# Transcript of Interview of Dr Richard (Rick) Davis by Dr Glenn Gravlee

**Dr. Glenn Gravlee:**

Welcome to this Series of Oral Histories of the Society of Cardiovascular Anesthesiologists. I'm Glenn Gravlee, a member of the SCA Task Force on History, as is my interviewee, Dr. Richard Davis, a longtime friend and colleague, as well as a past president of the Society of Cardiovascular Anesthesiologists. Let's start with the beginnings of getting into anesthesia.

Rick, When you were in medical school, did you come across any influential folks that helped direct you toward anesthesia as a career choice?

**Dr. Richard Davis**:

Well, I think- mine is a fairly common story, but I did not actually find anesthesiology until I was well into my senior year in medical school. It was during the clinical rotations and the influence of the people that you worked with during those rotations, and the work environment they created that, at least in my case, was strongly influential toward a specialty decision.

I had come into the senior year clinical rotations thinking probably some surgical discipline was in my future . As a senior, I took an elective in anesthesiology at the San Francisco VA Hospital. Robert Hickey was the service chief there, and together with one of his associates, Marilyn Harper, they sort of took me under their wing a bit and I was given significant responsibility in the clinical care of patients during anesthesia. There were many wonderful interactions with the residents, enjoyable interactions with the anesthesiology and surgery staff there.

So, I think Bob and Marilyn -were the first two primary -influencers of my specialty choice. But, in fairness, given the tight relationship between the discipline of anesthesiology and the basic medical sciences including anatomy and physiology, pharmacology and biochemistry, the faculty of the basic science courses were very influential for me as well. My second anesthesiology rotation was-at the University Hospital, and I had the opportunity then to work with some of the luminaries from that very well-known department. Those interactions simply reinforced the decision. So by the time I was ready to graduate, I was pretty firmly convinced that it was going to be a year in internal medicine followed by anesthesiology residency.

**Gravlee:**

Now, at that time, did one have to match into anesthesia as a senior in medical school or more just an internship?

**Davis:**

It was it was an internship match for me. My impression was that most of the residency selection was pretty much at the discretion of the Department Chairs and I don't think there was an organized match at that time (1973-74) such as there is now.

**Gravlee:**

I believe you're correct. And in fact, I remember being offered a position for a residency at the place where you went to medical school in the Chairman's office by Dr. William Hamilton.

**Davis:**

That was that was pretty much the drill. Yes.

**Gravlee:**
Any other inspirational people that you came across at UCSF?

**Davis:**
Well, it became obvious to me that there was not always a close relationship between the strength of a faculty member's "academic reputation", their skill as a clinician in their own right, and their skill as an inspirational clinical educator. Simply stated some of the best clinical scientific minds were not the best clinical educator minds. And this cut across virtually all disciplines that I encountered. One real standout for me is a person that, in my opinion, has not received his share of in the field, but who was an outstanding clinician, teacher and role model for me was, Robert L Willenkin, who was both an outstanding clinician and outstanding teacher. I remember doing cases with Bob where he was my attending and I was basically functioning as an anesthesia resident, as a senior in medical school with more straightforward anesthetics. One case discussion particularly stuck with me over the years. During that case we began to discuss basic cardiopulmonary physiology and before the case was finishing we had derived clinically applicable ventilator settings to achieve required oxygen delivery and carbon dioxide elimination. I was fascinated and definitely hooked.
I did a number of cases during that rotation with Dr. William K Hamilton, who was the Department Chair. He was also an outstanding clinician and a very, very capable clinical teacher who used to chide me about being sort of ham fisted with my spinal techniques. But other than that, I guess I did okay.

**Gravlee:**
Tell us how you arrived at your residency program decision.

**Davis:**
Well, it turns out that I had obtained a scholarship through the US Air Force that defrayed my expenses for medical school with a "payback" of 3 months of Active Duty commitment after graduation for each month of scholarship sponsorship. So after accelerating my graduation a bit I had a 9 year Active Duty service commitment when I graduated. At the time I was applying for anesthesiology residency I needed permission from the USAF to delay my Active Duty in order to undertake a civilian residency. The Air Force at that time had a Board of senior physicians that made assignment recommendations for people moving from internship into their residency positions. And, it turns out that the department chair at Wilford Hall, the only site for anesthesiology training in the Air Force, was a fairly influential member of that Board. And I guess he liked my internship performance reports because he apparently made a strong argument that I should not go to UC San Francisco, but I should stay at Wilford Hall for my residency. I was not at all happy at the time with that mandate, but I stayed of course, which in retrospect was a fortuitous occurrence because those two years in residency at Wilford Hall helped open doors for me that may well not have existed otherwise.

**Gravlee:**
Whether you wanted to or not.

**Davis:**
Yes. And me being a lowly captain and him being a full colonel, you can imagine how the answer went. So I proceeded with residency at Wilford Hall Hospital.

**Gravlee:**

And how did that turn out?

**Davis:**

It was an excellent experience. My very first rotation as a resident was in the surgical intensive care unit, and well known academic intensivist anesthesiologist, John B Downs was doing his Berry Plan military commitment at that point in time.

So I got to take advantage of two months of his tutelage to get started. We had a number of excellent clinicians as staff attendings while I was a resident, many of whom were fresh out of their own fellowships, doing their Berry Plan service paybacks in the Air Force.

**Gravlee:**

Which involved the Army or Air Force paying for your medical school, and then you having to pay them back with time, right?

**Davis:**

Yes, That's basically what that amounted to**,** but the Berry Plan**-** was for people who got a deferral of their physician draft during the Vietnam era so that they could do a specialty program. And then in return for that deferral, they had a certain amount of active duty that they had to perform. Two individuals stand out for me in in those years, one was a surgeon, a cardiac surgeon, Cary Akins and the other is one of our colleagues, John L Waller.

They were both very influential in my decision to move toward cardiac anesthesia as a subspecialty after I finished residency. And they were both very, very helpful in making contact for me with the cardiac anesthesia program at Massachusetts General Hospital.

Both of them had done their own fellowship training at MGH.

John went to Emory University after he got out of the Air Force. And**-**Cary did go back to the Harvard system to MGH.

**Gravlee:**

And how and when did you get involved with the Society of Cardiovascular Anesthesiologists?

**Davis:**

I think I learned of the SCA first in early fall of ‘79, shortly after I'd returned to San Antonio after finishing my two years in the Cardiac Anesthesia fellowship at MGH. And I joined the society in the spring of 1980 in preparation for the second annual meeting of the Society at Kiawah Island. I had submitted an abstract of some research work that I did while a fellow and it was selected for presentation at that Kiawah Island meeting.

And I liked what I saw of the SCA’s meeting and the structure of the society. I was moderately turned off, I guess, by the structure of the only other Cardiac Anesthesia society at the time, which was a fairly cliquish group that was rigidly capped at 50 members. Literally, someone had to die or quit the field in order to bring someone new into the group. I saw a totally different orientation in the way the SCA presented itself.

The SCA was much more inclusive, much more welcoming. And so I just I really enjoyed that meeting and it took root. The next interaction was at the San Francisco meeting, the third annual meeting, and there was a solicitation at that meeting for people interested in joining standing committees of the society. I was thinking of myself as heading toward academic medicine at that point, and I wanted that kind of an experience, so I

volunteered to be part of the Program Committee, chaired at that point by Paul Barash.
Paul and I got along quite well. So I was part of the Program Committee for a number of years under Paul. When Paul moved into the President-Elect role, Earl Wynands came in as Program Chair. And I worked with Earl for a couple of years. Then, when he advanced also into the President-Elect position, my associate, Dick Buckingham, who had been on the Program Committee since its inception, became Program chair for two years. I was Vice-Chair of the Program Committee under Dick and then I succeeded Dick as Chair after he moved on.

**Gravlee:**
And then how did you progress from there to being an officer in the SCA?

**Davis:**
**I** was interested. I hung around and I expressed my interest to other Board members. I was nominated for the Secretary-Treasurer position about a year after my term as Program Chair was completed. I was fortunate to be elected.

**Gravlee**:
This was in the late 1980s and early 1990s?

**Davis:**
Great point. Yes, I was Secretary-Treasurer of the Society for two terms of two years each. -Before that, I was the Program Chair for a single term of 2 years.
It was a two year cycle as well. Okay. So I'd had two years as Program Vice Chair and then two years as Program Chair, and then served the two 2-year terms as Secretary-Treasurer.

**Gravlee:**
Now, wasn't that a little unusual to do two terms as Secretary-Treasurer? -Were there some other candidates for the President-Elect position that the Board and the Nominating Committee felt were deserving of the nomination?

**Davis:**
There was no line of succession from Secretary-Treasurer to President-Elect to President established in the Bylaws of the SCA, as there was between the President-Elect and President positions. But there were a couple of very deserving members in the queue, so to speak, for the President-Elect position and the Presidency. So there was at least the appearance of a kind of a line developing, I guess. And so I gratefully accepted the nomination for a second term as Secretary-Treasurer, thinking in part at least that I would be in a stronger position for the President-Elect nomination in later election cycles.
Subsequent to that, and I'm forgetting the exact mechanism, but it occurs to me there was a year's hiatus in my service on the Board after my second Secretary-Treasurer term before I was the nominee for the President-Elect position from the nominating committee.

**Gravlee:**
So you succeeded who as President-Elect**?**

**Davis:**

Mike Roizen. The two individuals I mentioned earlier as being “in the queue”, were Mike Roizen and Alan Schwartz, two of the best exemplars of academic cardiac anesthesia who were heavily engaged in the SCA at that time, in my opinion. Alan preceded Mike as President-Elect and President. I was nominated for President-Elect when Mike moved from President-Elect to President. I was SCA President from 1997 to 1999.

**Gravlee:**
Now, while you were President, a number of important issues were addressed and changes made that have a strong impact, I would say, on the Society to this day. Let's talk about some of those. The first one that comes to mind is the creation of our website. So tell us how that situation came down.

**Davis:**
Well, let me back up from that just a little bit.

**Gravlee:**
Sure.

**Davis**:
I had what I considered really three pretty much top priorities that I wanted to develop as incoming President-Elect and then President. One of them was the creation of the website. Another was dealing with the processes around accreditation of training programs in cardiac anesthesia. But the hot button issue at the point when I became President-Elect was our interaction with the American Society of Echocardiography around a certification process for practitioners in echocardiography, especially in perioperative transesophageal echocardiography, or TEE.
It was a hot button for several reasons. One is I think there was a rightful perception on the part of some SCA members that they were at risk of not being able to do perioperative echo because the echocardiography community's approach to certification didn't really allow an entry route for non-cardiologists and it didn't really have much of a focus on perioperative TEE at all.
So there was a bit of a clamor in the cardiac anesthesia community to do something to to solidify the rightful interests of cardiac anesthesiologists to utilize TEE on a level playing field with our cardiology colleagues. This was during my terms as President-Elect (1995-97) and President (1997-1999). I recall that Mike Roizen first brought this topic to a Board meeting I think because several of his colleagues expressed their concerns about the issues to him. Mike obtained Board approval to actually appoint a task force to bring a proposal for action back to the Board, after a long board meeting. He appointed a task force that became chaired by Sol Aronson to look at developing, through nationally recognized standards, a certification examination process for, specifically, perioperative transesophageal echocardiography, and that underwent a very rapid development. And as you know, as a preface to the SCA meeting in Baltimore in 1997, there was a test run of the initial examination that something like 100 people took which seemed to be a resounding success. So plans were then made to run the first formal examination the subsequent year at the 1998 Annual Meeting in Seattle.

**Gravlee:**
So how did we get from the formation of the task force to the acceptance of a test run and implementation of a real examination?

**Davis:**
Well, it was a process that was linked to the National Board of Medical Examiners. They pretty much vetted the exam development and the questions and its initial test and first administration, as well as the statistical

analysis of the results and all that. And so that first 1997 exam was a test of the exam and a test of the process to make certain that it was meeting the relevant validity standards of the industry at the time**.**

**Gravlee:**
Was there pushback from American Society of Echocardiography or other cardiology groups about anesthesiologists being eligible?

**Davis:**
During this same time, there was a group being formed that was a spinoff from the American Society of Echocardiography called ASE Exam, and they realized very quickly when they saw the SCA exam that we were serious about a certification process for Perioperative Echo. And for some reasons that I do not fully understand, there were some friction points between members on the SCA side and members on the cardiology side around that issue of the certification exam.

**Gravlee:**
And how do you think that got resolved?

**Davis:**
Well, I'm pretty sure that a big step forward was something that I implemented in early winter of '98 when I asked for an ad hoc meeting of three people from the echocardiography community and three people from cardiac anesthesiology to get together to discuss the issues. I invited Dan Thys to join our group in his role as President-Elect of the SCA, because of his obvious interest and expertise in the TEE field, and also because I had an inkling that the whole process would spill over into his term as President. It turns out that I was correct in that whole assessment. We six met at the Chicago O'Hare Hilton. And over the course of a day, we ironed out most of the fundamental ideas that led to the formation of the current organization called the National Board of Echocardiography, which was conceived as functionally a kind of bifurcated oversight structure with one limb in the traditional general echocardiography in clinic and hospital settings and the other limb focused in perioperative transesophageal echocardiography, primarily in the intra-operative and critical care settings. More recently this limb has evolved to include some of the TEE work performed in interventional radiology and cardiac catheterization suites, particularly around TAVR (and similar) cath lab procedures, some electrophysiology interventional procedures involving atrial septal puncture, such as for atrial fibrillation ablation procedures and other catheter based interventions commonly performed in the radiology suite.
And I think the negotiation was fairly persuasive with the SCA Board as regards continued participation in the process by the SCA because we set up bylaws of the new NBE structure so that a 75% majority vote from the NBE board was required to change the~~ir~~ bylaws, and the NBE Board was set in the bylaws to have six members, with 3 each being appointed by the respective "parent" organization (the American Society of Echocardiography and the Society of Cardiovascular Anesthesiologists). This mechanism prevented either limb of the new NBE structure from changing the bylaws to favor one limb or the other without having members from the other limb concurring with the proposed change.

**Gravlee:**
Well, that was an astute way of organizing it. It sounds like a good piece of diplomacy on the part of you and your colleagues**.** Who other than you were key figures in this echo initiative from our side**?**

**Davis:**

Well, there were many. I think Daniel Thys was a critical player. Dan was President-Elect during my term as President, and when he became President he adroitly picked up the TEE/NBE ball and completed the touchdown, if you will pardon the football analogy. He was then, and has remained, a key contributor to SCA's success in this arena and numerous others as well. I think the contribution of Sol Aronson with his task force and putting together, on really a very compressed time schedule, a state of the art examination covering perioperative application of TEE, made a very credible statement supporting SCA's rightful interests in perioperative TEE.

That echo exam was a key part of the success, if only for demonstrating the SCA's sincerity and for pushing the process. Bob Savage was key. The whole group that was built around the mid-year echo meeting and how it was organized was spectacular. A significant part of subsequent SCA leadership emerged from the mid-year echo meeting organizers. So it was it was by no means an individual effort at all.

**Gravlee**:

Was there a role for the development of the comprehensive echo course in this evolution, do you think?

**Davis:**

Actually, I believe that meeting evolved directly from the initial mid-year TEE meeting as the whole field continued to develop. It became a point of strong interest on the part of the overall echo community as well. The cardiology side, because they recognized the strength of the meeting and the broad based interest in it and also, frankly, the potential remunerative aspects to it from tuition etcetera became interested. The organizers of the meeting, Bob Savage and Stan Shernan among others recognized that the meeting needed expert names in echocardiography from the cardiology community, the surgical community and others to participate in the meeting to lend strength to the meeting.

So there was a very wide base of people with a mutual desire to make that meeting successful. And none of the friction that I sensed around the initial certification exam seemed to exist in the in the interactions specific to the echo meeting. So, yeah, there was some other major society interest in seeing that the meeting was successful.

**Gravlee:**

And do you think that smoothed the path towards the collaboration between the cardiologists and anesthesiologists and for the NBE?

**Davis:**

Well, I think that there were senior leaders in the echocardiography society who strongly supported the meeting. And I'll call out Ned Weyman as one who recognized that the multidisciplinary approach was the correct way to go.

He was already a convert when we first started talking about collaborative approach to the to the certification exam.

**Gravlee**:

Well, among other things, it seemed that it wasn't all that convenient for cardiologists to be able to drop everything and come to the OR when the surgeons needed them to be there.

**Davis:**

There is that and the traditional approach to echocardiography in the cardiology community is to have a technician actually perform the ultrasound exam and then to review the videos from the exam after the fact. And that, of course, doesn't fit very well in the operating room where the best approach is a physician actually performing the exam and interacting directly with the surgeon from both a diagnostic and a technical outcome of the procedure perspective.
So it's kind of a natural pairing for cardiac anesthesiology to be the primary resource in the operating room.

**Gravlee:**
Well, I don't know about you, but I in the early days, I remember having to maneuver around a cardiologist and cardiology fellow just to get to the patient to do what I needed to do.

**Davis:**
And I had the same experience.

**Gravlee:**
Yes. All right, anything more about that echo initiative or do you want to move on to other topics?

**Davis:**
Well, I think the good news is that the National Board of Echocardiography is still alive and well and progressing. And so it seems like that 20 year-old partnership, 20 plus year-old partnership, is functioning well. I think it was a great step forward.

**Gravlee:**
So websites and the Internet were we're coming on strong as you were rising to SCA leadership.

**Davis:**
So they were.
**Gravlee:**
How did we respond to that?

**Davis:**
Well, the SCA didn't have a web presence until right around the year 2000. At the midyear SCA Board meeting during my last year as President, I convened a half-day sort of seminar or symposium to discuss web interactions with the intention of getting a Board proposal to sponsor an official SCA website. I invited David Reich from Mt. Sinai, who had substantial expertise in cardiac anesthesia and in website development and management to be our guest at the symposium.
We talked intensely for the full half a day about what an SCA website could look like, what it would cost, how we'd go about developing it, who would manage it all. All of those various and sundry questions came out. But at the end of the day, literally at the subsequent board meeting in the afternoon following the symposium, there was a motion made and unanimously passed that supported and created some seed funding for starting website development for the SCA.
I invited David to be the initial webmaster, if you will, to undertake the initial organization of it. And his idea, which I strongly supported, was that it shouldn't be necessarily the SCA membership or the SCA management company that supported the website. It needed a focused and dedicated professional approach. And so we looked around at various web management companies and came up with leading candidates. Our new

webmaster would make a selection (with Board approval) and would choose a work group among SCA membership. That group would then work with the selected web management company to develop the new website. At about that time my term as President was completed and I passed this ball on to my successor and colleague, Dan Thys.

One interesting anecdote about the development of our website is the following, which occurred close to the end of my term as President. So it was midyear of 1999, and I was looking for a possible name for our website. And we were all a bit bummed and chagrined to find out that the URL, SCA.com, had already been taken by the Society of Crystallography of Australia.

They have since partnered with New Zealand and now they're called SCANZ. But anyway, one day I was I was just browsing around the web and I was on the ASA website. Of course, that's ASAhq.org. I thought, hmm. I did a little bit of sleuthing. And as far as I could tell, SCAhq.org was an available URL name.

I got on the phone and called Dan. "Hey Dan," I said, "what do you think of this idea?" We could be SCAhq.org And he said, "Take it." So I did. My guess is the ASA became ASAhq.org for similar reasons.

**Gravlee:**

Well, the other thing that happened that was I think, a big step forward during your presidency, or at least during your term on the executive committee, was the beginnings of pursuit of cardiothoracic anesthesia fellowship accreditation. Talk to us about that a little bit.

**Davis:**

Well, it turns out that that's a fairly deeply rooted discussion in SCA from early years.

And Jerry Reves had spoken a number of times about an accreditation process for people being trained in cardiac anesthesia at one of our meetings.

**Gravlee**:

Tell us what accreditation actually means.

**Davis:**

Well, there are three terms that commonly get sort of slurred together. Accreditation, certification, and then the process of credentialing and privileging at a local level. But accreditation fundamentally is the standard application and formalized approval of training programs in a given discipline.

And certification is the process of testing and certifying that a given physician who has gone through training as prescribed in the accreditation process, is accomplished in actually having the knowledge and clinical skills to provide clinical care in that discipline. So there are two separate things. One is training requirements and one is individual physician-related demonstration of competency, if you will. And you have to start with the accreditation, I believe.

Well, there is a prescribed process through the American Board of Medical Specialties, where an emerging discipline will first seek accreditation for their training programs. Then, once having developed a number of accredited training programs and a cadre people who have done their training through them, it's appropriate to begin the steps involved in developing a bona fide certification examination process for the individual practitioners.

So the initial discussions of accreditation in SCA, involving Jerry Reves, as I mentioned, and Fawzy Estafanous, sort of fell on deaf ears at the SCA Board level, which didn't approve further action.

**Gravlee:**

So about the time of early 1980s, right?

**Davis:**

Yeah. When I became President-Elect over a decade later '(95 to '97 were my two years in that position), and I think it was brought up in 1996 in a Florida hotel ~~at~~ one of the mid-year Board meetings,

I brought up for discussion the topic of accreditation of fellowship training in cardiac anesthesia. The room became very silent. I felt as if I had maybe sprouted a third eye on my forehead because it was clear that there was not anything like majority support on the board at that time, but there were some supportive voices, notably from ~~J~~erry Reves and Fawzy Estafanous~~.~~

There was some support, but not enough. Not at the level of the majority of the board. But I was pretty persistent about it.

**Gravlee:**

You did a lot of speaking and educating about the process.

**Davis:**

Yes, I did. One of the first things was in my first mid-year Board meeting as president, I organized a day-long symposium on education in cardiac ~~a~~nesthesia with specific targets of accreditation of training programs.

I invited a number of guests. It was a very, very rich discussion lasting the entire day and out of the subsequent board meeting actually came a unanimously approved motion with some seed funding to investigate the SCA's potential role in developing accreditation standards for training programs in cardiac anesthesia and beginning to walk down the Accreditation Council for Graduate Medical Education (ACGME) pathway. In that regard, I also got myself invited to a meeting of the Association of Cardiac Anesthesiologists, the other cardiac anesthesia group I mentioned earlier. I developed a PowerPoint talk about the accreditation and certification of post-graduate medical education programs in general, and presented it at their annual meeting in 1998, I believe. The audience was cool to the topic but polite and attentive. How much persuasion was accomplished, I do not know, but perhaps some.

In 1998, I invited David Leach, who at that point was President of the ACGME, to give the President's lecture at the SCA annual meeting. And he basically walked through what I just summarized about accreditation and certification etcetera and ~~-~~was very complimentary toward the SCA about initiating a process. At the Board meeting that year I brought ~~-~~the topic up again and this time there was a unanimously approved motion to convene a task force specifically designed to move us in the direction of achieving accreditation standards for cardiac anesthesia training.

I asked Alan Schwartz and Jerry Reves to co-chair that task force, and they accepted. They took that mission to heart and really pushed it hard. There was a task force created. I believe you were part of that and that Dan Thys was part of that. I can't remember the entire group, but it worked very diligently. The first trial application didn't quite get reach muster, and so it failed.

The proposal came back again. And subsequently, what was it, 2006 that accreditation was finally approved? Something like that. And it kept going.

**Gravlee:**

So now there is a certification channel and that only took another 15 years.

**Davis:**

Yeah~~,~~ the point isn't how fast it was. It was an idea that didn't quit and I don't think would have happened without the SCA firmly pushing it.

**Gravlee:**
I think it probably would not have because there would have been no push for a major organizational change like that.

**Davis:**
Right. But there were there were other influences. I mean, the Pediatric Anesthesia Society came before us in achieving accreditation and certification. And they had to play pretty pointed hardball with some of the other societies to achieve that.
So I think that helped pave the road a little bit. I think the fact that we had accreditation and that we could pursue some sort of certification process on our own was another piece of the puzzle. And finally, the resistance seemed to melt away, not totally, but ultimately through a lot of people's good work, including your own.
**Gravlee:**
Thank you, sir. In going over your President's Messages in the SCA Newsletter, which gratifyingly were electronically transmitted, I hope in time for you to get one or two of them out electronically before you departed the presidency.

**Davis:**
We did transmit some through the website. Because before that it was all just mail. So it was it was part of the mail out hard-copy-only Society Newsletter.
But we finally sort of squeaked under the wire and got some of them out.

**Gravlee:**
Well, one of the topics you addressed was when the New York State Society of Anesthesiologists requested that SCA comment on whether or not it was okay for anesthesia to leave the operating room at all during cardiopulmonary bypass. And you wrote a piece on that, but you were pretty clear to be speaking for yourself and not for the Society.

**Davis:**
Well, I hope that was clear. That was my intent because in discussions at the board there were significant and probably justified legal concerns about liability the society might incur if it came out as a Society policy requiring anesthesiologists to be present. So **I** sort of sidestepped that potential problem, but I was uncomfortable not saying something. So I used my soapbox as President, but phrased it hopefully adequately as a personal opinion. Also, around that time, I had been doing a number of program reviews for a group called the American Medical Foundation out of Philadelphia.
I was part of the cardiology/cardiac surgery/cardiac anesthesia team that would review a cardiac program normally at the institution's request due to outcome related issues. Although not a universal observation by any means, but **a** fairly frequent observation among these programs, that were all being reviewed because they had problems, was the lack of presence of an anesthesiologist in the operating room throughout cardiopulmonary bypass. And then if you look at the practice standards from the American Society of Anesthesiologists, if it's not number one, it's right up there in the top ten, that of continuous presence throughout an anesthetic.
And so from that kind of an ethical standpoint, it seemed to me that it was inappropriate for there not to be someone there. And another common thread that I observed was that there was no apparent subtraction of

the time that the anesthesiologist was out of the room from the billing because we examined the financial component of these practices as well.
And that should have raised any number of accounting and fiscal red flags. Charging for time when you're not actually providing the service. So that's basically what I said in that editorial. But I don't recall the specific circumstances that led to the New York Society making that inquiry.

**Gravlee:**
Do you have any favorite anecdotes or stories about the SCA that you wish to share?

**Davis:**
May I speak freely?

**Gravlee:**
Absolutely. It's just between us.

**Davis:**
Yeah. Well, one of my favorites happened at a Seattle meeting fairly early. I think it was the first time we had a meeting in Seattle where there was a controversy around a President-Elect position election. During the business meeting, I believe that George Burgess was President at that point in time and the nominee from the Nominating Committee for President-Elect was John Waller**.** One of the previous Presidents favored a different candidate**, a**nd he had collected what he called proxy votes from a substantial number of bona fide SCA active members who, had they been present at the meeting, would undoubtedly have cast their vote in favor of this other candidate. Bear in mind that the average attendance at the business meetings at the time was probably somewhere between 30 and 50 people for a membership of a little over a thousand and overall Annual Meeting attendance in the 500-1000 range.
The thing that sticks in my mind about that is that George came to the podium obviously having been tipped off about what was being planned and he just made a point blank statement very calmly, but very directly, at the beginning of the Business Meeting, stating that the SCA was a corporation incorporated under the laws of the state of Louisiana and in the state of Louisiana, proxy votes are not allowed for corporate activities such as that under discussion.
And I thought then, that was quite a remarkable demonstration of leadership qualities.

**Gravlee:**
Yes, for sure. Well, what do you think are the most important issues facing this society as a subspecialty organization or medicine as a discipline?

**Davis:**
At this point, I have few words of wisdom, huge questions and no crystal balls. I think it's s going to be difficult to sustain the momentum and the growth curve of the society through the next 25 years.
My hope is that the existing level of participation and invention, ingenuity, etc. can be sustained, but how realistic is it to follow the same growth trajectory? I'm not so sure. I think the development of the SCA Foundation, and the support for our research programs are fundamental. I think the existing continued issues around publication may keep cycling back, as we were discussing today at lunch. At some point whether we have continued participation in a journal is a question awaiting resolution.

I don't pretend to know what the right answer is there, but the context of the question becomes different when you're talking about the SCA in 1985 with a thousand members and the SCA in 2025 would probably be upwards of 5000 members, probably if not six.

**Gravlee:**
Well, you were involved at a high level in the organization of medicine as a whole with the VA, as I recall, on a national level. Do you have any perspective from that experience or any thoughts about how medicine should be organized going forward that would differ from the way it is now?

**Davis:**
Yes, I do. And it's immediately crossing into the political arena to voice the opinions. But I think that a purely capitalistic approach to the practice of medicine, as one might do in some other service industry or manufacturing industry, for the health care model just doesn't fit
We're not providers, we are physicians. The term provider substituting for physician is something that just sort of raises my hackles. So the financing of health care, I think, ultimately will be better served if a model more like what's commonly seen in Western Europe could be adopted here where there is at least a base level of care that's universally provided with access to other perhaps more advanced service**s,** if you have the resources to be able to pay for that. So how does a professional society interact with that? We've debated at a number of Board meetings about the limitations placed on us as a not-for-profit professional society and how much we can engage in political activities.

**Gravlee:**
Yeah, we're not allowed to lobby. Zero is the amount that we can do that.
So I'm just asking for your personal opinion.

**Davis:**
You know, I am not speaking on the VA example as a perfect example of what a health care system should look like. The VA is annually funded. Only under very special circumstances can a facility carry funding from one fiscal year over into the next. And this simple fact makes it virtually impossible to sustain programs over the long haul, especially when the system is such a political football and with all of the budgetary uncertainties that creates. There simply has to be a longer term budgeting mechanism, has to be a firm fiscal foundation for a governmentally-funded health care system, because people's lives depend on it.
I'm not convinced that the traditional fee for service, i.e. "no fee, no service" kind of thing, can ever be that solid foundation for health care on into the future.

**Gravlee:**
It sounds like you're not convinced that the VA model is necessarily the best either.

**Davis:**
Absolutely not. Our VA health care system is pretty unique. It's the VA model for care, not one that should necessarily be generally adapted. Once you're into it, the care quality is great. The problem is accessibility and sustainability.
But as a management model with annual funding only, depending on the whims of a Congress, that can sometimes move in any direction it is almost untenable for health care in the US society at large.

**Gravlee:**
Well, anything else we should be talking about?  Final comments?

**Davis**:
I don't have final comments.

**Gravlee:**
All right. Thank you. Thank you very much.