



AUA

Association of University Anesthesiologists

Update

Fall 2004

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Spotlighting Our Academic Mission

*David L. Brown, M.D., AUA President
Edward Rotan Distinguished Professor and Chair
Department of Anesthesiology and Pain Medicine
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Houston, Texas*

As I write this, many of us have just returned from the AUA 51st Annual Meeting in Sacramento, California, which was hosted by the Department of Anesthesiology and Pain Medicine at the University of California-Davis (UC-Davis) on May 13-15.

Twenty-six new members were invited to join AUA during the meeting, and we were treated to presentations that ranged from nanotechnology of microemulsions to GABA receptor hypotheses to why thoroughbred racehorses have not increased in speed since the early 1980s. This meeting remains one of the truly interesting scientific events of the

year for me. Again, our thanks to Joseph F. Antognini, M.D., and Peter G. Moore, M.D., Ph.D., and the local institution, UC-Davis, for being such warm hosts and allowing our academic fellowship to be so nicely stimulated.

In spite of the wonderful Annual Meeting, our academic specialty faces challenges across the country. Programs are finding it increasingly difficult to balance the three linked missions of our academic practices. To review the definition of our AUA mission in the bylaws, we are to advance the art and science of anesthesiology by: 1) encouraging our members to pursue original investigations in the clinic and in the laboratory; 2) developing the method of teaching (anesthesiology); and 3) creating a setting for a free and informal interchange of ideas. This mission defines what most in our specialty believe is the real practice of academic anesthesiology.

We have many academic interest groups within our specialty working toward a renewal (or perhaps development) of sustainable and more widely distributed research within our current academic departments. The generation of new knowledge (research) is believed by most to be the primary marker of a viable profession and specialty. Even though there are many who are encouraging a more technical approach to the specialty, I believe if we step away from creation of new knowledge and instead turn to the distribution of current knowledge, the field begins to appear to be purely technical. For the future of our patients and our specialty, we must not accept that approach.



David L. Brown, M.D.



Some of AUA's past and present leaders struck a presidential pose at last year's 50th Anniversary Meeting in Milwaukee, Wisconsin. They are, from left to right, Joseph G. Reves, M.D., Donald S. Prough, M.D., Margaret Wood, M.B., John P. Kampine, M.D., Ph.D., and Alex S. Evers, M.D.

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STA Offers Opportunities for Faculty and Residents

Jeffrey M. Feldman, M.D., M.S.E., President
Society for Technology in Anesthesia

Almost 20 years ago while training as a resident in anesthesiology, I was introduced to a small group of academic anesthesiologists who founded the Society for Technology in Anesthesia (STA). At that time, standards for intraoperative monitoring had not been established, yet the increasing role of technology in anesthesiology practice was obvious. The founding group recognized the importance of dialogue between clinicians and developers of medical technology as well as the need for scientific investigation into the role of technology in clinical practice. Furthermore it was difficult to publish manuscripts about technology, and few meetings focused on this topic. The result: the founding of STA in 1989.

From its humble roots, STA has grown to be a vibrant organization. STA members are clinicians, educators, students, engineers, marketers, executives and virtually anyone with an interest in the use of technology in anesthesia care. STA now organizes a breakfast panel each year at the American Society of Anesthesiologists (ASA) Annual Meeting, and there are numerous abstracts in the technology section. STA also is a component society represented in *Anesthesia & Analgesia* with a place on the editorial board and in numerous manuscripts submitted to the journal's "Section on Technology and Computing."

STA sponsors various programs each year intended to foster dialogue about the role of technology in clinical practice. Our Annual Meeting is the major event for STA each year and is something of a metaphor for the Society as a whole. Attendees find a welcoming, relaxed atmosphere combined with a stimulating program and an audience given to sharing expertise and critically examining how technology impacts patient care. Topics such as human performance, new monitoring technologies, novel approaches to therapy, simulation, physiologic modeling and clinical information technology are explored in formal lectures, scientific sessions, workshops and small-group discussions. Immediately following the ASA Annual Meeting each year, STA sponsors a meeting devoted solely to computing related to anesthesiology called "Computers in Anesthesia."

Supporting research is an important aspect of STA's mission. The STA research award program is designed to provide seed money to young investigators who start research programs concerning the use of technology in clinical practice. A \$5,000 award is available annually, and the funds accumulate each year that the grant is not awarded. This past year, a \$10,000 grant was awarded to Derek Sakata, M.D., of the University of Utah for his work "Computer-Controlled Carbon Dioxide Injection for Faster Wakeup From Volatile Anesthetics." STA also recognizes important research with awards presented at both the ASA Annual Meeting and the

STA Annual Meeting. In addition STA makes annual contributions to the Foundation for Anesthesia Education and Research and the Anesthesia Patient Safety Foundation.

The role of technology in the practice of anesthesiology continues to grow. The national interest in patient safety has highlighted the role that equipment design can play in medical errors. Whereas patient monitoring was a major topic in the early years of STA, technology topics now encompass simu-



Jeffrey M. Feldman, M.D.,
M.S.E.

lation, medical informatics, human factors and anesthesia delivery systems. Indeed, after several years of nurturing the simulation component of the Annual Meeting, STA has fostered the creation of the Society for Medical Simulation, which is destined to grow into a vibrant organization in its own right. STA embraces all aspects of technology and welcomes new members with an interest in developing these technologies to benefit patients.

For many young investigators, STA has provided an opportunity to find mentors and share ideas. STA encourages new members to become involved with the many activities of the Society. When I was first introduced to STA as a resident 20 years ago, I did not imagine how richly the Society would contribute to my own professional development. The future members and leaders of STA are among the current residents and young faculty in departments around the country.

STA's "Computers in Anesthesia XXV" meeting will be held just after the ASA Annual Meeting on October 27-30, 2004, at the Hyatt Regency Lake Las Vegas Resort. The STA Annual Meeting will be held January 13-15, 2005, in Miami, Florida. Specific information about the meetings, the grant program and other STA programs can be found on the STA Web site at <www.anestech.org>. Encourage the members of your department to come to one of our meetings, apply for an STA grant or just join the Society and get involved.



Visit
<www.anestech.org>
for more information on STA

SAB Report

Proteomics: What It Is and Where It's Going

Jonas S. Johansson, M.D., Ph.D.
Associate Professor of Anesthesia and
Biochemistry/Biophysics
Johnson Research Foundation
University of Pennsylvania
Philadelphia, Pennsylvania

Proteomics: a branch of biotechnology concerned with applying the techniques of molecular biology, biochemistry, and genetics to analyzing the structure, function, and interactions of the proteins produced by the genes of a particular cell, tissue, or organism, with organizing the information in databases, and with applications of the data (as in medicine or biology).

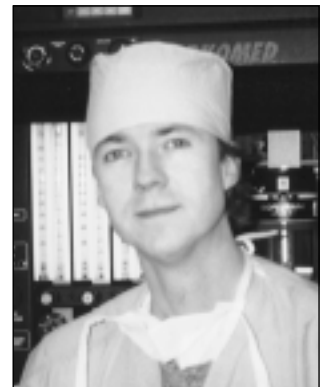
— Merriam-Webster Medical Dictionary, 2002

In its broadest meaning, proteomics (PROTEin complement to a genOME) represents a dauntingly formidable challenge to the biomedical research community. The goal is to describe all the proteins expressed in an organism, all the way from their amino acid sequences on up to their high-resolution, three-dimensional structures, using traditional biochemical approaches along with X-ray crystallography and nuclear magnetic resonance spectroscopy. This undertaking also will include a catalogue of all the post-translational modifications made to the proteins such as phosphorylations, glycosylations, acetylations and the addition of other chemical groups along with the various enzymatic activities inherent to the proteins in these different states. In addition the aim is to describe the way different proteins interact with each other to form macromolecular assemblies and networks and how they form complexes with other molecules, including therapeutic agents.

In a more limited sense, proteomics refers to any investigation that simultaneously examines a large number of different proteins. For example, in a plasma proteomics study, samples from healthy volunteers would be compared with those obtained in patients with various disease states in an attempt to identify specific early pathological markers, or to follow the course of a disease, and any potential responses to therapeutic interventions. Studies of this type have already revealed differential protein expression during the temporal progression of squamous cell carcinoma in the oral cavity.

From a technological standpoint, proteome analysis is currently at a considerably earlier stage in its evolution compared to what is possible with genomics and gene expression (microarray) studies. Some of the earliest work in this area used two-dimensional gel electrophoresis to allow visualization of the large numbers of different proteins present in a typical biological sample. More recently such two-dimensional gel electrophoresis has been coupled with the rapidly developing field of mass spectrometry to allow for the identification of the different proteins. The yeast two-hybrid system permits the characterization of protein-protein interactions and is a technique that is beginning to become applicable to proteomics research. One of the initial goals of the Human Proteome Organization is to develop antibodies to all human

proteins. Using a battery of such antibodies, it is envisioned that it will be possible to produce analytical microarrays, or biochips, that can be used to quantify the levels of different proteins in various biological and clinical specimens. Additional high-throughput technologies for rapidly analyzing the concentrations and activities of large numbers of different proteins are currently being developed along with the computational methods required for analyzing large data sets.



Jonas S. Johansson, M.D.,
Ph.D.

Proteomics analysis also will radically change the way in which clinical chemistry and biochemistry is performed. We are just beginning to see the effects that this exciting new field will have on the future of our specialty.

How will the field of proteomics help to move the knowledge base of anesthesiology forward into new domains? Since most therapeutic agents act by modifying protein function, one area will be in helping to understand mechanisms of drug action and identifying novel targets for therapeutic agents. Two studies have appeared so far using proteomic techniques to expand on our understanding of inhaled anesthetic action. Roderic G. Eckenhoff, M.D., and his group at the University of Pennsylvania used a proteomics approach to identify novel targets for halothane in rat brain neuronal membranes (*J Biol Chem.* 2004; 279:19628-19633), and Klaus F. Waschke, M.D., and his group at the Faculty of Clinical Medicine at the University of Heidelberg in Mannheim, Germany, showed that desflurane anesthesia alters the levels of protein expression in the rat brain (*Anesthesiology.* 2004; 100:302-308).

In critical care medicine and chronic pain medicine, plasma proteomics is expected to have both diagnostic and prognostic utility. Proteomics analysis also will radically change the way in which clinical chemistry and biochemistry are performed. We are just beginning to see the effects that this exciting new field will have on the future of our specialty.

Confessions of a Convert: The New Apple of My Eye

Keith J Ruskin, M.D.
Associate Professor of Anesthesiology and Neurosurgery
Yale University School of Medicine
New Haven, Connecticut

I made a major lifestyle change nearly two years ago: I bought my first Apple computer, and it was no small event. I have been using PC-compatible computers and DOS/Windows since a company I worked for bought one of the first IBM personal computers in 1981. At the time I bought my Apple laptop, I had never used one before and had more than 20 years' experience with a competing platform. Overall my experience has been highly positive. The computers are well-designed with comfortable keyboards and big, bright displays. Apple computers are pretty much functional right out of the box; you just plug them in and turn them on.

Fifteen minutes after I opened the box, I had installed Microsoft® Office and was able to read and share all of my existing documents. All of the secretaries and about half of the faculty in my department use Windows computers, and I am able to share presentations, spreadsheets and documents with them. The only problem I have noted so far is that on rare occasions, PowerPoint® slide formatting does not translate perfectly. This problem usually occurs only if the presentation includes nonstandard fonts. Fixing the slide formatting, if it is necessary, usually requires less than 10 minutes per presentation.

Using the Internet is simple. OS X (the Macintosh operating system) is based on Unix, on which the original Internet was built. There is essentially no setup required; when I turn on a new computer, it detects my wireless network and offers to connect to it. The Apple Mail program checks each of my mail accounts and automatically sorts mail for me. Because

nearly all worms and viruses are written for PC-compatible computers running Windows, the possibility of getting infected is very low. Safari, the Apple Web client, is stable, fast and easy to use. A program called iSync automatically synchronizes my bookmarks across computers. (iSync also synchronizes names and addresses on my hand-held and mobile telephone.) Some of my university's Web applications (and my bank) require Internet Explorer, and every one of these applications works with Microsoft Internet Explorer Version 5.5 for Macintosh.

Apple has truly outstanding customer support. The AppleCare Protection Plan costs approximately \$250 and provides several years of warranty service and a toll-free support number. Unlike most other support lines, Apple's number still connects you to a person who understands your problem and can solve it.

Overall I have been very happy with my switch to Apple. Most of the programs that I use on a daily basis are available for the Macintosh. I use VirtualPC <www.microsoft.com/mac>, which lets me run the few programs that require Windows and a PC on my Macintosh. Learning the new user interface was easy because the software is designed well. The system is in general much more stable than any Windows computer that I have ever used. Some of our residents and faculty have seen my experiences and are considering making the switch.

Would I do it again? Absolutely.



Keith J. Ruskin, M.D.



Anesthesia in the News

Here are a few of the things going on in the world of anesthesiology (you can copy and paste these URLs from the online newsletter at <www.auahq.org/AUAFall04.pdf>.

"Comfortably Numb: Anesthetics Are Slowly Giving Up the Secrets of How They Work" from Science News online, written by John Travis. July 3, 2004
<www.sciencenews.org/articles/20040703/bob8.asp>

"Hidden Specialties: Meet the Doctors of Sleep, Images, and Microscopes" from USNews.com, written by Thomas Hayden. July 12, 2004
<www.usnews.com/usnews/health/hosptl/articles/12hidden.intro.htm>

"Bush Signs Bill Creating Anesthesiology Assistants" from First Coast News. June 18, 2004.
<www.firstcoastnews.com/news/florida/news-article.aspx?storyid=20224>

"Judge Awards Patient \$700,000" from Roanoke.com, written by Tad Dickens. July 2, 2004.
<www.roanoke.com/roatimes/news/story169150.html>

And here is one department's online weekly newsletter, from West Virginia University.
<www.hsc.wvu.edu/som/anesth/NewsLetter_Page.html>

(Let me know if you would like yours mentioned here.) — W.A.K.

Call for Abstracts

AUA 52nd Annual Meeting

The Scientific Advisory Board (SAB) invites you to submit an original research abstract for presentation at the AUA 52nd Annual Meeting to be held May 6-8, 2005. As is tradition, all properly submitted abstracts will be accepted. However, open acceptance could result in more abstracts than available space. Only one abstract per member (authored or sponsored) will be accepted. SAB peer review will assign abstracts to oral, poster discussion and poster sessions.

Individuals whose abstracts are selected for oral presentation will be asked to not be overly technical in their presentations and to provide adequate background and context for their work. Oral presentations are not intended for postdoctoral fellows or senior faculty. To maintain the traditional high quality of abstract submissions, it is essential that member authors and sponsors critically review their submissions. If, in the opinion of the membership, this new process results in a diminished quality of abstract, then SAB will return to peer-review for acceptance of abstracts. Members are encouraged to consider submission of clinically oriented abstracts, for there has been a decline in the numbers of such submissions for recent meetings.

New to this year's abstract submission process, each package must include a diskette or CD of your abstract submission in Microsoft® Word format and a hard copy of your blinded and unblinded abstract. Abstract packages may not be sent as a facsimile. All abstract packages must arrive at the AUA office by 5 p.m. (Central Standard Time) on Friday, November 5, 2004. Abstracts arriving after November 5 will be considered late and may not be accepted.

An abstract submission form is required for each abstract. The submission form provides SAB with information regarding authors and membership, institutional and corporate affiliations, notification of prior or other presentation(s) of the research and the need for conflict-of-interest disclaimers. A disclosure form also is required for each abstract and must be submitted should there exist relationships of a personal or professional nature that are relevant to the research that was conducted. Abstract submission and author disclosure forms as well as the specifications for abstract submissions may be found on the AUA Web site at <www.auahq.org>.

Abstracts selected for presentation at the AUA 52nd Annual Meeting will not be published, allowing members to submit essentially the same abstract to the ASA 2005 Annual Meeting. **Abstracts presented at the AUA Annual Meeting also will be posted on the "Members Only" section of the AUA Web site.**

Number of copies: TWO COPIES PLUS A DISKETTE OR CD WITH THE ABSTRACT IN MICROSOFT WORD FORMAT. Enclose the original plus by two copies (one blinded and one unblinded). If an abstract is two pages long, leave the original copy unstapled. However, do staple together the pages for the two copies.

Typeface: The following are necessary to ensure legibility after photocopying and to facilitate review by SAB:

- Type size: 12 point or larger (equivalent to pica typewriter font).
- Line spacing: No more than six lines per vertical inch.
- Fonts: Any font may be used, including proportional and fixed-pitch fonts.

Page length: Abstract text must fit onto one 8-1/2" x 11" page. Please use reasonable margins, typically one inch at the left and one-half inch at the right. An optional second page may be used only for the following items:

- Figures with brief legends
- Tables
- References
- Acknowledgements

IMPORTANT: NO abstract text is permitted on the second abstract page.

Text composition: It is recommended that the abstract be divided into the following sections:

- Introduction: Briefly state the rationale and objective of the project.
- Methods: Summarize the key points succinctly.
- Results: Cite the essential results; give statistical and systemic errors.
- Conclusions: Discuss the significance of the results.

Heading: Include title, authors (first initial and surname) and institution name at the top of the unblinded abstract page.

Authors: Each abstract must be authored or sponsored by an AUA member. If none of the authors is an AUA member, list the AUA sponsor's name after the authors as follows: (Spon: J.O. Doe). **REMEMBER: AN AUA MEMBER MAY ONLY AUTHOR OR SPONSOR ONE ABSTRACT.**

References: Inclusion of one to three references is recommended to facilitate abstract review.

Clinical Studies: Include a statement regarding IRB approval.

Animal Studies: Include a statement of adherence to the APS/National Institutes of Health guidelines.

Copies: Send the submission and disclosure forms and the abstract to:

C. Michael Crowder, M.D., Ph.D.
Chair, Scientific Advisory Board
Association of University Anesthesiologists
520 N. Northwest Highway
Park Ridge, IL 60068-2573

Deadlines: The complete submission packet must be received by 5 p.m. **Friday, November 5, 2004.** In fairness to those authors who do abide by these rules, SAB may remove from consideration those abstracts not following these instructions.

For complete abstract submission information, including abstract submission forms, see
<www.auahq.org>.

AUA 2005 Annual Meeting

Baltimore, Maryland
May 6-8, 2005

The AUA 2005 Annual Meeting will be held in Baltimore, Maryland, on May 6-8, 2005, at the Marriott Waterfront Hotel, and will be hosted jointly by the Department of Anesthesiology and Critical Care Medicine (ACCM) at Johns Hopkins University and the Department of Anesthesiology at the University of Maryland.

Spring is one of the most attractive and desirable times to visit Baltimore and its adjacent areas. Temperatures are usually in the mid 60s but without the humidity of the ensuing summer months. The Baltimore area offers multiple cultural and recreational opportunities, many of which are distinctly unique to the area. Baltimore, a maritime city, offers the expected opportunities associated with its location on the Chesapeake Bay, and it has a world-renowned aquarium. There are multiple cultural (symphony, theater, museums) venues in the area. Both the Baltimore Museum of Art and the Walters Art Gallery house their own unique and distinctive collections. As in other cities, spring brings major league baseball to famous Camden Yards. Spring also represents the peak of lacrosse season — Baltimore is the epicenter of the lacrosse world (it houses the NCAA Lacrosse Hall of Fame on the grounds of Johns Hopkins University). Finally Baltimore's proximity to Washington, D.C. (about 40 miles away) makes day trips to Washington readily feasible.



The University of Maryland School of Medicine, the oldest public medical school in the nation and the fifth oldest medical school overall, will celebrate its 200th Anniversary in 2007. The original teaching building, Davidge Hall, is now a National Historical Landmark and is the oldest continuously used facility for medical instruction in the United States. In 1823 the faculty of the School of Medicine built the nation's first teaching hospital, the Baltimore Infirmary. The faculty paid for the facility themselves at a cost of \$40,000. This medical school started the nation's first residency teaching program. The University of Maryland Medical System (University Hospital, R. Adams Cowley Shock Trauma Program, Greenebaum Cancer Center, Kernan Orthopedic Hospital and the University of Maryland Hospital for Children), Baltimore VA Medical Center and the School of Medicine physical facilities have

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The Johns Hopkins Medical Institutions and each of the academic departments encompass not only the primary Hopkins campus but also the Bayview Medical Center. The current chair of anesthesiology and critical care medicine is John Ulatowski, M.D., Ph.D. The seminal features of the department of anesthesiology and critical care medicine at the Johns Hopkins medical institutions owe much to the vision of Mark C. Rogers, M.D., who became chair in the late 1970s. Although almost completely unrecognized, Alfred Blalock, M.D., had earlier (in the 1950s) espoused a vision of an anesthesiology department at Hopkins similar to that which evolved in the 1980s under Dr. Rogers' guidance, i.e., an academic department with strong research and education features. On assuming the chairmanship, Dr. Rogers developed a robust, premier research component within the department. Moreover critical care medicine

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Maryland

expanded to accommodate specialized needs in the pre-clinical and clinical arenas. In 2003 campus external research funding reached

\$262 million. The University of Maryland Hospital is a major innovative teaching hospital in downtown Baltimore that provides a full range of health care to more than 250,000 patients each year from Maryland and the Mid-Atlantic region. It serves as a regional referral center for the most serious and complicated health problems in adults and children, including cancer, trauma, heart disease, neurological conditions and organ transplants. The 1,038 attending physicians use the 648 beds and 220 intensive care unit beds in the hospital for their patient care. All of the physicians are on the faculty of the University of Maryland School of Medicine

In the department of anesthesiology, clinical and research programs have experienced significant growth over the past five years with departmental research increasing three-fold over the last decade. The department leader since 1986, Jane Matjasko, M.D., holds the Martin Helrich endowed chair in anesthesiology. Gary Fiskum, Ph.D., Professor and Vice-Chair of Research, directs the research division. The research subdivisions are clinical, human factors and neuroprotection.

Anesthesiology clinical research is conducted by a multidisciplinary team of academic physicians, fellows, technicians and research assistants who provide the clinical interface in the University of Maryland operating rooms, intensive care units and other clinical sites for studying new techniques, pharmaceuticals, methods and the like. Led by Timothy B. Gilbert, M.D., M.B.A., M.Sc., Associate Professor and Associate Vice-Chair of Research, these investigators work intradepartmentally and interdepartmentally with other University of Maryland departments and campuses and with industry on a variety of translational (cardiac, inflammation, neuro-reno protection, pharma trials) and medical economics projects.

The Human Factors Research Program is a multidisciplinary program that strives for excellence in three research areas: patient safety, coordination studies and information technology. Led by Associate Professor Yan Xiao, Ph.D., and Professor Colin F. Mackenzie, M.D., a team of 11 investigators participate in a multidisciplinary program that integrates human factors, technology and medicine. The program is supported by grants and contracts from the National Science Foundation, Agency for Healthcare Research and Quality, the U.S. Army, NASA and several corporations.

The mission of the neuroprotection research program is to reduce the neurologic morbidity and mortality that affects the several million people worldwide who suffer from stroke, cardiac arrest and trauma to the head and spinal cord. While based on mechanistic hypotheses, the neuroprotection program also is translational and benefits from close collaboration between approximately 20 basic scientists and clinician investigators within the department. Their efforts are supported by grants from several institutes of the National Institutes of Health, the U.S. Army, the American Heart Association and various industrial partners. Interdepartmental collaboration also is very strong and is promoted by the department-organized Neuroprotection Research Focus Group, which consists of more than 50 investigators within the University of Maryland neuroscience program.

Hopkins

was incorporated into the department (currently all surgical intensive care units are staffed by anesthesiology and critical care medicine [ACCM] intensivists), and the residency training program grew in quality and quantity to levels comparable with other top anesthesiology training programs. Dr. Rogers and the leadership were among the earliest to recognize the need for anesthesiology departments to function as full-fledged members of academic medical centers if they were to retain longevity. Many outstanding and dedicated individuals, both during and following Dr. Rogers' tenure, ensured that these objectives were realized.

The department of anesthesiology and critical care medicine has continued to enjoy enormous academic success, illustrated by the ongoing success in procuring extramural funding and, perhaps more importantly, by the large number of faculty (more than half) responsible for obtaining this funding.

A conspicuous feature of the research efforts of the ACCM faculty is its diversity. Although several major areas of research involve large groups, the department faculty is not just concentrated in one or two areas of research. The major areas of interest include both clinical and basic science research and involve the spectrum of approaches from the organism to the genome. These areas of research include patient safety and outcomes, acute lung injury, airway reactivity, vascular biology, brain injury and neuroprotection, neuromodeling, clinical and basic science aspects of pain, cardiac and cellular physiology, and perioperative inflammation and coagulation. It also is noteworthy that this research involves numerous collaborative efforts with other departments within the school of medicine, with other schools within the university and with other institutions.

The contribution of The Johns Hopkins Department of Anesthesiology and Critical Care Medicine to academic anesthesiology is well illustrated by the fact that four anesthesiology chairs at noted academic medical centers have spent much of their formative academic careers at Hopkins, including Thomas J.J. Blanck, M.D., Ph.D. (New York University); Jeffrey R. Balsler, M.D., Ph.D. (Vanderbilt University); Jeffrey R. Kirsch, M.D. (Oregon Health Sciences Hospital and Clinics); and Lee A. Fleisher, M.D. (University of Pennsylvania).

Finally The Johns Hopkins School of Medicine campus is currently undergoing profound change. Several new research buildings are being added, and the clinical facilities are being replaced with state-of-the-art buildings.

You can read more about these two leading departments at:

[<www.hopkinsmedicine.org/anesthesiology>](http://www.hopkinsmedicine.org/anesthesiology)

and [<www.umm.edu/anesthesia>](http://www.umm.edu/anesthesia).

For further information, contact:

[<jmatjasko@anes.umm.edu>](mailto:jmatjasko@anes.umm.edu)

[<gfisk001@umaryland.edu>](mailto:gfisk001@umaryland.edu)

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Spotlighting Our Academic Mission

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An example of our need to regain/develop a true focus on the creation of new knowledge is that our specialty typically makes up almost 5 percent of all academic physicians yet garnered less than 1 percent of all National Institutes of Health (NIH) research funding in FY 2003 <www.aamc.org/data/facultyroster/usmsf03/03table17.pdf>. Further, in FY 2003, anesthesiology departments accounted for 10 research training grants funded by NIH while our surgical colleagues had more than four times that many training grants available for focused research training within their academic field.

The challenge is to grow our research focus while many departments continue to work hard to just get the cases done, leaving little creative energy for the generation of new knowledge. This fatigue seems particularly evident in the limited number of young physicians 30 to 45 years of age who are truly building solid academic careers. This is not just a challenge for academic anesthesiology; rather, 10 to 15 years from now, it will impact our private practice colleagues when the loss of intellectual curiosity and the potential for dramatically decreased growth in new knowledge within the specialty discourages the best and brightest of our medical students from entering the field.

I offer that the original purpose of AUA is as important today as it was when the Association was founded in the 1950s. We need our entire specialty focused on shining a very needed spotlight on our academic mission; it remains foundational for future success. Our efforts to keep the spotlight shining on this issue will include developing a panel of experts for next year's Annual Meeting in Baltimore, Maryland, which will tackle the issue of academic renewal within our departments and support of our promising young physician scientists.

Presenting a New Type of Patient-Controlled Analgesia ...



(Photo created by S. Jourin, <jourin00@yahoo.com> ; <www.jourin.com>).