

who received certification before 2000 to participate in its Maintenance of Certification in Anesthesiology process. She suggests that this approach may contribute to skepticism related to maintenance of life-long learning and the board certification process. I would suggest that clinical competency is primarily an assessment best performed locally in health facilities and systems. Although board certification and participation in maintenance of certification processes provide local facilities and systems with valuable information and help assure them that participants have met minimal but important requirements related to medical knowledge, performance reporting, and licensure, these processes do not necessarily reflect clinical competence. The ABA and its parent organization, the American Board of Medical Specialties (ABMS), have appropriately recognized during the past several decades that diplomates who were issued nontime-limited board certificates should not retroactively have time restrictions placed on them. Instead, the ABA and other ABMS member boards have encouraged voluntary participation in maintenance of certification processes for their diplomates who hold nontime-limited certificates. It is a decision best left to local health facilities and systems as to whether they wish to require participation in maintenance of certification processes by physicians who hold nontime-limited certificates as one measure within a continuum of methods of evaluating clinical competence.

Eger provocatively suggests that one potential factor associated with the findings of Tessler *et al.*¹ may be that older anesthesiologists as a population are generally less competent physicians than younger anesthesiologists. Given the context, it appears that he is directing his comments at Canadian anesthesiologists. However, I presume he means to suggest that his postulated factor applies to the United States as well, since he quotes John Lundy, formerly of my own institution. Interesting thought, yet clearly not provable or disprovable. What we do know is that pass rates of ABA written exams during the 50-yr period of 1960–2010 do not vary significantly. These exams do not measure clinical competence, but they do reflect minimal knowledge acceptable to the ABA for physicians who took these examinations annually during this period. Whether or not this information would alter Eger's thinking rests solely with Eger.

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Unresponsiveness versus Unconsciousness

To the Editor:

The review article¹ writes about connectedness as an aspect of anesthesia. This is a major insight into what we mean by the term anesthesia. In 1986, I had defined anesthesia as paralysis defined as nonmovement, attenuation of the stress response, and unconsciousness.² Unconsciousness I divided into amnesia and hypnosis, consistent with the classic terms used for anesthesia. The article was written as a protest to the arguments as to what is a real anesthetic at that time. Connectedness better defines a problem that I described in that only amnesia was typically used to prove that we had unconsciousness. The review clearly shows that amnesia should not be our only goal. Like most good theories, connectedness opens the door to more questions. Connected to what?

If we cut a nerve, it will respond. Is connectedness lost if it never gets past the spinal nerves, as in spinal anesthesia? If the impulse gets through the spine, where in the brain must it be unconnected for us to consider that we have fulfilled the criteria of our job as anesthesiologists? From chronic pain patients, there is a general understanding that a memory exists in nerve tissue, not just the higher centers. Should our goal be to make all nerve tissue unresponsive?

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In Reply:

We are grateful to Dr. Pinsker for his complimentary letter and also to the insightful question posed. We specifically use the term “connectedness” to define the potential that an external stimulus will trigger an experience.¹ All experience is primarily internally generated; it may be independent of external events (such as a dream), or triggered – or modified – by external stimuli. We use “connectedness” to imply a connection between the patient's internally manufactured consciousness and the environment so that an external event may trigger an experience. We primarily have focused our discussion on general anesthesia because of the widespread assumption that these subjects should be unconscious. We propose that, at a minimum, they should be disconnected and thus unaware of surgery.¹ However, we agree there are multiple ways by which

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