



AUA

Association of University Anesthesiologists

Update

Winter 2005

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Tulane Anesthesia Department Responds to *Katrina*

W. Andrew Kofke, M.D., M.B.A.
AUA Update Editor

Hurricane Katrina struck New Orleans just before the Labor Day weekend. The city seemed initially to weather the storm, but then the 17th Street levee broke, and the ensuing flood covered the city, including the hospitals of the Tulane School of Medicine. At the time of the hurricane, there were anesthesiology residents on duty and some residents and faculty who were in the hospital for cover from the hurricane. With the flooding and consequent looting, they found themselves unable to leave. Although outside of the hospital law and order deteriorated, the hospital and staff were protected by the military. Nonetheless basic services such as air conditioning and food and water became problematic, resulting in an emergent rooftop helicopter evacuation of the hospital's patients and staff, all provided by Hospital Corporation of America (HCA), and with no loss of life.

Total Loss of Clinical Practice

The impact on the Tulane anesthesiology program was a total loss of its clinical practice, as the city was under mandatory evacuation and the clinical facility became nonuseable. The responses of faculty and residents were dual. One was to depart at the earliest possible time to another institution or training program whereas the other was to stay with the Tulane program. To facilitate continuation of the training of those who chose the latter, the South Texas Anesthesia Alliance was formed.

The first meeting of this group, which comprised chairs from Baylor (Lydia A. Conlay, M.D., Ph.D.), the University of Texas Health Science Center (James F. Arens, M.D.), M.D. Anderson (David L. Brown, M.D.) and the University of Texas Medical Branch, Galveston (Donald S. Prough, M.D.), resulted in an evaluation of the educational capacity available in the four programs. The resulting conclusion was that the available training experiences, taken all together over the four programs, looked like a reasonable educational curriculum that could be offered to Tulane residents. This was rapidly approved by the Accreditation Council for Graduate Medical Education, and before the end of September, there was an orientation for the 24 of 31 remaining Tulane residents, who then resumed their residency program among the four host institutions in the South Texas Anesthesia Alliance. Educationally there was relatively minor interruption, notwithstanding the considerable personal problems most of them have had to solve. The Tulane faculty who remained were redeployed to other HCA hospitals, including those around New Orleans.

Where to Go?

The impact on the residents was highly individual, with many of the CA-3s who already had fellowships arranged migrating to the locales of their fellowships, some residents choosing to go closer to their

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Hurricane Katrina Affects Nearly 20,000 Physicians — Up to 6,000 Patient Care Physicians Displaced by Flooding

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Hurricane Katrina and subsequent flooding and related damage may have dislocated up to 5,944 active patient care physicians, which is the approximate number of physicians doing primarily patient care in the 10 counties and parishes in Louisiana and Mississippi that have been directly affected by flooding. More than two-thirds of those (4,486) are in the three central New Orleans parishes that were evacuated. This number is more than one-quarter of the total number of new physicians who begin practice in the United States each year.

A large proportion of the practicing physicians in the area also are in training in residency programs. In the immediate three-parish New Orleans area, more than 1,270 resident physicians were in training at the time the hurricane struck on August 29.

Of the physicians in the flood-affected areas, which include six Louisiana and four Mississippi counties or parishes, the majority (2,952) were specialists with 1,292 in primary care, and 272 practiced obstetrics/gynecology. These totals exclude the residents in training who also provide various levels of primary and specialty care.

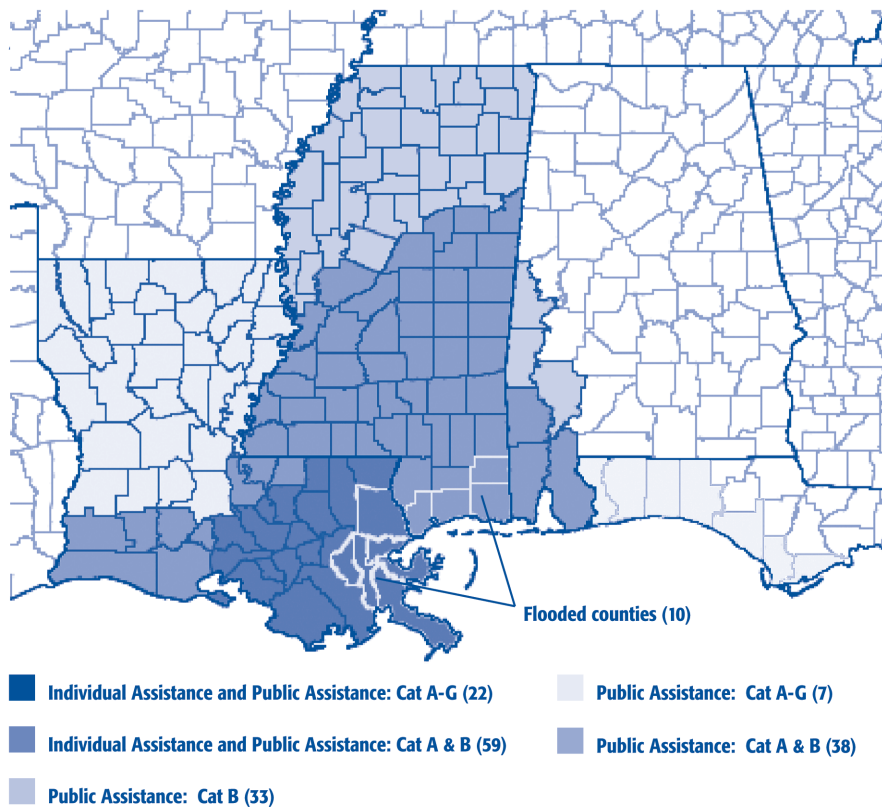
The two New Orleans medical schools, Tulane University and Louisiana State University, enrolled approximately 1,300 medical students in all years in 2004, and those students have been moved to other programs in the region, primarily to the Baton Rouge area and to east Texas. Their relocation has been coordinated by various agencies and organizations, including the Association of American Medical Colleges, state and regional area health education center programs in Texas and Louisiana, and the Liaison Committee on Graduate Medical Education.

There are another 2,052 physicians in 16 Louisiana parishes that are identified by the Federal Emergency Management Agency (FEMA) as being severely affected (level 1 disaster declaration). This includes 144 residents in training as well as 1,032 specialists, 724 primary care physicians and 140 obstetricians/gynecologists. Physicians involved primarily in administration, research or education are excluded from the total. Physicians working for the federal government are included in these numbers.

In all FEMA-designated areas on the Gulf coast, there were 16,427 active patient care physicians in 159 counties and parishes; 5,562 were in primary care, 1,058 in obstetrics and gynecology and 9,638 in medical and surgical specialties and other fields of practice. There were an additional 2,742 licensed physicians in residency training.

State licensing bodies for physicians have reacted in various ways to the emergency. Louisiana has modified its licensing rules to allow volunteer physicians to practice in the state, and the governor has issued changes to malpractice liability laws as part of the public health emergency. The Texas Medical Board is granting a 45-day temporary license allowing out-of-state physicians who have been required to follow their patients or who are volunteering to care for refugees to practice in that state. That license requires a Texas physician sponsor. The Federation of State Medical Boards has set up a 24-hour license verification process for Louisiana physicians who

Federally Declared Disaster Areas – Counties by Type



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Katrina: A Different Perspective at the Ochsner Clinic Foundation

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The effects of Hurricane Katrina on the Ochsner Clinic Foundation (OCF) were different from those at other area hospitals but nonetheless posed specific challenges. What distinguished this hurricane from others is the sharp, easterly turn it took once reaching the Gulf of Mexico and the acceleration in intensity and speed, which left relatively little time (48 hours) to prepare. OCF is located in Jefferson Parish on the eastern border of Orleans Parish, just minutes away from the Garden and Uptown districts. Fortunately OCF sits on relatively high ground compared with other areas of New Orleans, and although the physical plant sustained significant wind damage, the area immediately surrounding us did not flood. That was little consolation as we learned of the plight of the city and area hospitals.

Team A

At the time that Katrina hit, we had an inpatient census of approximately 400 patients. OCF responds to potential disasters with an essential personnel list (Team A), which includes, among others, almost all of the physician and nursing leadership as well as administrative and ancillary management. Team A for anesthesiology consisted of five attending anesthesiologists, five nurse anesthetists and two residents (one

CA-2 and one CA-3) who would be expected to cover during the storm and for whatever necessary period afterward until a relief team could be mobilized. As the winds picked up, OCF lost power early (essential equipment was run off back-up emergency generators), and the challenges of caring for patients without air conditioning, electricity and running, potable water became quickly evident. Fortunately limited power was restored relatively quickly at OCF, within four days. Once partial electricity resumed, an onsite water well provided nonpotable water for the functioning of lavatories.

Continuous Operation

Ochsner was, and has been, in continuous operation since the storm. In September we performed almost 1,000 anesthetics, including liver transplant, neurosurgical and cardiac procedures. Because residents constitute only one-third of the anesthesia workforce at Ochsner, although our total volume was reduced, we were still able to provide a good clinical case load for instruction. We also took the opportunity to assign our residents outside rotations, such as critical care, during that period. An unanticipated challenge for us was timing the mobilization of the relief teams since civil unrest was spreading throughout the city, and we were concerned for the safety of our staff and employees. Relief teams were mobilized by the fifth day after the storm, when sufficient numbers of law enforcement, military and the National Guard had secured the city. Since almost all non-Team A personnel had evacuated the city, relief teams were staged at

OCF sites in Baton Rouge where they “convoyed in” with protection to OCF. Relief team rotations also were important, not only to relieve staff that had already been working six to seven days, but also as a morale booster to show employees that OCF had been relatively spared as compared to reports in the national media. By October 1, all of our residents were back training at OCF, and by November 1, our didactic programs were fully implemented, with the exception of our monthly visiting professor series, which resumes in January. We have seen our case volume increase dramatically due to the fact that there are only a handful of hospitals that are in full operation. Indeed, this November, we have exceeded the total number of anesthetics administered last November.

Unwavering Support

Through all this, what has been notable and consoling has been the outpouring of support from anesthesiologists and nurse anesthetists around the globe and from our professional organizations,



Survivors of Hurricane Katrina arrive at New Orleans Airport where FEMA had set up a medical hospital and where people were flown to shelters in other states. Photo courtesy of Michael Rieger/FEMA.

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Rethinking *the Role of Civilian Anesthesiologists* in Homeland Disaster Response

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In the aftermath of the devastation wrought by Hurricanes Katrina and Rita and their severe impact on the communities affected, it is important that each sector of our society take time to rethink and re-evaluate individual roles in disaster response. Images unfolding before us left little doubt that there was a system-wide emergency management failure. As such, a comprehensive evaluation of what went wrong and what worked well must be implemented at all levels. Undoubtedly this will lead to major revisions of local, state and national response plans.

Unprepared for a Catastrophic Disaster

As early as 1991, in a special article in the *Journal of the American Medical Association*,¹ Peter Safar, M.D., and I concluded that the United States was not prepared to deal with the consequences of a catastrophic disaster. We called for immediate changes in federal disaster response policy. An assessment of the adequacy of local, state and federal disaster planning and preparedness is needed but is beyond the scope of this article. Instead I would like to focus on the role of the civilian anesthesiologist in homeland disaster response. Does this role need to be updated?

No Two Disasters the Same

One of the important principles of disaster response is that no two disasters are the same. Each disaster will have a different set of needs and priorities. Therefore health care workers require flexibility to adapt to changing situations unfolding during a disaster. Some disasters will generate casualties requiring immediate surgical services — other disasters will not. Traditionally hospital disaster plans direct anesthesiologists to report to the operating room (O.R.) when any disaster strikes. This practice may not always be the most effective use of anesthesiologists.

To illustrate this point, I will briefly present past and future disaster scenarios, where the expertise and skill of anesthesiologists working outside the O.R. could have been, was and will be crucial to lifesaving efforts.

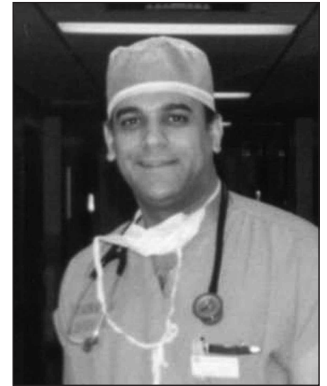
In 1984, 27 tons of methyl isocyanate gas leaked from a holding tank at the Union Carbide plant in Bhopal, India, causing exposure to more than 600,000 people and respiratory injury to 200,000. More than 6,000 died due to asphyxia resulting from acute lung injury, chemical pneumonia and respiratory distress syndrome, many for lack of immediate respiratory management.² This was the largest industrial incident in the history of mankind and serves to foreshadow the consequences of a chemical terrorist attack on a major urban center.

In a 1995 Tokyo subway attack, 5,500 victims were exposed to high concentrations of the lethal organophosphate gas sarin, resulting in 11 deaths. Severely ill victims experienced immediate difficulty in breathing and excess secretions leading to respiratory compromise. The medical response to treat cardiac and respiratory arrest among victims was effective in preventing deaths.³

Worst Is Yet to Come

The worst case scenario of all, however, is yet to come and may not involve terrorism. An avian flu pandemic is expected in the near future.^{4,5} A vaccine is currently not available. If and when one becomes available, it may not be manufactured in time or in sufficient quantities to avoid widespread illness. Gauging from experiences in the 1918 influenza pandemic that resulted in 500,000 deaths in the United States alone, it is not unreasonable to expect that today many thousands will require respiratory therapy and intensive care services. The nightmare scenario of thousands dying from treatable respiratory failure because of shortages of ventilators or inadequate respiratory management is a grim possibility. Undoubtedly there will be an extraordinary need for intensive care beds, ventilators, respiratory therapists, respiratory equipment and experienced physicians to help manage these patients.

What further rationale is there for expanding the role of the civilian anesthesiologist in the response to disasters in the United States? Anesthesiologists are acute care physicians with special expertise in airway management, physiologic monitoring, patient stabilization and life support, volume



Ernesto A. Pretto, Jr.,
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“The nightmare scenario of thousands dying from treatable respiratory failure because of shortages of ventilators or inadequate respiratory management is a grim possibility.”

resuscitation and crisis management. These are among the most important emergency medical functions in a disaster. When not needed in the O.R., this skill set will be in short supply outside of it. In disasters, including wars, anesthesiologists have and will continue to serve crucial roles in the resuscitation and anesthetic management of trauma victims in the familiar setting of the O.R., military field hospitals and, in isolated cases, at the scene of injury (i.e., amputations for extrication of victims buried under heavy rubble). But when a disaster generates a different set of priorities, as illustrated above, this role should be expanded to include supporting roles in emergency rooms and intensive care areas, and perhaps, leadership of mobile respiratory (airway) management teams (a new concept). These new roles should be incorporated into existing hospital disaster plans.

Anesthesiologists' Role

What are the specific tasks anesthesiologists can perform in a disaster? The following is an incomplete list of some key life-saving emergency care functions anesthesiologists are well qualified to perform in a disaster:

- Sort, triage, stabilize and resuscitate casualties in the field, emergency room and O.R.
- Establish definitive airway control
- Provide external hemorrhage control
- Diagnose and treat life-threatening nonsurgical conditions commonly observed among victims of disasters (i.e., acute respiratory failure, acute renal failure, poisoning with organophosphates, hemothorax or pneumothorax)
- Establish central venous access
- Guide fluid resuscitation and blood component therapy
- Perform regional or general anesthesia wherever needed or feasible
- Transport critically ill, unstable patients
- Manage acute pain among survivors

- Alleviate pain and suffering among victims triaged to die
- Manage critically-ill patients in the intensive care unit (ICU) or in ICU-designated (nonintensive care) areas.

The ability of anesthesiologists to more effectively participate in these activities is enhanced by learning advanced trauma life support, principles of disaster management and by becoming more familiar with field anesthesia techniques and equipment.

Planning Is Needed

In summary, past and future disaster scenarios demonstrate the need to plan for disasters that will require both surgical and nonsurgical care. In homeland disasters causing widespread acute respiratory injury, civilian anesthesiologists can play a crucial, lifesaving role. To enhance this capability, it may be prudent to plan for mobile respiratory or airway management teams. Because of the times in which we live, it behooves us to rethink our traditional role in disaster response and plan for new exigencies.

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Katrina: A Different Perspective at the Ochsner Clinic Foundation

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particularly the American Society of Anesthesiologists, the American Board of Anesthesiology, the Association of Anesthesiology Program Directors/Society of Academic

Anesthesiology Chairs and the Accreditation Council for Graduate Medical Education Residency Review Committee for Anesthesiology. At every step of the way, we are grateful for their support and guidance in helping us to lead our training program through this unprecedented disaster.

EAB Report:

Coping With Resident Duty Hour Limitations in Anesthesiology

Christopher E. Swide, M.D., Associate Professor
Robert E. Shangraw, M.D., Ph.D., Professor

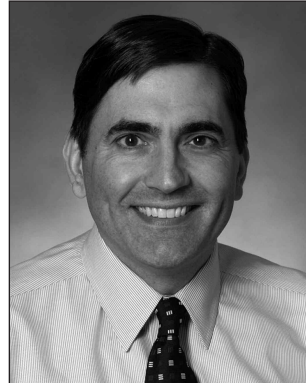
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In July 2003, the Accreditation Council for Graduate Medical Education (ACGME) instituted duty hour limitations that apply to all residents. This is commonly known as the “80-hour work week.” The duty hour rules, however, entail more than an 80-hour work limitation, and, in fact, the 80-hour work week in practice is the easiest component with which to comply. Program directors must be very familiar with ACGME rules and ensure compliance within their programs. Resident duty hours are meticulously reviewed by site visitors and by the residency review committees (RRCs) in all specialties. The purpose of this article is to explain some features and help program directors in anesthesiology conform their programs to the new resident duty hour rules.

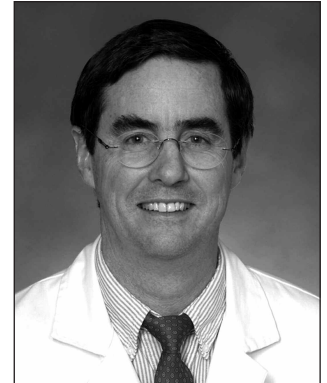
Duty hour rules are included in the common ACGME program requirements and in specialty-specific requirements. Individual RRCs can make their duty hour rules more restricted than the common requirements but may not allow their specialty rules to be noncompliant with the common requirements. The common requirements of all ACGME programs can be found on the ACGME Web site at: <www.acgme.org/acWebsite/dutyHours/dh_dutyHoursCommonPR.pdf> .

The 80-hour work week: This is one of the most commonly misunderstood requirements. ACGME does allow residents to exceed working 80 hours in a given week as long as they *average* less than 80 hours per week over a four-week period. The four-week period is not a “rolling” four-week period but is intended to be a specific rotation in a four-week block or a calendar month rotation. Most anesthesiology programs can easily conform to this requirement due to postcall days and proper scheduling of resident assignments.

One day in seven free of all educational and clinical responsibilities: This is another area where citations can occur. The ACGME common program requirements define a day off as a continuous 24-hour period. While a 24-hour period after a night of in-house call technically meets this definition, it is the intent of ACGME for these periods to provide appropriate rest time for residents. A program that only provides postcall days as days off is at risk of a citation for violation of resident work hour limitations. Some specialty RRCs have specifically addressed that the “day off” per week should be a “calendar day.” Anesthesiology program directors are encouraged to provide “real” day off duty — that is, a day where a resident wakes up in his or her own home with the day off as well as postcall days from in-house call. It is impor-



Christopher E. Swide, M.D.



Robert E. Shangraw, M.D.,
Ph.D.

tant that programs provide a complete 24-hour period off, meaning that residents should be relieved from educational obligations (such as didactic sessions) as well as in-house patient management and evaluation on their off days. A day off after at-home call, where the resident does not have to appear in the hospital, does meet the requirement of a 24-hour day off (a calendar day).

Adequate time for rest after duty periods: ACGME requires a rest period after all duty periods. The recommendation is 10 hours; however, this can be adjusted for educational reasons such as “critical didactic lectures” or cases of great educational value to a resident, such as rarely seen pathology. Exceptions to the 10-hour break rule, however, require specific justification, which translates that program directors are best served to provide full 10-hour break periods between duty periods to ensure compliance.

24 + 6 rule: Residents may not be on continuous in-house duty for a period exceeding 24 hours. They may, however, stay up to six additional hours after the 24 continuous hours to complete paperwork, attend teaching sessions, transfer care of patients or maintain continuity of care. They may not take on new patients. To have a resident start a case after 24 hours would be a violation, but having him or her complete an ongoing case would not. It is noteworthy that if a resident remains on duty for more than 24 hours, the overlapped day is automatically disqualified as a “day off.”

At-home call or pager call: Residents who take call from home are excused from the 24 + 6 rule and the frequency of call rule (no more than every third night averaged over four weeks). At-home call, however, must not be so burdensome that the resident is frequently in-house at night. There have been frequent citations for inappropriately designating call slots as “pager” call to avoid duty hour rules. Program directors must closely monitor pager call to ensure compliance and

avoid citations in this area. When a resident is on “pager call,” the hours spent in-house do count toward his or her weekly duty hours. These residents also still must be provided at least four 24-hour periods free of all duties over the course of four weeks’ time.

Moonlighting: In-house moonlighting within the resident’s training institution(s) does count toward the resident duty hours. In contrast, moonlighting outside of the training institution(s) does not count toward the resident’s work hour limitation. This rule is designed to prevent programs from obscuring working hours by using “moonlighting” residents to provide call coverage in an attempt to circumvent duty hour limitation rules. It also is designed to ensure that all residents meet the same duty hour standard in the teaching institution.

Exceptions to the 80-hour limit: The RRC for Anesthesiology does not currently allow exceptions to the 80-hour limit.

Outside rotations: Program directors are responsible for duty hour violations for their residents at all times, even if on rotations with other departments or in other institutions. This is a frequent source of duty hour citations.

ACGME uses several methods to determine compliance with duty hour rules. The gold standard for evaluating compliance is the site visit as part of the scheduled RRC review. ACGME also elicits input from residents via required resident surveys. Either a specialty RRC or ACGME also may receive direct complaints from residents about a specific program.

At our institution, we became aware of a duty hour compliance issue through the ACGME resident survey. We met with the residents and quickly identified the problem on an intensive care unit (ICU) rotation managed by another department. We met with involved faculty members and with residents who had done this rotation. Two patterns quickly became clear. First, the residents spent an inordinate amount of time “prerounding” to have notes ready for faculty signature by 7 a.m. One resident had been coming in at 3 a.m. to be ready at 7 a.m.! These prerounding stints, caused by a 7 a.m. deadline for the ICU faculty signature for billing matters, were responsible for driving work hours above an 80-hour

“Since ACGME does not mandate a specific monitoring system, program directors within an institution should communicate with one another regarding best practices to ensure compliance.”

average over the four-week rotation. We corrected the problem by changing the ICU “staff signature time” to early afternoon and limited prerounding to no more than one hour before rounds. The second problem was finding “four days off.” Scheduling these days into the call schedule, and communicating to the residents that they could not come in on these off days, solved this problem. These changes brought the rotation into compliance for all the programs utilizing this unit for training.

Duty hour rules must be clearly explained to the residents. Further, all departments must have written policies on this topic to ensure compliance. Institutions have a responsibility to monitor compliance in all residents. Since ACGME does not mandate a specific monitoring system, program directors within an institution should communicate with one another regarding best practices to ensure compliance. It is advisable to set up a system that allows residents to freely report duty hour violations in a confidential manner. These systems can be developed in coordination with the institution’s graduate medical education (GME) office to give residents the ability to report concerns to a nondepartmental individual who can in turn help the department program director address the concern. At our institution, we set up a duty hours “hot line” for residents through the GME office. When a duty hour violation is reported, a subcommittee of faculty and residents evaluates the complaint and determines how it should be handled. The subcommittee is empowered to institute a “stat internal review” to quickly investigate and help program directors solve the problem. Program directors must take all duty hour violations seriously and work with their faculty members and the institution to ensure compliance.

Hurricane Katrina Affects Nearly 20,000 Physicians

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are trying to practice in other jurisdictions or as volunteers in the state. Mississippi has suspended the application process for physicians holding unrestricted licenses in order to accommodate volunteer physicians and to help absorb displaced doctors.

These data were drawn from the March 2005 American Medical Association Masterfile of physicians (current as of December 31, 2003) and FEMA-posted information as well as data reported by the Association of American Medical Colleges, Tulane University and Louisiana State University Medical Schools, the Texas Board of Medicine and the state of Louisiana.

Richard Austin Elwyn, M.D. (1930-2004)

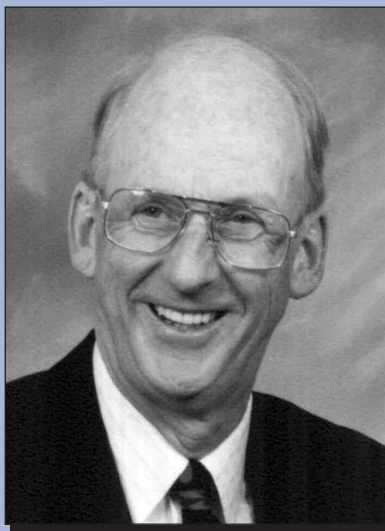
A Tribute to a Pioneer Utah Pediatric Anesthesiologist

Carter M. Ballinger, M.D.
Denver, Colorado

Richard “Dick” Elwyn was born on June 14, 1930 (Flag Day) in Sault Saint Marie, Michigan. He was the only child of Foss and Mildred Elwyn. His father was a school superintendent, and his mother was a teacher. While in high school, Dick was an honor student, played football and baseball and was in the Thespian Society. After two years at Albion College in Albion, Michigan, Dick enrolled in the Michigan Army National Guard and later served in Korea, Japan and England. He attended officer candidates school, graduating as Second Lieutenant in 1953.

Following graduation from Albion College in 1954, Dick began medical school and married Olive Manson on June 25, 1955, in Elmhurst, Illinois. In 1958, Dick graduated from the University of Michigan Medical School in Ann Arbor and moved west to Denver for an internship at Presbyterian Hospital.

In 1959 he moved to Salt Lake City, Utah, for residency training in anesthesiology. Following his residency, he received a fellowship in pediatric anesthesiology at Boston Children’s Hospital with Robert Smith, M.D., and faculty. Dick ultimately finished his fellowship at the University of Utah. He then joined the University of Utah anesthesiology faculty. Wanting to focus his practice on pediatric anesthesia, Dick aspired to join the staff at Primary Children’s Medical Center (PCMC). Although this facility had no openings, Dick acquired privileges and made himself available for emergencies or add-on cases. In 1966 he officially joined the anesthesia group at PCMC. A few years later,



Pediatric Anesthesiologists, Inc. was born on March 31, 1969.

Some further facts about Dr. Elwyn:

- From 1967 until 1973, he served as a District Director of the American Society of Anesthesiologists.
- From 1966 though 1974, he was Resident Director of Anesthesia at PCMC in Salt Lake City.
- In 1974 he became president of the Utah State Society of Anesthesiologists.
- In the 1970s, he was secretary of the PCMC staff.
- He served as Chairman of Anesthesia from 1974-79 at PCMC.
- In 1977, he helped form the first outpatient surgery unit at PCMC and served as the medical director from the opening of the facility in 1978 until his retirement in 1992.

Dick spent much of his 30-year career at PCMC. He was recognized as the first full-time pediatric anesthesiologist in Utah. He earned respect for his calming, winning ways with children. Dick used hand puppets to calm youngsters. “It would distract little patients from worries of the moment,” said anesthesiologist Roger Jones, M.D. “And there were plenty of those.”

Together with fellow anesthesiologists Wallace Ring, M.D., and John Adair, M.D., Dick helped to create “RAE tubes” (see photos below), so named for the last name initials of those three anesthesiologists. These tubes facilitated surgery on the neck, airway, face, etc., in little patients. At first, RAE tubes were individually made by anesthesiologists by hand for each patient. Pipe cleaners were used to keep warmed endotracheal tubes bent into the final desired shape before they were

allowed to cool and be inserted in their patients. Today these tubes are commercially produced in various sizes, and they no longer go by the name of “RAE” tubes.

Another early accomplishment of Dr. Elwyn and his associates at PCMC was the provision of emergency respiratory treatment of life-threatening croup and epiglottitis in young children. They used positive pressure ventilation and the inhalation of vaporized racemic epinephrine to produce calming, life-saving respiratory therapy for young patients without the need for often-delayed and dreaded emergency tracheotomies.

Dick was involved with the organization of Interplast and helped Interplast to obtain its first equipment. Near the end of Dick’s practice, Dick and Olive accompanied



Oral RAE tube with preformed acute-angle bend, left, and a series of nasal tracheal tubes, from 3.5 to 7.0 mm. I.D., showing acute-angle preformed bend.

“Dick spent much of his 30-year career at PCMC. He was recognized as the first full-time pediatric anesthesiologist in Utah.”

several Utah surgeons to Central American and South American countries to help provide anesthesia for surgical procedures on needy children. In 1991, the Utah State Medical Society named Dick the International Physician of the Year.

Dick retired on June 30, 1992, after practicing almost 30 years at PCMC. Following his retirement, Dick and Olive left Salt Lake City to build and live in a home in Star Valley Ranch at Thayne, Wyoming. During winters, they lived in Surprise, Arizona, a fast-growing suburb near Phoenix.

But then a serious medical problem threatened Dick and the happiness of his family, as they explained in their annual Christmas letter of December 2003. Dick was diagnosed with myelodysplastic syndrome. A bone marrow biopsy confirmed it, and treatment options were explored. A bone marrow transplant was the only definitive treatment available, but this was ruled out for many reasons. Dick ended their Christmas letter with this low-key postscript to us:

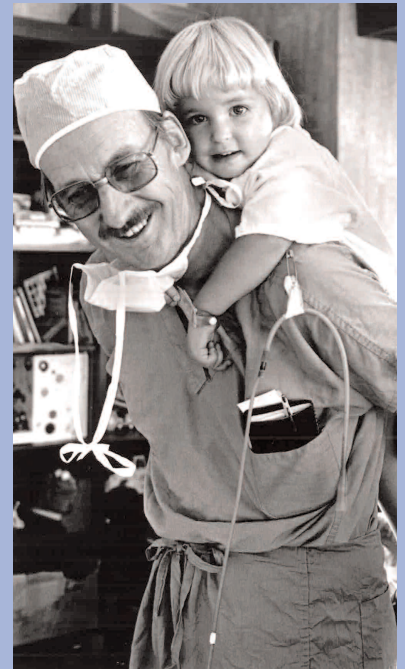
Not much more to say. We remain upbeat! I had a Christmas card from Bob Smith, M.D. [formerly Chief at Boston Children's Hospital]. He just had his 91st birthday. He is in a care center and his wife is in an Alzheimer facility. Getting old is not for sissies!

Dick died in Surprise, Arizona, on December 18, 2004. More than 200 family members, friends and professional colleagues attended Dick's funeral service on December 23, 2004, in Surprise. They recalled how many lives Dick touched, his professional accomplishments, his sense of humor, his hobbies and his devotion to his family. In the eulogy given by Barry J. Anderton, M.D., a fellow anesthesiologist friend from PCMC, he recalled and discussed Dick's life. He pointed out that Dick had many interests besides just making a living prac-

ting anesthesiology. He loved to spend time with Olive and their four children and 10 grandchildren. He helped with the scouting program, went rafting on the Colorado River in the Grand Canyon, played golf and often attended professional sports games in the arenas of Salt Lake City.

The family has asked that contributions celebrating Dick's life be sent to the Aplastic Anemia and Myelodysplasia International Foundation, P.O. Box 613, Annapolis, MD 21404-0613.

For a copy of Dr. Elwyn's bibliography, contact Faye Moore or Donna Groves in the PCMC Anesthesiology Office, 100 North Medical Drive, Salt Lake City, UT 84113; telephone (801) 588-3270 or fax (801) 588-3279.



United Council for Neurologic Subspecialties Approves Neuro-Intensive Care for Membership

The United Council for Neurologic Subspecialties (UCNS) has approved its fifth subspecialty membership. The neurological subspecialty area of neuro-intensive care was approved for membership by the UCNS Board in October 2005.

The Neuro-Intensive Care application was sponsored by the American Academy of Neurology's (AAN's) Critical Care and Emergency Neurology Section, the Neurocritical Care Society and the Society of Neurosurgical Anesthesia and Critical Care.

Membership is the first step in UCNS accreditation and certification process. The UCNS Accreditation Council will now work with the subspecialty on requirements for fellowship programs. Then programs will be able to apply to become accredited by the UCNS. The UCNS Certification Council, via its Examination Committee, also will work with the subspecialty to develop the

examination that will be used in certifying individuals. In addition, as a member of UCNS, the neuro-intensive care subspecialty will be granted one voting seat on the UCNS Board of Directors.

The UCNS is an independent, nonprofit, professional medical organization sponsored by five parent organizations: the AAN, American Neurological Association, the Association of University Professors of Neurology, the Child Neurology Society and Professors of Child Neurology.

Its primary mission is to provide for accreditation and certification with the goal of enhancing the quality of training for physicians in neurological subspecialties and the quality of patient care.

The UCNS is designed to recognize added competence and to assist subspecialties that have matured to the point where accreditation of training programs and certification of graduates is appropriate, yet these subspecialties are not able to seek, or have not grown sufficiently for, American Board of Psychiatry and Neurology certification.

For more information, please contact Mari Mellick, CAE, UCNS Director at <mmellick@ucns.org> or (651) 695-2719; <www.ucns.org>.

International TraumaCare Today



James G. Cain, M.D.
President, International TraumaCare
Director, Trauma Anesthesia, Children's Hospital of Pittsburgh
Associate Professor, University of Pittsburgh

International TraumaCare (ITC) was founded two decades ago as the International Trauma Anesthesia and Critical Care Society (ITACCS). Membership now numbers nearly 2,000 with members and leadership from all trauma care specialties. ITC's scope is global. Interaction among international colleagues with diverse backgrounds and experiences invariably leads to new and exciting ideas and solutions.

International Chief Emergency Physician Program

ITC's International Chief Emergency Physician (ICEP) program is one example of new growth and ideas. We live in uncertain times, facing ever-growing prospects of terrorism and mass casualties worldwide along with an increasingly hostile natural environment. ICEP develops expertise in managing mass casualties. Formal training in on-scene trauma care leadership and systems management is central to the ICEP program. ICEP programs have been held in concert with governments throughout the world, most recently in New Zealand in July 2005. ITC's next ICEP program will be hosted in Romania this fall.

"TRIGER"

ITC has reinvigorated its research endeavors with the formation of the Trauma and Resuscitation International Group for Experimentation and Research (TRIGER). ITC recognizes the constraints of increasing clinical demands, diminishing funding and increasingly restrictive regulatory environments. TRIGER was formed as a multidisciplinary central clearinghouse to facilitate contact between researchers along with funding groups such as industry and government. TRIGER also is establishing an independent institutional review board panel as a component to facilitate compliance with an increasingly complex regulatory environment.

Emphasis on Education

ITC's hallmark is education, providing state-of-the-art trauma care education to improve trauma patients' health and welfare worldwide. The Annual Trauma Anesthesia and Critical Care Symposia provide a scientific forum for traumatologists. The recent TraumaCare 2005 Paris and TraumaCare 2004 Sydney brought together traumatologists from all continents except Antarctica to discuss and exchange ideas and information with the common goal of improving care of the trauma patient. ITC looks forward to TraumaCare 2006 Chile, TraumaCare 2007 U.S.A. (ITC's 20th anniversary) and TraumaCare 2008 Japan. ITC's Accreditation Council for Continuing Medical Education-accredited programs such as "Trauma: the Team Approach" are also exceptionally popular,

reaching a large and varied audience. ITC's educational efforts do not end with these programs. ITC counts more than 100 major trauma care textbooks and monographs. ITC's most definitive textbook to date will be in print within the next few months. Last, but certainly not least, ITC's peer-reviewed journal, *TraumaCare*, is essential reading for all desiring to remain current in international trauma care.



James G. Cain, M.D.

Helping Developing Nations

Improving trauma care in developing nations also is an important ITC mission. ITC assists national and international organizations in developing trauma care guidelines, educational programs and systems. A variety of educational and supportive programs are in place to assist countries. The Latin American Trauma Anesthesia and Critical Care Society ("LAT-ACCS"), a reinvigorated South American societal component, is central to these efforts. A Spanish/English TraumaCare educational program will be hosted in Panama soon. Chile will host TraumaCare 2006, the 19th Annual Trauma Anesthesia and Critical Care Symposium, September 26-29, 2006.

Worldwide Scope

The breadth of ITC is one of its strengths. Sharing ideas and experiences with those around the world gives ITC unique perspective. Often we find shared issues, and occasionally we find marked differences. Among shared issues recently coming to the forefront among anesthesiologists within ITC is the concern of how best to evaluate and care for trauma patients at risk of spinal cord or column injury requiring airway management. ITC's international survey noted that despite a number of published guidelines, including from advanced trauma life support and the Eastern Association for the Surgery of Trauma, marked differences in practice patterns exist not only when comparing international centers to U.S. centers but also even between U.S. centers located within a few miles of each other. Nonetheless, the over-riding theme was frustration in the inconsistency. Anesthesiologists were particularly frustrated that others' actions — such as disregard for published guidelines, inconsistent trauma team documentation of neurological and cervical spine exams and/or the refusal of radiology departments to perform, evaluate and provide reports of studies in a timely fashion — directly impact anesthesia patient care. In view of these concerns, ITC established a committee to study and formulate an updated set of guidelines. These guidelines shall be the first such with significant anesthesia involvement in their development.

Different Roles in Different Countries

One marked dissimilarity between U.S. and international anesthesiologists is U.S. anesthesiologists' rather limited scope of practice. Anesthesiologists are the leaders of trauma teams for a large portion of the world. Anesthesiologists not only care for trauma patients in the operating room but also are first responders at trauma scenes. They direct trauma care from the receiving bay in the emergency department through the critical care unit. In this role, anesthesiologists are indispensable and uniformly held in higher regard by medical colleagues. Sadly, while American anesthesiologists once led a spectrum of advances in trauma care, they have now largely deserted or allowed themselves to be marginalized in many aspects of trauma care. Emergency medicine physicians provide prehospital and hospital-receiving care, even supplanting anesthesiologists in many centers as emergency airway management experts. Notably, some of you may have even recently received a mass mailing from an emergency medicine physician inviting anesthesiologists to attend his difficult airway management seminars.

Critical Care to the Forefront

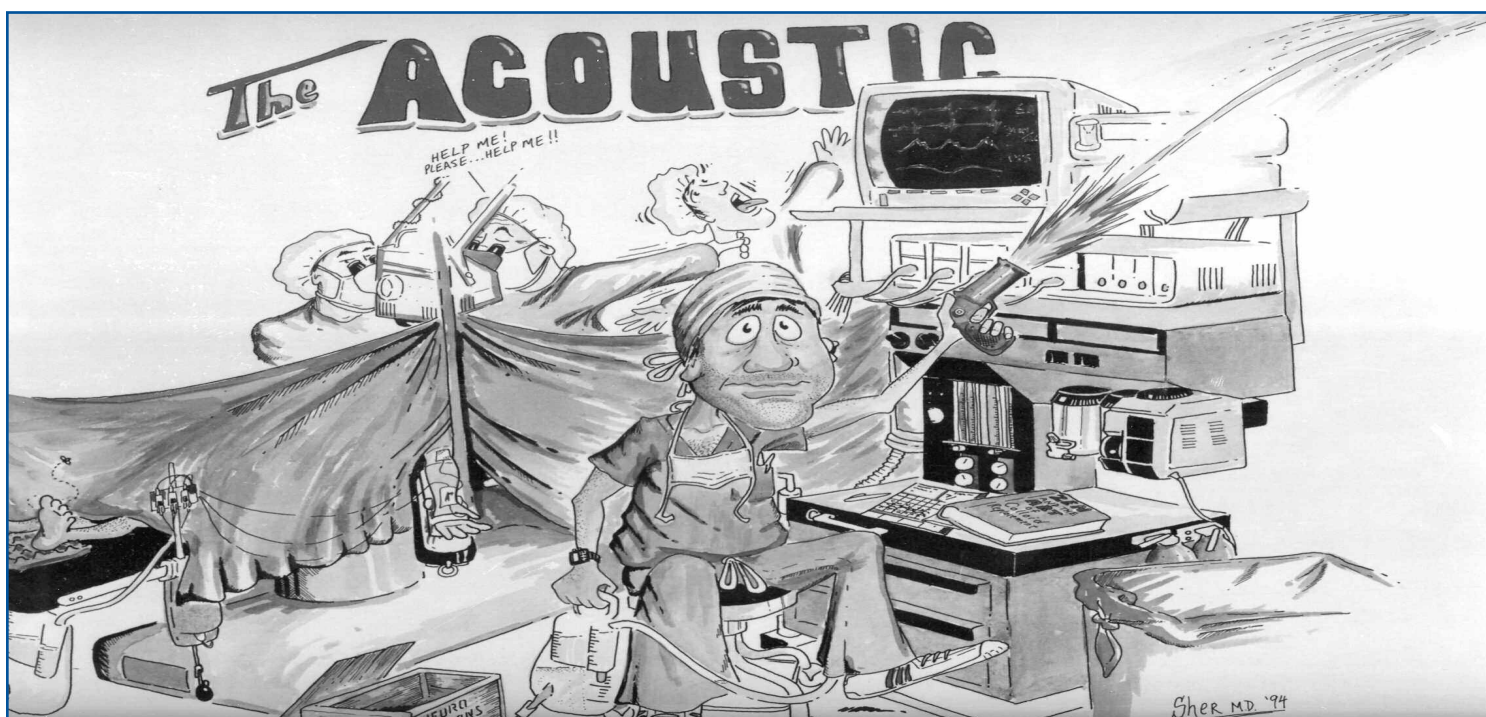
Another area of U.S. trauma care originally led by anesthesiologists, yet now with diminishing anesthesia involvement, is critical care medicine. Despite a recent push to staff critical care units with full-time intensivists due to economic pressures exerted by such groups such as LEAPFROG upon health care systems, critical care medicine continues its trend of staffing the majority of critical care units with pulmonary intensivists. While recent discussions suggested increasing emphasis on critical care in anesthesiology residency training, a variety of largely economic reasons have abated such efforts. This is unfortunate for patients and anesthesiologists. Anesthesia intensivists' unique background as perioperative physicians and their comfort with managing rapidly changing

physiologic conditions of exceptionally ill and traumatized patients along with ventilator management and hemodynamic management offer an unparalleled skill-set to care for the critically ill and injured.

Such limitation in scope of practice amazes international traumatologists. They are shocked to find U.S. anesthesiologists constantly striving for respect from medical colleagues. They also find the notion inconceivable that physician extenders could replace anesthesiologists given the scope of medicine anesthesiologists practice elsewhere. While recognizing that economics have played an important role in shaping anesthesiology's current position in U.S. medicine, both in the development of fields such as emergency medicine and the reduction of anesthesia involvement in critical care medicine, the future of anesthesiology will be ensured by making U.S. anesthesiologists as indispensable as are anesthesiologists elsewhere in the world. Anesthesiologists must take visible roles in the development of trauma programs and systems in their institutions and communities. ITC is fortunate that there is a significant number of international and U.S. anesthesia leaders among its members to provide such leadership. Strong, visible leadership is necessary to provide mentors and role models for those now entering medicine and anesthesiology.

Never-ending Mission

In closing, ITC continues its mission to ensure excellence in trauma care through educational, research and supportive endeavors. Upcoming years will present numerous challenges for traumatologists. We must provide trauma care leadership in our institutions and communities to ensure safety for our friends and family. International TraumaCare enhances the opportunity for excellence in trauma care. I invite you to visit ITC's Web site at <www.itaccs.com> and look forward to seeing you at an upcoming ITC program.





AUA

Membership Nominations Deadline Is February 7, 2006

All AUA members are invited to nominate candidates for membership in the association. Qualifications for active membership are: An individual a) who occupies and has occupied a faculty position in anesthesiology in a medical school or its affiliated teaching hospital in the United States or Canada for at least 24 months, following completion of graduate university residency training in anesthesia, and b) whose work as anesthesiologist, teacher or investigator gives promise of a successful career in academic anesthesia. However, c) individual exceptions to the above residency qualifications shall be made at the discretion of the Executive Council when one of the following two conditions apply: 1) when the candidate has had a course of graduate training in anesthesia of a high standard or 2) when the candidate has shown a continued productive interest in, and contribution to, academic anesthesia.

The Council recommends for election by the general membership those candidates who seem best qualified. In Council's deliberations, great emphasis is placed on excellence in areas of pertinence to the goals of the Association. This year, the Council is requesting that the nominator identify — from among the areas of teaching, administration and research — the one in which the candidate is most outstanding. The nominating letter should discuss accomplishments and contributions in teaching, research, administration and patient care, but should emphasize the identified area of excellence.

The Council seeks evidence of a nominee's impact on anesthesiology beyond his or her own institution and of activity of more than local interest. Such documentation should be as objective and non-anecdotal as possible. Ensuring that all the documentation is in order will facilitate consideration of the nomination. Lack of documentation of achievements and lack of supporting letters are frequent causes of failure of a nomination.

Although the AUA is primarily oriented toward U.S. and Canadian anesthesiologists who have actively contributed to academic anesthesiology, occasionally it is appropriate to provide Honorary Membership to anesthesiologists residing in other countries. Honorary Membership in the AUA should be limited to those few exceptional individuals who have made sustained and significant contributions to the specialty. Their contributions should have significantly and fundamentally altered the practice of anesthesiology and/or enhanced the understanding of basic science related to anesthesiology. These individuals and their accomplishments should be known and recognized by most, if not all, members of the AUA. The reason for such Honorary Membership should be clearly stated by the nominators, emphasizing how such recognition would benefit the AUA. The format for nominations is the same as for Active Members; nominators should also state the willingness of the nominee, if elected, to meet the same meeting attendance requirements as Active Members.

Early submission is encouraged. To submit via AUA's Web site, visit www.auahq.org. Deadline for receipt of all information (nominating letter, seconding letter, curriculum vitae, list of peer-reviewed grant funding and list of referees) is **February 7, 2006**. If nominations are not submitted via the Web site, all correspondence (*in Microsoft Word only*) should be included on a CD and sent to:

Steven J. Barker, Ph.D., M.D.
Secretary
Association of University Anesthesiologists
520 N. Northwest Highway
Park Ridge, IL 60068-2573

Criteria for Election to Membership in the Association of University Anesthesiologists (Revised December 1, 2005)

General Principles:

1. The criteria for election to membership in the AUA should be relatively consistent from year to year, although they would be expected to evolve over time.
2. The criteria for election to membership in the AUA should be available in written form to members of the AUA.
3. The membership of the AUA should have the opportunity to provide input into the criteria for membership.
4. AUA members who nominate candidates for election to AUA should base nominations on comparison of candidates to the criteria for election.
5. The fundamental criterion for membership in the AUA should be substantial evidence of creative research scholarship or scholarly educational activities relevant to the field of anesthesiology.
6. Scholarly educational activity and research scholarship should be weighted equally in election of members; however, scholarly educational activity must be sustained for a considerable time period (no less than seven years) whereas outstanding evidence of research scholarship may be sufficient evidence for a promising young investigator (such evidence could include receipt of a highly competitive federal grant and publication as first or senior author of high-quality, peer-reviewed manuscripts). Election should be encouraged of clearly outstanding candidates who are relatively early in their careers.

7. Academic leadership (e.g., national society officers, membership or chairmanship of national academic committees) suggests research or scholarly educational activity but does not constitute sufficient evidence of scholarship.
8. Attainment of an administrative title (e.g., department chair, program director) or academic rank (e.g., associate professor) suggests research scholarship or scholarly educational activity but does not constitute sufficient evidence of scholarship.
9. Longevity in an academic department of anesthesiology does not constitute sufficient evidence of scholarship.

Application of Weighting System for Nominating and Evaluating Candidates for Membership:

1. Every candidate will be evaluated in comparison to a possible 100-point scale.
2. Of that scale, scholarly educational activity accounts for a maximum of 40 points, research scholarship accounts for a maximum of 40 points and academic leadership accounts for a maximum of 20 points.
3. The number of points in an individual category should be determined by comparing the candidate to semi-quantitative profiles.
4. Candidates receiving less than 25 points are not eligible for election in the AUA. 25 points are necessary but may not be sufficient for election in the AUA. Final decision regarding membership is based upon review of all materials received by the Council.

Semi-quantitative Weighting Profiles (*profiles are provided as barometers of relative achievement at various stages of academic careers; candidates may not meet each component of any individual profile but should resemble one profile more than others*):

1. Scholarly Educational Research (no more than 40 points in this category)

- A. 40 points:** Sustained history, for example, (at least 10 years) of presenting national lectures on topics relevant to anesthesiology. Multiple (three or more) prestigious lectures (e.g., ASA Refresher Courses; IARS Review Courses; subspecialty society plenary lectures). Multiple (10 or more) visiting professorships in academic departments. Multiple (10 or more) first-authored, peer-reviewed original publications relating to anesthesiology topics. Multiple (10 or more) first-authored book chapters in highly regarded texts. Editing of a highly regarded textbook related to anesthesiology. Selection to the editorial board of a national or international anesthesiology journal.
- B. 30 points:** Sustained history, for example, (at least five years) of presenting national lectures on topics relevant to anesthesiology. Two or more prestigious lectures (e.g., ASA Refresher Courses; IARS Review Courses; subspecialty society plenary lectures). Several (five or more) visiting professorships in academic departments. Several (five or more) first-authored, peer-reviewed original publications relating to anesthesiology topics. Several (five

or more) first-authored book chapters in highly regarded texts. Selection to the editorial board of a national or international anesthesiology journal.

- C. 20 points:** One or more national lectures on topics related to anesthesiology. Multiple (three or more) regional lectures on topics related to anesthesiology (e.g., state society lectures). Several (three or more) visiting professorships in academic departments. Several (three or more) first-authored, peer-reviewed original publications relating to anesthesiology topics. Several (three or more) first-authored book chapters in highly regarded texts. Substantial production of non-peer-reviewed teaching materials (e.g., Web sites, teaching manuals).
- D. 10 points:** Program director of an academic residency. “Best Teacher” awards from an academic residency.

2. Research Scholarship

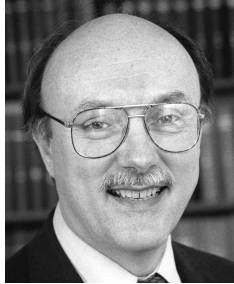
- A. 40 points:** Consistent record as principal investigator of competitive federal grants (10 years or more of funding). Service on national peer-review committees for grant reviews. Primary or senior author on 30 or more high-quality, peer-reviewed publications. Multiple (10 or more) invited national presentations on topics related to research. Multiple (10 or more) visiting professorships related to research. Selection to the editorial board of a high-impact national or international scientific journal.
- B. 30 points:** Principal investigator of competitive federal grants (five years or more of funding). Primary or senior author on 20 or more high-quality, peer-reviewed publications. Several (five or more) invited national presentations on topics related to research. Several (five or more) visiting professorships related to research. Selection to the editorial board of a high-impact national or international journal.
- C. 20 points:** First-time principal investigator of a competitive federal grant (e.g., NIH RO-1 or VA Merit Review). Primary or senior author on six or more high-quality, peer-reviewed publications. Several (three or more) invited national presentations or visiting professorships related to research.
- D. 10 points:** Recipient of NIH career development award (e.g., KO-8). Recipient of starter grant from FAER, IARS or subspecialty society. Primary author on five or more high-quality, peer-reviewed publications.

3. Academic Leadership:

- A. 20 points:** Officer of national medical or anesthesiology society (general or subspecialty). Major administrative responsibilities in an academic medical center (e.g., dean or associate dean, hospital CEO).
- B. 10 points:** Chair of academic anesthesiology department. Vice-Chair of academic anesthesiology department. Program director of academic anesthesiology residency. Committee membership on major national academic committee (e.g., ASA Committee on Research, ASA subcommittees for abstract reviews).

David E. Longnecker, M.D., Appointed to NASA Advisory Council

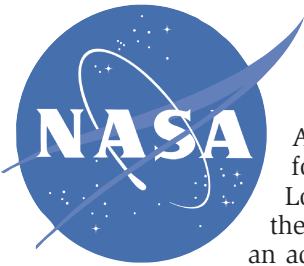
David E Longnecker, M.D., Robert D. Dripps Professor Emeritus and a Director in the Division of Health Care Affairs of the Association of American Medical Colleges (AAMC), has been appointed to the NASA Advisory Council. In 1967, the U.S. Congress directed NASA to form an Aerospace Safety Advisory Panel (ASAP) to advise



the NASA Administrator on safety issues and hazards in NASA's aerospace programs. This and another advisory committee structure were combined in 1977 to form the NASA Advisory Council (NAC) and its standing advisory committees, which focus on particular program areas. The NAC is the highest level advisory group within NASA, working directly with NASA Administrator Michael Griffin. Current membership includes such luminaries as Neil Armstrong, Apollo 11 astronaut (first on the moon), and the Hon. Harrison H. Schmitt, Apollo 17 astronaut (last on the moon) and former Senator from New Mexico.

As Chair of the Committee on Aerospace Medicine and Medicine for Extreme Environments, Dr. Longnecker will be working with the Exploration Committee and with an ad hoc life sciences committee that includes Stephen I. Katz, M.D., Director of the National Institute of Arthritis, Musculoskeletal and Skin Diseases, and Mr. Schmitt to review NASA's life sciences strategies.

For more information about the NAC, visit < www.hq.nasa.gov/office/oer/nac > .



University of Michigan's Ralph Lydic, Ph.D., Named to NSBRI External Advisory Council

Ralph Lydic, Ph.D., Bert LaDu Professor and Associate Chair for Anesthesiology Research at the University of Michigan, Ann Arbor, has been named to the External Advisory Council for the National Space Biomedical Research Institute (NSBRI).



The NSBRI, funded by NASA, is a consortium of institutions studying the health risks related to long-duration space flight. The Institute's External Advisory Council is composed of leaders in research fields central to the Institute's mission and advises management on strategic issues and programmatic effectiveness.

Through ongoing National Institutes of Health (NIH)-funded projects in his University of Michigan laboratory (and previously at Penn State), Dr. Lydic is studying the brain mechanisms that cause opioids, volatile anesthetics and sleep to depress breathing. He will advise the NSBRI's Human Performance Factors, Sleep and Chronobiology Team.

Dr. Lydic received his doctorate in physiology from Texas Tech University in Lubbock, Texas, and postdoctoral training at Harvard Medical School in Boston. Prior to joining the faculty of the University of Michigan, Dr. Lydic was the Julien F. Biebuyck Professor and Director of Anesthesia Research at the Pennsylvania State University College of Medicine in Hershey, Pennsylvania, where he served from 1986-99.

The NSBRI's research and education program involves investigators at more than 70 institutions and government laboratories across the United States. Projects address space health concerns such as bone loss, muscle weakening, cardiovascular changes, sleep disturbances, immunology, infection, balance and orientation problems, radiation exposure, nutrition, neurobehavioral and psychosocial factors and remote-treatment technologies.



AUA is proud to announce that the following AUA members are also members of the Institute of Medicine (IOM). IOM members are elected on the basis of their professional achievement and commitment to service to address critical national issues and give advice to the government and the public. Current IOM membership is around 1,400.

Michael J. Bishop, M.D.
VA Medical Center Anesthesia Services

Robert H. Brown, M.D.
Johns Hopkins University

Robert M. Epstein, M.D.
University of Virginia

Thomas F. Hornbein, M.D.
University of Washington

John P. Kampine M.D., Ph.D.
Medical College of Wisconsin

Richard J. Kitz, M.D.
Harvard University

David E. Longnecker, M.D.
American Association of Medical Colleges

Edward D. Miller, M.D.
Johns Hopkins University

Ronald D. Miller, M.D.
University of California-San Francisco

Debra A. Schwinn, M.D.
Duke University

Jeanine P. Wiener-Kronish, M.D.
University of California-San Francisco

Warren M. Zapol, M.D.
Harvard Medical School

AUA 53rd Annual Meeting

Loews Ventana Canyon, Tucson, Arizona

May 11-13, 2006

Thursday, May 11, 2006

- 12 noon - 9 p.m. Registration
- 1 - 1:30 p.m. Introduction and Welcome
Steven J. Barker, Ph.D., M.D.; Charles W. Otto, M.D.;
C. Michael Crowder, M.D., Ph.D.
- 1:30 - 3 p.m. Oral Presentations
- 3 - 3:30 p.m. Break and Poster Viewing and Discussion
- 3:30 - 6 p.m. Moderated Poster Discussion Session

Friday, May 12, 2006

- 7:50 - 8 a.m. Introduction to the 53rd Annual Meeting
Steven J. Barker, Ph.D., M.D. ; Keith Joiner, M.D.
- 8 - 9:45 a.m. EAB Program: Fatigue, Sleep and Anesthesia
- 8 - 8:05 a.m. Symposium Relevance for Practitioner and Patient
Peter Rock, M.D.; Ralph Lydic, Ph.D.
- 8:05 - 8:25 a.m. Impact of Sleep Deprivation on Clinical Care
Charles A. Czeisler, Ph.D., M.D.
- 8:25 - 8:45 a.m. Alpha-2 Receptors for Regulation of
Wakefulness
Mervyn Maze, M.B., Ch.B., F.R.C.P., F.R.C.A.
- 8:45 - 9:05 a.m. Sedating Drugs Have a Prolonged Effect on Sleep
J. Lance Lichtor, M.D.
- 9:05 - 9:25 a.m. Fatigue and Anesthesia Safety
Steven K. Howard, M.D.
- 9:25 - 9:45 a.m. Question and Answer Session
- 9:45 - 10:15 a.m. Break and Poster Viewing and Discussion
- 10:15 - 11:45 a.m. EAB Program: Managing Intergenerational Issues in
Academic Anesthesiology
- 10:15 - 10:45 a.m. Overview: Unique Characteristics of Different
Generations in the Workplace
Peter Rock, M.D.; Robert E. Shangraw, M.D., Ph.D.
- 10:45 - 10:55 a.m. A Vice-Chairman of Resident Affairs' Perspective on
Generational Issues in the Resident/Medical Student
Workforce
Charles W. Whitten, M.D.
- 10:55 - 11:05 a.m. The Effect of the New Generation(s) on the Function
of an Academic Department
Patricia A. Kapur, M.D.
- 11:05 - 11:15 a.m. What About Our Product? Expectations of a Private
Practice Group
Michael A. Ramsay, M.B.
- 11:15 - 11:45 a.m. Question and Answer Session
- 11:45 a.m. - 1 p.m. Luncheon

- 1-2 p.m. NIH Session: Being an Effective Advocate for Research
Funding
Lawrence S. Goldstein, M.D.
- 2 - 2:30 p.m. ASA President's Update
Orin F. Guidry, M.D.
- 2:30 - 2:45 p.m. Break and Poster Viewing and Discussion
- 2:45 - 4:15 p.m. AUA President's Panel Mentorship in Academic
Anesthesiology
- 2:45 - 2:50 p.m. What Is the Issue?
David L. Brown, M.D.
- 2:50 - 3 p.m. Academy of Mentors at UCSF
Ronald D. Miller, M.D.
- 3 - 3:10 p.m. Dartmouth Mentoring
D. David Glass, M.D.
- 3:10 - 3:20 p.m. Research Mentorship
Jeffrey R. Balsler, M.D., Ph.D.
- 3:20 - 3:30 p.m. What Is FAER Doing About
Mentorship?
John P. Kampine, M.D., Ph.D.
- 3:30 - 4:15 p.m. Discussion Session

Saturday, May 13, 2006

- 8 a.m. - 12 noon University of Arizona
Host Program
Keith Joiner, M.D.
Steven J. Barker, Ph.D., M.D.
- 8 - 8:50 a.m. Lightning - A Striking Phenomenon
E. Philip Krider, Ph.D.
- 8:50 - 9:40 a.m. The People and Pottery of Grasshopper Pueblo
J. Jefferson Reid, Ph.D.
- 9:40 - 10:10 a.m. Break and Poster Viewing and Discussion
- 10:10 - 11 a.m. Planetary Exploration at the University of Arizona and
the Discovery of Sub-surface Ice on Mars
William V. Boynton, Ph.D.
- 11 - 11:50 a.m. Nature's Logbook - Tree Rings and Our Changing
Environment, Malcolm K. Hughes, Ph.D.
- 12 - 1:30 p.m. Group Luncheon
- 1:30 - 3 p.m. Oral Presentations
- 3 - 4 p.m. Moderated Poster Session
- 4 - 5 p.m. SAB Plenary Session; Protection of Myocardium
Against Ischemia and Reperfusion Injury
David C. Wartier, M.D., Ph.D.

Visit www.auahq.org
For more information

AUA

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Vacant

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Tulane Anesthesia Department Responds to Katrina

Continued from page 1

hometowns and many others choosing to stay within the Tulane system working in south Texas hospitals. The hurricane and flood represented a loss of homes and produced significant family separations and dislocations with considerable financial stress. Fortunately the Anesthesia Foundation-ASA Disaster Relief Fund provided a \$2,500 grant-in-aid to help defray Katrina-related expenses for each resident committed to continuing his/her career in anesthesiology.

According to Department Chair and current Program Director Melvin C. Gitlin, M.D., the 174-year-old Tulane School of Medicine is committed to regrouping and continuing on after this enormous challenge, as is the Tulane Department of Anesthesiology and residency program. At the moment, although the Tulane Medical Group already is actively practicing in New Orleans, the surgical volume is not yet sufficient to sustain a return of anesthesiology and perioperative personnel to New Orleans. There is now, however, a massive influx of workers with the expectation that this represents the beginning of a new clinical base. As displaced New Orleans residents return and these workers settle, surgical volume should follow, and with that, the Tulane anesthesiology program will regenerate.

The American academic anesthesiology community in general, along with singular support of the South Texas Anesthesia Alliance, has been overwhelmingly supportive of the Tulane program, representing a "magnificent effort," according to Dr. Gitlin, to allow the Tulane anesthesiology residency program to be sustained.

Editor's note: *Information for this article was provided by Corey Sher, M.D., Dr. Conlay and Dr. Gitlin.*

"I would like to thank the American academic anesthesiology community for its overwhelming support for my department during our period of challenge. A magnificent effort by the anesthesiology departments of the Baylor College of Medicine, the University of Texas M.D. Anderson Cancer Center, the University of Texas at Houston and the University of Texas Medical Branch in Galveston has enabled us to maintain our residency. While it is undeniably true that we have experienced unprecedented challenge, I have no doubt whatsoever that if we can endure and persevere, Tulane's anesthesiology department will "weather the storm." Hurricane Katrina has witnessed the worst and best of human behavior; the academic anesthesiology community is to be lauded for its response to this historic event."

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