Military Advanced Regional Anesthesia & Analgesia
Spring 2006 Meeting
Minutes &White Paper Decisions*

*MARAA decisions and recommendations to service Anesthesiology Consultants to the Surgeons General can be found under the heading: **Service anesthesiology consultant recommendation.**

I. ATTENDANCE/OPENING REMARKS

Meeting Date: 6 April 2006, 1700-2000
Meeting Location: Rancho Las Palmas Marriott, Rancho Mirage, CA

Voting Members in attendance:

1. LTC Chester Buckenmaier – Army[2,3]	chester.buckenmaier@na.amedd.army.mil
2. MAJ Scott Croll – Army[2]	scott.croll@na.amedd.army.mil
3. Lt Col Todd Carter – Air Force[1]	todd.carter@andrews.af.mil
4. Maj Chris Wentzel - Air Force[2]	chris.wentzel@andrews.af.mil
5. CAPT Ivan Lesnik – Navy[1]	ilesnik@usuhs.mil
6. LCDR Dean Giacobbe – Navy[2]	dtgiacobbe@mar.med.navy.mil

Voting Members absent: None

New Voting Members (see section II-4 and Appendix A):

7. LTC Debra Clise – Army[2]	debra.clise@na.amedd.army.mil
8. Maj Katherine Ponton – Air Force[2]	katherine.ponton@langley.af.mil
9. CDR Andrew Biegner – Navy[2]	arbiegner@nmcsd.med.navy.mil

Other Attendees (listed as signed in)

CDR Patrick Boyle	Navy
COL Kenneth Harris	Army
LCDR Michael Verdolin	Navy
Capt Jon Rogers	Air Force
COL Deborah Brown	Army
CDR Andrew Biegner	Navy
Geselle McKnight	
Chris Rupprecht	
Patrick Sullivan	
Maj Katherine Ponton	Air Force
LCDR David Junker	Navy
LTC Debra Clise	Army
Rich Burncamp	
BG Bob Lennon	Army
Scott Gustavson	
Kelly Kiser	
Maisha Evans	
Alyson Auton	
Pamela Buckenmaier	

[1]Service Consultant
[2]Service Consultant's Designee
[3]MARAA President

a. Slide Presentation & Opening Remarks by LTC Buckenmaier. MARAA's purpose and function was outlined for the audience (see Appendix A – Revised MARAA Charter).

b. Presentation by CDR Patrick Boyle & LCDR Verdolin outlining National Medical Center San Diego Regional Anesthesia Service.

II. REVIEW OF PREVIOUS MINUTES/OLD BUSINESS

1. Both continuous peripheral nerve block (CPNB) and patient controlled analgesia (PCA) are successful programs established by MARAA. Issues:

- Logistics issues remain a problem for the full implementation of both CPNB and PCA.

Service anesthesiology consultant recommendation: The group consensus is that deployed individuals will have to work with their local medical supply officials to create visibility and demand for these technologies.

- PCA is approved for air evacuation (AE) flights and for use in theater. There is concern about a perceived lack of training and guidance for applying PCA technology.
  - Web-based training on both CPNB and PCA exists.
  - Consider training in-services on the AmbIT™ PCA by Sorenson Medical Inc.
  - Add a training link to the existing RATS (Regional Anesthesia Tracking System) website.

Service anesthesiology consultant recommendation: Increased emphasis will be applied in the distribution and advertising of these training programs in the AE system, Combat Support Hospitals, and at Landstuhl. Existing training programs will be added to the Army Regional Anesthesia & Pain Management Initiative web site (www.arapmi.org) which will be linked to RATS. Consultants should ensure that this material is reviewed by all deploying anesthesia personnel.

- Should routine benzodiazepine medications be prescribed with PCA to manage anxiety levels in patients prior to air evacuation?
  - The group consensus was that monitoring limitations made the use of benzodiazepines with PCA an unacceptable risk in the air evacuation environment.

Service anesthesiology consultant recommendation: Routine use of benzodiazepines with PCA is not recommended today. Individualized application of these medications by physicians traveling with patients remains at the discretion of said physicians.

- Are PCA settings too low to adequately treat pain in wounded traveling on air evacuation flights?
  - The group consensus was patients were traveling with inadequate morphine doses. Discussion on how best to implement morphine dose changes included automatic increases, CCAT physicians tasked to make changes and morphine injections to supplement PCA doses.
  - The group agreed that air evacuation medical personnel should be allowed to supplement the PCA with additional pain medications. It was further concluded that a mechanism for increasing the PCA doses was needed.

LTC Todd Carter will advise the group on how best to implement PCA dose changes in the air evacuation environment.

Service anesthesiology consultant recommendation: A decision on this issue is deferred pending LTC Carter's recommendations to MARAA.

2. Regional Anesthesia Tracking System (RATS) update:

Date	9-27-05	10-18-05	3-11-05	11-15-05	2-12-05	12-20-05	1-17-06	3-2-06	2-17-06	3-17-06
Number of patients	41	65	89	104	119	125	142	156	173	198
Registered users	34	39	47	51	54	57	64	77	80	82
Notes --										
Clinical	42	93	141	172	193	194	219	255	292	353
Procedure	49	84	110	128	149	158	179	197	210	235
Transfer	32	50	68	83	94	94	103	117	139	175
E-mails generated	138	301	423	622	816	858	979	1089	1198	1359

3. Status of epidurals on military aircraft.

- The Epidural Infusion Recommendations for Air Evacuation policy recommended my MARAA is in place and epidural infusions of local anesthetics can be used for pain management during air evacuation.
    - The group agreed that only local anesthetics should be allowed at this point.

Service anesthesiology consultant recommendation: Infusion Recommendations for Air Evacuation policy will be posted on the internet with other educational materials. Infusions of medications other then local anesthetics not recommended at this time.

4. Addition of CRNA voting Members to MARAA: Should CRNAs have a Vote? *CRNA representatives present: Debra Clise (Army), Andrew Biegner (Navy) and Katharine Ponton (Air Force). All comments have been edited for clarity.*

- COL John Chiles comments (provided via a prepared statement by MAJ Croll): Encouraged MARAA to approach this collaboration thoughtfully and logically. "This is a great opportunity to work with nurse colleagues on mutual credentialing issues."
- Cpt Lesnik – Would adding the CRNA nurse element confuse alignment with USAA & ASA? This question had previously been answered as 'no' by COL Paul Mongan who is the current President of the USSA. Yes, to adding CRNAs. Group should focus on the mission and ignore politics.
- Cdr Giacobbe - As subject area experts, CRNAs can provide valuable knowledge and opinions to the group. Yes, to adding CRNAs.
- MAJ Croll – Noted his numerous positive experiences with CRNAs in multiple environments to include the battlefield. However, physicians have spent a great deal of time obtaining advanced training (fellowships, etc) and the possibility of

"political" issues between physicians and CRNAs could originate. CRNAs should be involved, but no to adding CRNA vote.

- BG Lennon – CRNA input would make the group stronger. No need for vote, confer with service, and physician members would vote on behalf of that represented service.
- LCD Verdolin - Physicians lead this supra-specialized group because of their advanced training. Input from CRNAs is valuable, but ultimate responsibility should remain with physicians. Political issues a possibility.
- LTC Carter - CRNAs bring special skills to the arena. Adds power to MARAA to include The CRNA voice. CRNA representative must have Regional Anesthesia experience to be included. Yes, to CRNA vote.
- COL Harris – CRNAs should be included.

CRNA Invited Representative comments:

- LTC Clise - CRNAs are deploying frequently and can take valuable information and education generated by MARAA back to field/theater. Regarding CRNA vote, I am undecided because CRNAs are being included but then "not" being included because of no vote.
- Capt Biegner - Both physicians and CRNAs should work as a team on education, policy and patient care. CRNAs should be included to increase discussion/communication between both groups.
- Ponton - Work together to improve patient care. CRNAs are going to field often and having a CRNA voice/participation in MARAA would enable easier implementation of MARAA initiatives in the field.
    - This debate was significantly more extensive then the synopsis of comments provided here. The voting members voted 5 to 1 in favor of allowing one CRNA from each service, selected by each service's anesthesiology consultant, to become voting members of MARAA.
    - The MARAA charter will be adjusted to reflect this addition of voting members.

  Service anesthesiology consultant recommendation: The voting membership of MARAA will now include one voting CRNA from each service who is appointed to the position by that service's consultant for anesthesiology. See Appendix A for the new MARAA Charter that reflects this change.

III. NEW BUSINESS

1. Should other drugs or medications be recommended as part of PCA infusions or given prior to air evacuation?

- The consensus of the group was to establish current systems first before any new medications or equipment are added.

  Service anesthesiology consultant recommendation: This issue is tabled.

2. There was a call for collaborative research projects between military institutions. Ideas should be emailed to Giacobbe/Buckenmaier for coordination through MARAA. The group consensus was in support of this idea.

- The ROAR complication database currently under development at WRAMC was discussed as a possible collaborative project for everyone. Pending copyright information from the Henry Jackson Foundation this database will be distributed.

Service anesthesiology consultant recommendation: Collaborative research projects should be encouraged by all three service consultants.

IV. NEXT MEETING:

The next MARAA meeting will be held in conjunction with the Fall American Society of Anesthesiologists meeting in Chicago, October 2006. The meeting will be planned around the USSA meeting. Announcement of the 2007 members (selected by the service anesthesiology consultants) and election of the new MARAA president will be made at that time. A meeting agenda will be emailed to voting members a week prior to the meeting.

Appendix A

CHARTER OF THE

MILITARY ADVANCED REGIONAL ANESTHESIA & ANALGESIA

JUNE 2005

ARTICLE I: NAME AND OBJECT

1. Name. The name of the organization is "Military Advanced Regional Anesthesia & Analgesia (MARAA)."
2. Object. The object of the organization is the promotion of regional anesthesia and improved analgesia for military personnel and dependents at home and on the nation's battlefields.
3. Purpose. The organization will work to develop consensus recommendations from the Air Force, Army, and Navy anesthesia services for improvements in medical practice and technology that will promote regional anesthesia and analgesia in the care of military beneficiaries. The organization serves as an advisory board to the individual service anesthesia consultants to the surgeons general.

ARTICLE II: MANAGEMENT

The organization will consist of the anesthesiology consultant of each military service (or their designee) and a second appointee by each service anesthesiology consultant (six member board). Each member of the organization has one vote on issues that require agreement/collaboration between services. All decisions will be made by a simple two thirds majority. Issues that fail to obtain a two thirds majority consensus will be tabled and re-addressed at the next meeting called by the President of the organization.

ARTICLE III: DIRECTORS

The organization will select a President of the organization from organization members each fiscal year by simple majority vote. The President will be responsible for soliciting meeting issues from members and setting meeting agendas. The President will be responsible for generating organization position 'white papers' on decisions made by the organization. The position white papers will provide each service anesthesia consultant with collaborative recommendations for issues considered by the organization. The President can assign the writing of decision papers to committee members. The president will have final editorial authority over any white paper recommendations submitted to the service anesthesiology consultants.

ARTICLE IV: MEETINGS

1. Meetings. The organization will meet twice yearly. One formal meeting will be at the Uniformed Services Society of Anesthesiology meeting during the American Society of Anesthesiology conference. A second meeting will be scheduled during the Spring. Meetings will be coordinated by the organization president. Organization members can send proxies to attend meetings in their place (proxy voting is allowed) if approved by that member's service anesthesiology consultant. Teleconferencing is an acceptable means of attending a meeting. Meetings will only be held when a quorum of members (or their proxies) are available. A quorum will be defined as a majority of voting members with representation from each service.
2. Special Meetings. The president can call for a special meeting by organization members on issues requiring prompt attention.
3. Conduct of Meetings. Meetings will be presided over by the President or, in the absence of the President, a member of the organization designated by the President.
4. Meeting Agenda. The President will provide members with the meeting agenda one week prior to scheduled meetings. Members may add new items to the agenda during meetings with the President's request for 'new business'. Meetings will be concluded with review of old business.

ARTICLE V: ORGANIZATION SEAL

The organization seal is represented at the head of this document.

Amendment 1 (6 April 2006): The voting MARAA membership will include one CRNA vote per service. Representatives will be chosen by each service's anesthesiology consultants. There will now be 9 total votes (2 physician and 1 CRNA per service).