process mapping to establish by whom, when and where, each element of care is currently being delivered. For each element, we need to address whether the medical evidence demonstrates that it enhances the value of the service, by whom, and in what settings we are best-suited to deliver the care at the most competitive cost.

This research also seeks to understand the actual cost based upon a methodology that imputes the capacity of the resource for delivering clinical care – after which we can assign a time-driven cost for each of these elements. This will allow one to pose the question whether the value of the activity is worth the cost and, secondarily, if deemed worthwhile, whether the cost can be reduced using different resources.

Unless there is demonstrable added value in physicians being exclusively involved in the patient's care, based upon outcome measurements that are important to the patient, it is a societal benefit to consider a lower cost option.

Should the anesthesiologist seek further perioperative care opportunities for which their expertise enhances patient outcomes? Physician anesthesia providers need to explore activities that are shunned by the anesthesiologist, even though they can bring immense value to patient care, because under the current fee for service payment system, it is not rewarding.

All of these efforts demand that we change our perception of who should be the focus of the value framework – the physician or the patient. Because this Bundled Payment for Clinical Care research program has such far-reaching consequences, it is precisely the activity in which we, as a Department, should be engaged.

## CAREER FACULTY

### Silke Leonie Bicknell, MD

*Assistant Clinical Professor*  
Joined Faculty November 1, 2011

#### MEDICAL SCHOOL:

Albert Ludwigs  
University Freiburg  
Freiburg, Germany

#### INTERNSHIP:

Anesthesiology (4 mos)  
University Hospital Freiburg  
Freiburg, Germany

Internal Medicine (4 mos)  
University Hospital Zurich  
Zurich, Switzerland

Trauma Surgery (4 mos)  
University Hospital Freiburg  
Freiburg, Germany

#### RESIDENCY:

Anesthesiology  
University Hospital Freiburg  
Freiburg, Germany  
University Hospital Düsseldorf  
Düsseldorf, Germany

#### PREVIOUS EMPLOYMENT:

*Visiting Assistant Professor*  
Department of Anesthesia  
and Perioperative Care  
UCSF  
San Francisco, California

### Joshua Cohen, MD

*Clinical Instructor*  
(Liver Transplant Fellow,  
2011-2012)  
Joined Faculty July 1, 2011

#### MEDICAL SCHOOL:

University of Illinois  
College of Medicine at Chicago

#### INTERNSHIP:

Internal Medicine Advocate  
Lutheran General Hospital

#### RESIDENCY:

Anesthesiology  
UCSF  
San Francisco, California

### Robert Scott Dingeman, MD, FAAP

*Assistant Clinical Professor*  
Joined Faculty July 11, 2011

#### MEDICAL SCHOOL:

Michigan State University  
College of Human Medicine  
East Lansing, Michigan

#### INTERNSHIP:

General Surgery  
St. John Hospital  
and Medical Center  
Detroit, Michigan

#### RESIDENCIES:

General Surgery  
St. John Hospital  
and Medical Center  
Detroit, Michigan  
Anesthesiology  
New York Presbyterian Hospital,  
Weill Medical College  
of Cornell University  
New York, New York

#### FELLOWSHIPS:

Clinical Anesthesiology  
Harvard Medical School  
Boston, Massachusetts

Pediatric Anesthesiology  
Children's Hospital Boston  
Boston, Massachusetts

#### PREVIOUS EMPLOYMENT:

Associate in  
Perioperative Anesthesia  
Children's Hospital Boston  
Boston, Massachusetts

### Pamela Flood, MD

*Professor*  
Joined Faculty July 1, 2011

#### MEDICAL SCHOOL:

College of Physicians and  
Surgeons of Columbia University  
New York, New York

#### INTERNSHIP:

Internal Medicine  
New York Presbyterian Hospital  
New York, New York

#### RESIDENCY:

Anesthesiology  
New York Presbyterian Hospital  
New York, New York

#### FELLOWSHIPS:

Obstetric Anesthesiology  
College of Physicians and  
Surgeons of Columbia University  
New York, New York

#### POST-DOCTORAL FELLOWSHIP:

Neurobiology  
College of Physicians and  
Surgeons of Columbia University  
New York, New York

#### PREVIOUS EMPLOYMENT:

*Professor of Clinical  
Anesthesiology*  
College of Physicians and  
Surgeons at Columbia University  
New York, New York

*Associate Director,  
Obstetrical Anesthesia Division*  
College of Physicians and  
Surgeons at Columbia University  
New York, New York

### Matthew Haight, DO

*Clinical Instructor*  
Joined Faculty September 19, 2011

#### MEDICAL SCHOOL:

Western University  
of Health Sciences  
Pomona, California

#### RESIDENCY:

Anesthesiology  
UCSF  
San Francisco, California

#### FELLOWSHIP:

Critical Care Medicine  
UCSF  
San Francisco, California

#### PREVIOUS EMPLOYMENT:

*Attending Anesthesiologist*  
Hoag Hospital  
Newport Beach, California

### Christina Inglis-Arkell, MD

*Clinical Instructor*  
Joined Faculty July 1, 2011

#### MEDICAL SCHOOL:

University of California,  
San Diego  
La Jolla, California

#### INTERNSHIP:

Internal Medicine  
California Pacific Medical Center  
San Francisco, California

#### RESIDENCY:

Anesthesiology  
UCSF  
San Francisco, California

### Stephen King, PhD, MD

*Assistant Clinical Professor*  
Joined Faculty February 1, 2012

#### ADVANCED DEGREE:

PhD, Biochemistry  
University of Southern California  
Los Angeles, California

#### MEDICAL SCHOOL:

University of Miami  
Leonard M. Miller  
School of Medicine  
Miami, Florida

#### INTERNSHIP:

Transitional  
Presbyterian/  
St. Luke's Medical Center  
Denver, Colorado

#### RESIDENCY:

Anesthesiology  
UCSF  
San Francisco, California

#### FELLOWSHIPS:

NIH Postdoctoral  
California Institute of Technology  
Pasadena, California

Anesthesia Research  
UCSF  
San Francisco, California

Pediatric Anesthesia  
UCSF  
San Francisco, California

#### PREVIOUS EMPLOYMENT:

*Director of Pediatric Anesthesia*  
Santa Clara Valley Medical Center  
San Jose, California

### Ludwig Lin, MD

*Clinical Professor*  
Joined Faculty November 14, 2011

#### MEDICAL SCHOOL:

UCSF  
San Francisco, California

#### INTERNSHIP:

Internal Medicine  
St. Mary's Medical Center  
San Francisco, California

#### RESIDENCY:

Anesthesiology  
UCSF  
San Francisco, California

#### FELLOWSHIP:

Critical Care Medicine  
UCSF  
San Francisco, California

#### PREVIOUS EMPLOYMENT:

*Associate Professor of Anesthesia*  
Stanford University  
School of Medicine  
Stanford, California

### Jemiel Nejim, MD

*Clinical Instructor*  
Joined Faculty July 1, 2011

#### MEDICAL SCHOOL:

David Geffen School of Medicine  
at the University of California,  
Los Angeles

#### INTERNSHIP:

Internal Medicine  
Santa Clara Valley Medical Center  
San Jose, California

#### RESIDENCY:

Anesthesiology  
UCSF  
San Francisco, California



# Honors & Awards

## Hung Gia Nguyen, MD

*Assistant Professor*

Joined Faculty July 1, 2011

**MEDICAL SCHOOL:**

School of Medicine  
University of California, Davis  
Davis, California

**INTERNSHIP:**

General Surgery  
University of California, Davis,  
Medical Center  
Sacramento, California

**RESIDENCIES:**

General Surgery  
University of California, Davis,  
Medical Center  
Sacramento, California

**ANESTHESIOLOGY**

University of California, Davis,  
Medical Center  
Sacramento, California

**FELLOWSHIP:**

Pediatric Anesthesiology  
University of California, Davis,  
Medical Center  
Sacramento, California

Children's Hospital,  
University of California, Davis  
Sacramento, California

## VISITING FACULTY

## Pedro Gambus, PhD, MD

*Visiting Associate Professor*

Joined Faculty January 3, 2012

**ADVANCED DEGREE:**

PhD, "Applications of EEG as a  
measure of depth of anesthetic  
drug effects"

**MEDICAL SCHOOL:**

University of Barcelona  
School of Medicine  
Barcelona, Spain

**RESIDENCY:**

Anesthesiology  
Hospital General de Granollers  
Barcelona, Spain

**POSTDOC FELLOWSHIP:**

"Clinical Pharmacology in  
Anesthesia: PKPD Modeling of  
Intravenous Anesthetics"  
Stanford University  
School of Medicine  
Stanford, California

## Ahmed Shalabi, MB ChB, MSc, AFSA

*Visiting Assistant Professor*

Joined Faculty July 1, 2011

**ADVANCED DEGREE:**

MSc Master of Science  
in Anesthesia  
Alexandria University  
Alexandria, Egypt  
  
Attestation de formation  
Spécialisée approfondie (AFSA)  
in Anesthesia and Reanimation  
Faculty of Medicine Henri  
Warembourg, University of Lille II  
Lille, France

**MEDICAL SCHOOL:**

Faculty of Medicine  
Alexandria University  
Alexandria, Egypt

**INTERNSHIP:**

Alexandria University  
Alexandria, Egypt

**RESIDENCY:**

Anesthesia and Intensive Care  
Alexandria University  
Alexandria, Egypt

**FELLOWSHIPS:**

Pediatric Anesthesia and  
Reanimation  
University of Lille II,  
Jeane de Flandre Hospital  
Lille, France

Liver Transplant Anesthesia  
(2012-2013)

UCSF  
San Francisco, California

**PREVIOUS EMPLOYMENT:**

*Attending Anesthesiologist,  
Assistant Lecturer in Anesthesia*  
Alexandria University  
Alexandria, Egypt

*Attending Anesthesiologist,  
Assistant Lecturer in Pediatric  
Anesthesia*

Alexandria University  
Alexandria, Egypt

## Claas Siegmüller, MD

*Visiting Assistant Professor*

Joined Faculty December 5, 2011

**MEDICAL SCHOOL:**

Christian-Albrechts University  
Kiel, Germany

**RESIDENCY:**

Anesthesiology  
Imperial School of Anaesthesia  
London, United Kingdom

UCSF Department  
of Anesthesia and  
Perioperative Care,  
1st in NIH Grant Funding,  
3rd Consecutive Year, 2011

UCSF named by the NIH  
as a Center of Excellence  
in Pain Education, 2012  
Principle Investigator:  
Mark Schumacher, MD, PhD

## FACULTY HONORS, AWARDS AND APPOINTMENTS

### A. Sue Carlisle, MD, PhD

**CAMPUS APPOINTMENT:**  
Vice Dean, UCSF School  
of Medicine, 2012  
**CAMPUS HONOR:**  
Chancellor's Award for the  
Advancement of Women, 2012

### Michael Gropper, MD, PhD

**CAMPUS APPOINTMENT:**  
President, Medical Staff,  
UCSF Medical Center, 2011

### Tomoki Hashimoto, MD

**EXTRAMURAL AWARD:**  
American Heart Association,  
Northern California  
Research Awardee, 2011

### Errol Lobo, MD, PhD

**CAMPUS APPOINTMENT:**  
Medical Director,  
Perioperative Services,  
UCSF Medical Center, 2012

### Mark Rollins, MD, PhD

**CAMPUS APPOINTMENT:**  
Director, Undergraduate  
Medical Education,  
Department of Anesthesia  
and Perioperative Care, 2012

### Laura Siedman, MD

**CAMPUS APPOINTMENT:**  
Director, Ambulatory  
Surgery Center, 2012

### Kevin Thornton, MD

**CAMPUS APPOINTMENT:**  
Director, Cardiac Anesthesia  
Fellowship Program,  
Department of Anesthesia  
and Perioperative Care, 2012

### C. Spencer Yost, MD

**CAMPUS APPOINTMENT:**  
Vice Chair, Clinical  
Planning and Strategy,  
Department of Anesthesia  
and Perioperative Care, 2012

### Maurice Zwass, MD

**CAMPUS APPOINTMENT:**  
Chief, Pediatric Anesthesia,  
Department of Anesthesia  
and Perioperative Care, 2012

## RESIDENT HONORS AND AWARDS:

### CA3

#### Laura Lang, MD

**EXTRAMURAL HONOR:**  
3rd Place, Case Report, Western  
Anesthesia Residents  
Conference, 2012

### CA2

#### Lawrence Stephen Long, MD

**EXTRAMURAL HONOR:**  
3rd Place, Hypothesis  
Generating Poster,  
Western Anesthesia Residents  
Conference, 2012

WARC 2012: from left, Lawrence  
Stephen Long, and Laura Lang  
with Mark Rollins



# New Residents

CLASS OF 2014 | CLASS OF 2015



Kerry Apostolo



Carolina Cernicica



Tony Chang



Catherine Chen



Meghan Bhave



Michael Bokoch



Michael Doden



German Echeverry



Brian Gilliss



Pablo Guzman



Jonathan Cheah



Richard Chou



Melissa Haehn



Lindsey Huddleston



Phebe Ko



Vijay Kollengode



William (Alex)  
Edwards



Janine Ghannam



Phillip Kuan



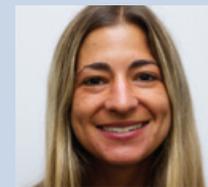
Young Lin



Michael Lipnick



John Markley



Alexandra  
Ianculescu



Brian Kim



Andrew Ray



Neil Ray



Paul Riegelhaupt



Hanna Serdarevic



Janice Man



Anne Newcomer



Devon Smith



Stephen Weston



Jed Wolpaw



Grant Sanders



Candace Shavit



Edward Yap



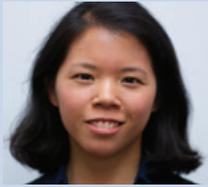
Wei Zhou



Wendy Smith



Liz Whitlock



Emily Chanan



Joyce Chang



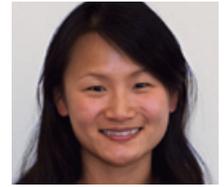
Benedict Alter



Atisa Beihaghi



Sarah Burke



Ann Cai



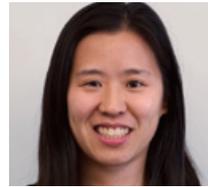
Jerome Crowley



Julee Dalton



Adrian Coon



Tina Dong



Matthew Dudley



Kevin Efras



Thomas Hertel



Robyn Hillis



Erika Frank



Melanie Hall



Christopher (Kit)  
Johnson



R. Bryan Klassen



Stephanie Lim



Shin-e Lin



Andrea Olmos



Kristin Pappas



Maxwell Thompson



Adam Weiss



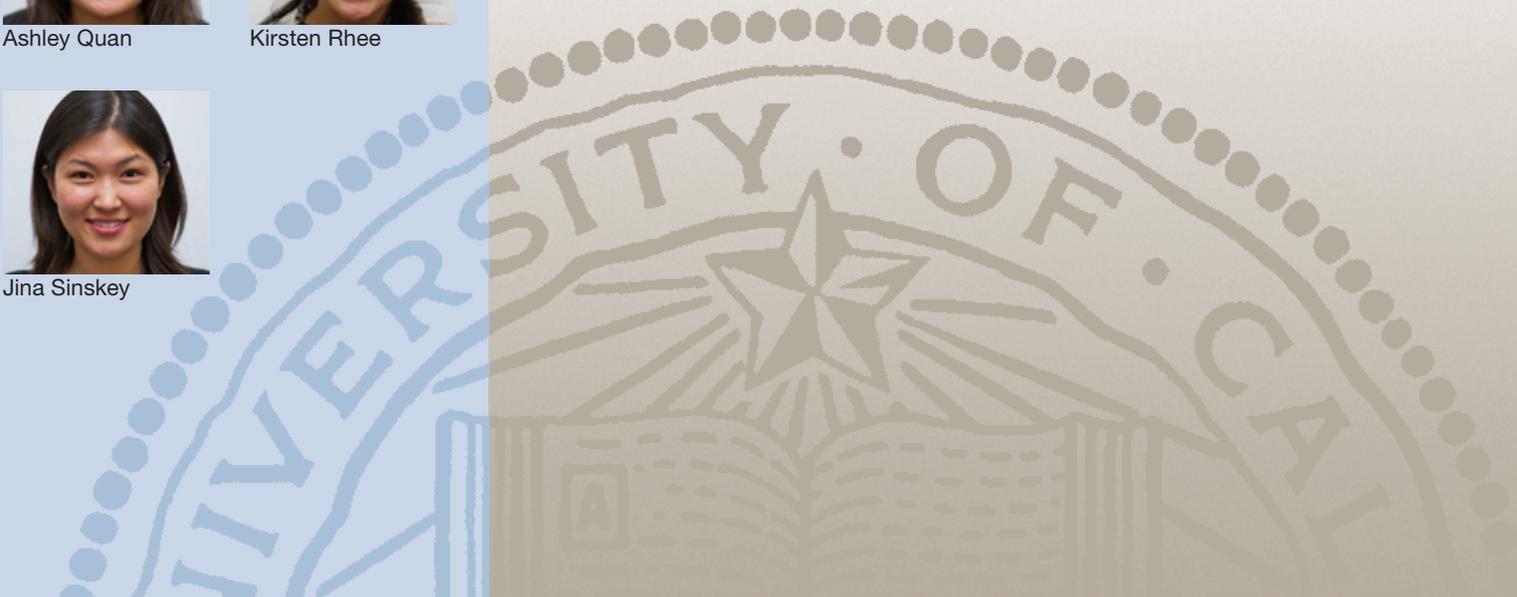
Ashley Quan



Kirsten Rhee



Jina Sinskey



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## Upcoming Events

### **Critical Care Medicine and Trauma 2013**

**May 30–June 1, 2013**

Westin St. Francis Hotel / San Francisco, California

#### **COURSE CHAIRS:**

**Michael A. Gropper, MD, PhD**  
 Professor and Vice Chair  
 Department of Anesthesia and Perioperative Care  
 Director, Critical Care Medicine  
 UCSF Medical Center

**Rochelle Dicker, MD**  
 Associate Professor in Residence  
 Department of Surgery  
 San Francisco General Hospital

**Program and registration information:** [www.cme.ucsf.edu](http://www.cme.ucsf.edu)

### **Maintenance of Certification in Anesthesia Simulation Courses at SFGH**

The American Society of Anesthesiologists (in collaboration with the American Board of Anesthesiologists) recently organized a nationwide educational collective known as the Simulation Education Network. This is a very small group of medical simulators through which a Board-certified anesthesiologist can satisfy the Part IV MOCA requirements for Board recertification by participating in an intensive, day-long medical simulation.

We are happy to announce that the UCSF Department of Anesthesia's Anesthesia Simulation Center at SFGH has recently met all of the ASA's stringent requirements to qualify for inclusion in this network. Three MOCA simulation courses have been scheduled for 2012 and 2013, respectively, and we encourage all Board-certified staff to take advantage of this provision.

As spaces are already filling up, please visit our Simulator website for more information and registration instructions at <http://tinyurl.com/mocasim>

Upcoming Course Dates:

**2012: September 28 / October 19 / November 2**

**2013: January 25 / February 8 / March 22**

#### **COURSE CHAIR:**

**Adam Collins, MD**

*Associate Professor of Clinical Anesthesia,  
 Director, UCSF Anesthesia Simulator Center*

UCSF