AUA
Association of University Anesthesiologists

Update

Summer 2006

AUA 53rd Annual Meeting

May 11-13, 2006

Tucson, Arizona

Reception held at Pima Air and Space Museum, Tucson, Arizona

Mingling outside

Pres. Kennedy's Air Force One

New friendships made

Dr. Brown and Dr. Hines

Old friendships renewed

AUA ice sculpture

Chatting with residents

Proposed Changes in CMS Teaching Rule:

A Vital Element in Ensuring the Future of Academic Anesthesiology

Roberta L. Hines, M.D.
AUA President-Elect

Roberta L. Hines, M.D.

The financial impact of the current Centers for Medicare & Medicaid Services (CMS) teaching rule on academic anesthesiology is well-known by anyone who has been involved in it for the past decade. A brief review of the present state of affairs follows for those unfamiliar or new to academic anesthesiology.

As a result of historical negotiation with CMS, anesthesiologists are currently reimbursed at a rate of only 50 percent (for each resident) of the standard Medicare reimbursement when teaching/supervising two residents. Anesthesiology is the only specialty where this reduced reimbursement policy for teaching exists. As you are likely aware, our colleagues in surgery bill 100 percent for each resident they teach/supervise, as long as they comply with Medicare's definition of availability for "critical portions" of the procedure. The impact of this CMS regulation on reimbursement is estimated to be $400,000 for the "average" academic department's anesthesiology training program with a total cost of $32 million to all approved training programs.

> *"The implications of this 50-percent reduction for resident teaching extend far beyond the immediate consequences of its impact on recruiting and retaining talented faculty."*

Presently this methodology applies only to Medicare patients. Some commercial payers such as United Healthcare, however, have attempted to apply similar payment reductions in several states. Will other third-party payers be far behind? I suspect not. At first glance, the significance of reimbursement methodology for anesthesiology teaching may appear to have only a nominal impact on our overall academic mission, but its short- and long-term ramifications are profound. The implications of this 50-percent reduction for resident teaching extend far beyond the immediate consequences of its impact on recruiting and retaining talented faculty. As we implement strategies aimed at encouraging the development of educational excellence and those that foster the growth of clinician scientists, the dollars lost as a result of this methodology will significantly impede our efforts to support faculty development. This lost revenue also translates into decreased support for young investigators interested in a research career.

At our 53rd Annual Meeting in Tucson last May, the membership heard wonderful and inspiring presentations highlighting novel mentorship programs aimed at faculty development and innovative strategies for increasing peer-reviewed funding. Without sufficient financial resources, however, we in academic anesthesiology will continue to struggle on an uneven financial playing field. The field threatens to become even more imbalanced if we are not successful in reversing this discriminatory CMS policy. Perhaps that old phrase of "no margin, no mission" says it all.

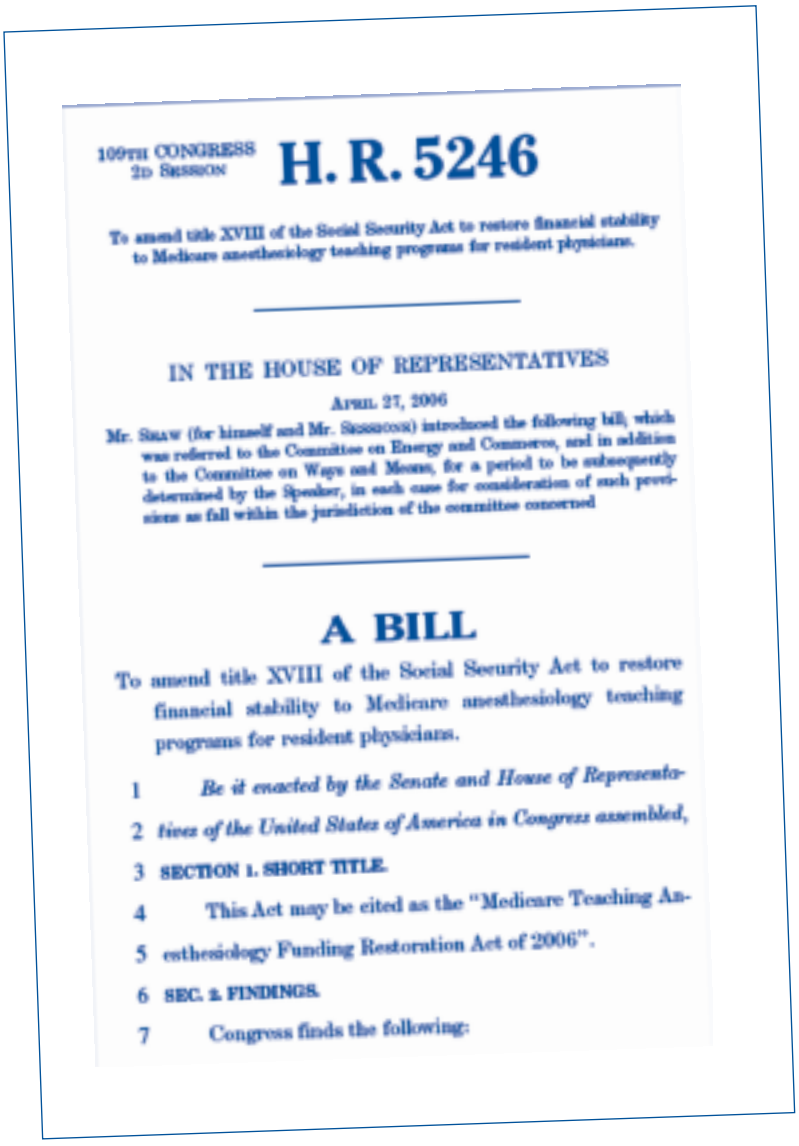
I urge all of you to become actively engaged in current efforts by the American Society of Anesthesiologists to revise the current CMS teaching rule reimbursement methodology to establish parity with the payment methodology afforded to colleagues engaged in resident education. Just think of the amazing opportunities that $32 million would provide for augmenting research and supporting education.

ASA President Delivers Stirring Talk at AUA Meeting

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

American Society of Anesthesiologists (ASA) President Orin F. Guidry, M.D., gave a riveting talk on May 12, 2006, at the AUA 53rd Annual Meeting that discussed several issues of concern to academic anesthesiologists. These included sedation rules, the upcoming movie "Awake," the post-Super Bowl "Grey's Anatomy" episode and, among other things, the Centers for Medicare & Medicaid Services (CMS) teaching rule, which I address here.

Dr. Guidry explained the Medicare 50-percent payment penalty for anesthesiology teaching programs and the serious implications of this policy. The financial ramifications of this policy present serious obstacles for the advancement and perhaps future viability of academic anesthesiology and are more fully discussed in the article by AUA President Roberta L. Hines, M.D., on the previous page.



109TH CONGRESS
2D SESSION

H. R. 5246

To amend title XVIII of the Social Security Act to restore financial stability to Medicare anesthesiology teaching programs for resident physicians.

IN THE HOUSE OF REPRESENTATIVES

APRIL 27, 2006

Mr. SHAW (for himself and Mr. SESSIONS) introduced the following bill, which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to restore financial stability to Medicare anesthesiology teaching programs for resident physicians.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Teaching Anesthesiology Funding Restoration Act of 2006".

SEC. 2. FINDINGS.

Congress finds the following:

W. Andrew Kofke, M.D., M.B.A.

I believe academic anesthesiology has undergone substantial negative changes in the course of my 25-year career and cannot help but believe that these reimbursement rules have contributed to it. Financial pressures created by the 50-percent payment penalty have contributed to the demise of programs throughout the country. Alarmingly, before the policy went into effect in 1994, there were 162 anesthesiology teaching programs nationwide. In 2006, there are only 130, with more programs on the brink of closure.

If programs continue to close, medical students could be hindered from pursuing the medical specialty of anesthesiology, and, more importantly, the tradition of anesthesiologists creatively contributing to ongoing advances in medicine will be placed in jeopardy, to patients' detriment. Without a change to current policy that would alleviate the financial pressures on academic anesthesiology programs, America's patients could see substantially decreased availability of medically provided anesthesiology care.

Because of these important issues, for years now ASA has been urging CMS to change the reimbursement rules for teaching anesthesiologists to reflect reimbursement policies used for other physicians. Despite verbal agreements, the rules mysteriously never made it into the final version of their regulations, year after year. There has been significant to-and-fro communication between CMS and ASA. A recent notable communication to ASA:

"We stated in the final rule that we would continue to review the information and data presented by the commenters and to consult with relevant stakeholders, including the American Society of Anesthesiologists and the ***American Association of Nurse Anesthetists****…"* [emphasis added].

Despite the fact that the 50-percent payment penalty only affects anesthesiologists, the American Association of Nurse Anesthetists (AANA) has consistently fought against full funding for anesthesiology teaching programs. Their opposition efforts are disappointing and perplexing, since nurse training programs are wholly separate from anesthesiology medical residency programs. Nonetheless CMS is treating AANA as a stakeholder in this issue of reimbursement for physician services.

After years of futile interactions with CMS, ASA is now seeking a legislative fix to the teaching rule payment penalty. In May, Representatives Clay E. Shaw (R-FL) and Pete Sessions (R-TX) introduced H.R. 5246, the Medicare Teaching Anesthesiology Funding Restoration Act of 2006. Rep. Fortney "Pete" Stark (D-CA) introduced H.R. 5348, and Senator David Vitter (R-LA) introduced S. 2990 in the Senate. All of these

Continued on page 12

University of Chicago *to host* AUA 54th Annual Meeting

Jonathan Moss, M.D., Ph.D.
Jeffrey L. Apfelbaum, M.D.
University of Chicago

The University of Chicago will host the AUA 54th Annual Meeting on April 26-28, 2007. The primary location for the meeting is the Sheraton Hotel and Towers in downtown Chicago. Tours of the University of Chicago campus, five miles south of downtown Chicago in Hyde Park, will be available.

The University of Chicago was incorporated in 1890 and founded by John D. Rockefeller. During the subsequent 106 years, more than 70 Nobel Prize winners have been associated with the university as faculty members, students or researchers. Areas of current international recognition include economics, law and physics. The university has had a profound impact on American higher education with its reputation as the "teacher of teachers" — more than one out of seven graduates opts for a career in education.

Notable faculty have included Milton Freidman, George Stigler, James Heckman, Gary Becker and Robert Fogel, each of whom received the Nobel Prize in economics. In the sciences, Enrico Fermi conducted the first self-sustaining nuclear chain reaction on December 2, 1942, which initiated the modern nuclear age under the field stands at the University of Chicago. Charles Huggins received the Nobel Prize for his work on hormonal treatment of prostate cancer. REM sleep also was first described at the University of Chicago by Nathaniel Kleitman, Ph.D.

The Division of Biological Sciences and the University of Chicago Hospitals (which is ranked among the top 16 hospitals in the nation by *U.S. News & World Report*) sits in the middle of the university complex. The Department of Anesthesia and Critical Care is chaired by Jeffrey L. Apfelbaum, M.D. Anesthesiologists perform the full range of perioperative medical services, including operating room anesthesia, preoperative assessment and management, management of acute and chronic pain patients and full participation in critical care medicine.

All anesthesiology subspecialties are included within the clinical expertise of the department, which administers more than 26,000 anesthetics per year in 30 operating rooms, off-site locations and in a full-service obstetrical site. Anesthesiologists attend in the surgical, medical and cardiothoracic and burn intensive care units. Comer Children's Hospital, which opened in 2005, is immediately adjacent to the University of Chicago Hospitals. Preoperative assessment and management, under the leadership of Bobbie Jean Sweitzer, M.D., is an important component of the anesthesiology program and is recognized nationally. Currently there are more than 50 faculty members in anesthesiology, critical care and pain medicine at the university. Nine current members of the faculty are AUA members. Numerous other AUA members have been faculty or have been trained at the University of Chicago.

University of Chicago campus, south of downtown Chicago in Hyde Park.

Members of the department have had leadership positions throughout the medical center in the practice plan, medical school executive committees and health care system, the medical staff organization, tenuring and promotion committees, the institutional review board and the institutional animal care and use committees. Specialties of the institution include cardiac and lung transplantation as well as an emphasis on translational research.

Research

Research in the Department of Anesthesia has always been a key mission. Given the outstanding basic science research on campus and the proximity of the hospital complex, the university provides ample opportunity to integrate research efforts. In the early days of the department, the pioneering work was on blood gases and physiologic monitoring. Subsequently the molecular locus of anesthesia was determined.

At present the psychopharmacology of anesthetic drugs and agents is investigated in the Psychomotor Laboratory under the leadership of James Zacny, Ph.D., and Dr. Apfelbaum. This laboratory offered the first evidence of nitrous oxide as a reinforcing agent and was the first to identify the abuse potential of propofol. Dr. Zacny's work on prescription drug abuse has been acknowledged by continuous National Institutes of Health (NIH) funding over the past decade.

A robust NIH-funded program in basic sciences is led by Daniel McGehee, Ph.D., and Ming Xu, Ph.D., who do seminal work in the central neuropharmacology and molecular biology of drug reinforcement. Research by Steven Roth, M.D., focuses on understanding the biology of neuroprotection of the eye and on the clinical manifestations of visual loss after anesthesia. The Tang Center for Herbal Medications, which is chaired by Chun-Su Yuan, M.D., is unique in the country for its studies of the efficacies and safety of medicinal herbs and dietary supplements and the mechanisms by which herbal products act.

The Tang Center opened at the university in early 2000 with a generous gift from the Cyrus Tang Foundation. Dr. Yuan also serves as editor of the *Textbook of Complementary and Alternative Medicine* and editor-in-chief of the *American Journal of Chinese Medicine*. The Cognitive Technologies Laboratory (directed by Richard Cook, M.D., and Mark Nunnally, M.D.) and the Patient Safety Laboratory (directed by Stephen D. Small, M.D.) have both been recognized nationally and internationally for their efforts in promoting safety within our specialty.

Clinical research has been a strong component of the research effort at the University of Chicago. Among the faculty doing clinical research are John E. Ellis, M.D., Wendy B. Binstock, M.D., William A. McDade, M.D., Ph.D., Allan Klock, M.D., Dr. Sweitzer, Jimmy Xie, M.D., Mark A. Chaney, M.D., Patricia M. Gramling-Babb, M.D., David B. Glick, M.D., Thomas W. Cutter, M.D., Michael F. O'Connor, M.D., Dr. Nunnally and Avery Tung, M.D. Dr. Tung's laboratory effort investigates sleep in the same building where REM sleep was first identified. Research in the intensive care unit by Dr. Chaney, Dr. O'Connor, Dr. Nunnally and Dr. Tung has greatly contributed to our overall knowledge of patient care. Recently methylnaltrexone, a peripheral opiate antagonist developed in our laboratory by Dr. Yuan and Jonathan Moss, M.D., Ph.D., was licensed to a major pharmaceutical company. Studies with this drug have permitted differentiation between the central and peripheral effects of opiates and are expected to benefit patients with chronic pain or postoperative ileus. Dr. Moss' outstanding efforts in academic scholarship were recognized by his selection as convocation speaker at the University of Chicago in 2005.

Education

The Department of Anesthesia and Critical Care provides a full spectrum of education in anesthesiology, including undergraduate, graduate, medical student, resident and postgraduate training. The department currently accepts 16 new anesthesiology residents per year. It trains fellows in pain medicine, critical care and cardiac anesthesiology. The University of Chicago Medical Center, which includes the adjacent newly opened Comer Children's Hospital, provides numerous collaborative locations for training. The cooperation of the University of Chicago with the Argonne National Laboratories is another strength of the institution.

Associate Chair for Education, Jerome M. Klafta, M.D., directs the residency program and has received multiple awards for his abilities as an educator, including the 2002 International Anesthesia Research Society Anesthesiology Teaching Recognition Award. The University of Chicago's Pritzker School of Medicine student education, directed by Catherine Bachman, M.D., is the envy of all clinical departments in the medical center with the department of anesthesia and critical care faculty having been voted "best clinical faculty" by the Pritzker students eight of the past 10 years. One unique aspect of the department is the airway clinic, which specializes in management of the difficult airway. It is directed by Andranik Ovassapian, M.D. The department, under the direction of Dr. Moss, teaches an undergraduate course in the biology of pain and consciousness.

Beyond the university lies a vital and important city. Chicago has long been recognized as a business center in the United States for its options and commodities trading. Business, however, is only part of the Chicago story. Chicago also enjoys world-class museums, symphony, ballet and opera. Within the immediate venue of the conference is the museum campus of Chicago encompassing the Adler Planetarium and Astronomy Museum, the world-famous Field Museum and the John G. Shedd Aquarium. The Art Institute of Chicago in the South Loop is recognized as one of the premiere museums in the country. The Museum of Science of Industry, on the south side near the University of Chicago campus, has been recognized as an important museum and also is an interesting and worthwhile site to visit. The Chicago Symphony Orchestra and the Hubbard Street and Joffrey ballets offer other wonderful cultural opportunities for our members and their families. Chicago's theater scene, including plays at the Steppenwolf Theatre and literally dozens of other productions, is recognized as being among the best in the country. The comedy of Second City, the genesis for Saturday Night Live, is still a vital part of the entertainment venue. Jazz and blues performances are found throughout the city and close to the conference venue.

We are delighted to host the AUA 54th Annual Meeting and welcome you to our city and university.

SAB Annual Meeting Report

C. Michael Crowder, M.D., Ph.D.
Departments of Anesthesiology and Molecular Biology/Pharmacology
Washington University School of Medicine
St. Louis, Missouri

The scientific content at the 53rd Annual Meeting on May 11-13 in Tucson, Arizona, was typically diverse and represented the broad range of anesthesiology practice. Sixty-nine abstracts were presented, 12 as talks and the remainder as poster-discussions and posters. The oral presentations ran the gamut of the evolutionary tree. Two talks described genetic experiments in invertebrate model organisms, identifying genes required for hypoxic preconditioning in C. elegans and for an intact blood brain barrier in *Drosophila melanogaster*. Six studies utilized rodent models to define mechanisms for various clinically relevant conditions, including endotoxin-induced myocardial depression, hyperglycemia-mediated cell injury, bacterial-lipoprotein-triggered pulmonary inflammation, tactile allodynia, ischemic brain injury and xenon-induced preconditioning. A particularly provocative study in dogs suggested that cardiopulmonary resuscitation with 100 percent oxygen may worsen neurological outcome compared to pulse oximetry-guided management where O_2 was titrated to maintain mid-90 percent oxygen saturations. An outstanding translational study was reported where studies in rats led directly to a randomized, double-blinded, human trial testing the safety and efficacy of glutamine administration in critically ill patients where, indeed, glutamine administration was associated with a decrease in intensive care stay. Finally, the

One study showed that glutamine administration in critically ill patients was associated with a decrease in ICU stay.

results of two human studies were presented. One was a randomized, double blinded, placebo-controlled trial in 84 gynecological surgery patients which found, surprisingly, that on postoperative day one, patients anesthetized with isoflurane reported significantly higher pain scores and used more patient-controlled morphine than propofol-anesthetized cohorts. The other human study examined whether a known risk factor for dementia, the epsilon 4 allele of the apolipoprotein E gene, might increase the risk of postoperative delirium; and, in fact, in the 165 patients studied who underwent major noncardiac surgery, the epsilon 4 allele was associated with a three-fold increase in the incidence of postoperative delirium.

C. Michael Crowder, M.D., Ph.D.

The plenary talk this year was given by David C. Warltier, M.D., Ph.D. Dr. Warltier summarized work from his prolific career in the field of protection from myocardial ischemia. In particular, Dr. Warltier discussed the phenomenon of volatile anesthetic-induced preconditioning (AIP). Dr. Warltier's laboratory and his colleagues have been the leaders in describing AIP and defining the molecular and cellular mechanisms that are responsible for AIP. AIP can be viewed not only as a potential means to protect our patients from myocardial injury but also as a window into the intrinsic mechanisms that exist in myocardium to survive ischemia. Some of these mechanisms discussed by Dr. Warltier include a peculiar potassium channel subtype called the KATP channel. Myocardial KATP channels in mitochondria are activated by volatile anesthetics, and by a mechanism yet to be elucidated, the activated channel indirectly protects the myocardium from subsequent ischemic injury. Because of the work of Dr. Warltier and others, more specific activators of the KATP channel are being developed that may be utilized as drugs to reduce myocardial ischemic injury.

Finally, the National Institutes of Health (NIH) session this year was devoted to the current dismal plight of NIH funding and, more importantly, what we might do about it. This topic has already been discussed in the Spring 2006 AUA newsletter, so please refer to it for more details. In short, the current NIH budget is the tightest that it has been since the careers began of most active scientists. For the good of medical research in general and anesthesiology research in particular, we should become vocal advocates for increasing federal support for NIH. One easy way to keep abreast of legislation related to research funding is to join the Congressional Liaison Committee (CLC) < www.jscpp.org/clc.cfm, which is affiliated with the Joint Steering Committee for Public Policy < www.jscpp.org. Membership in the CLC is free and unobtrusive. Much the same way that the American Society of Anesthesiologists keeps us informed of important legislation impacting anesthesiologists, I receive e-mails from the CLC notifying me whenever legislation that impacts science funding is being considered, and I can respond by writing my representatives as I see fit. Please consider adding scientific advocacy to your political agenda.

In summary, the AUA Annual Meeting in Tucson continued the tradition of being the best American forum for discussion of anesthesiology research. I encourage all AUA members to attend the meeting next spring in Chicago and sponsor or present your latest work, or show your support for anesthesiology research while learning about the latest findings and advances in our specialty.

VHA Academic Expansion

Michael J. Bishop, M.D.
National Director of Anesthesia
Veterans Administration Central Office
Washington, D.C.

The Department of Veterans Affairs (VA)-Veterans Health Administration (VHA) is expanding the number of residency training positions in line with the recommendations of an external federally chartered advisory committee. The additional positions will have a major impact on VA training opportunities and will enhance patient care delivery as well. Currently the VA is focusing on:

- Facility-identified "critical needs"
- "Emerging specialties" (e.g., recently accredited specialties such as sleep medicine or neurology pain medicine)
- Affiliations for new VA facilities and
- Expansion of affiliations and sites of care

"GME Enhancement: Critical Needs and Emerging Specialties" positions <ww.va.gov/oaa/Archive/GME_Enhancement2006.doc> will be used to encourage VA sites to offer new or expanded residency programs in specialties critically needed for veteran care, either in existing or in new and emerging specialties. Wherever appropriate, innovative interdisciplinary or interprofessional training opportunities are strongly encouraged. Facilities may request positions in any combination of critical needs or emerging specialties. Requests may include fractions of positions and may be made in multiple specialties or in a single specialty, provided the facility has sufficient clinical workload to support the training objectives and VA faculty for each specialty requested. Eligible facilities must have 25 or more resident positions.

Specifically mentioned anesthesiology-related emerging specialties are Anesthesia Pain Medicine and Anesthesia Critical Care Medicine. The VA recognizes that although these specialties are greater than five years from Accreditation Council for Graduate Medical Education accreditation, they are relatively new to the VA or under-represented in the VA. In addition the VA graduate medical education enhancement calls for additional training in vascular and colorectal surgery, interventional cardiology, cardiac electrophysiology and neuroradiology, and all of these disciplines offer opportunities for training additional anesthesiologists to provide care in both the operating room and interventional suites.

Please discuss this new opportunity with your VA colleagues. Applications are due to the VA no later than August 2, 2006, for programs proposed for the 2007/2008 academic year (starting July 1, 2007).

Full information is posted on the VA's Office of Academic Affiliations Web site under the title of "Graduate Medical Education Enhancement" <www.va.gov/OAA>.

Michael J. Bishop, M.D.

"'GME Enhancement: Critical Needs and Emerging Specialties' positions will be used to encourage VA sites to offer new or expanded residency programs in specialties critically needed for veteran care, either in existing or in new and emerging specialties."

2006 Treasurer's Report

W. Andrew Kofke, M.D., M.B.A.
Treasurer

As of December 31, 2005, Society assets totaled $432,609, with somewhat more in investments than in the bank [Figure 1], and a modest revenue after expenses as indicated in Figure 2.

This past year, we decided to move investments from certificates of deposit to an investment portfolio. Although virtually risk-free, the CDs were deemed to be not liquid and with a poor rate of return. Merrill Lynch was enlisted to oversee the Society investments. The distribution of such investments was to be very conservative and is depicted in Figure 3.

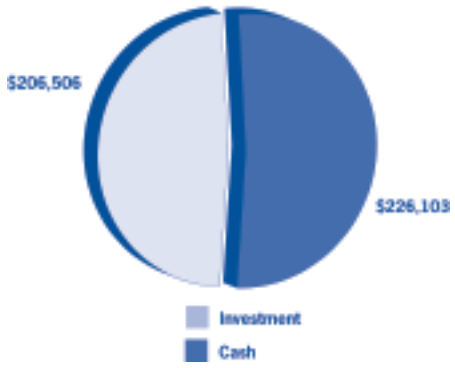
The return on these investments is thought to have been satisfactory for the year to date, July through April, running about 10 percent [Figure 4], producing a return of almost $20,000 [Figure 5].

Based on this performance and anticipated expenses, upon my recommendation, the council has approved placing another $50,000 in the Merrill Lynch account.

AUA is in satisfactory financial condition.

Figure 1

Balance Sheet



Income Expense Statement

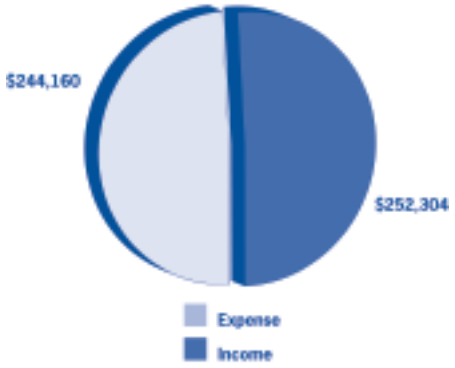
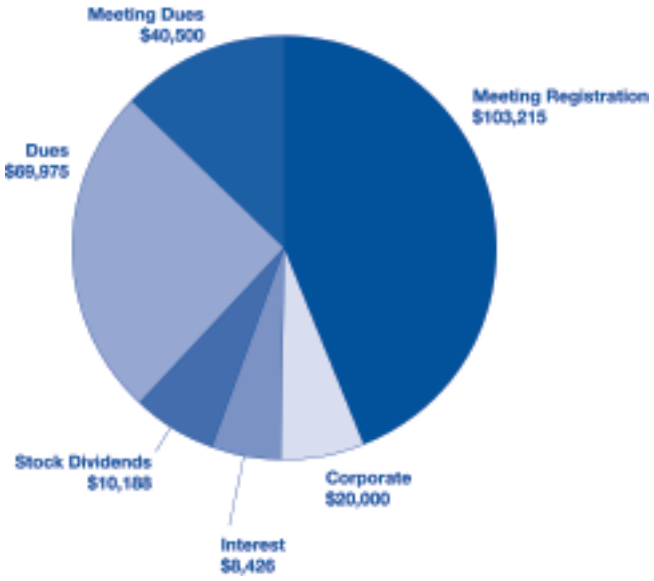
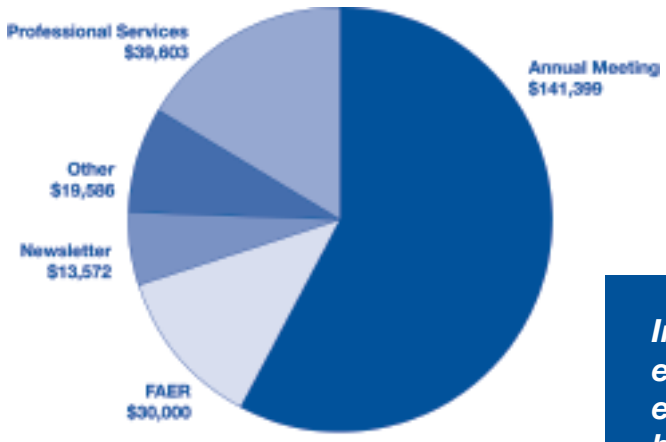


Figure 2: Income and Expenses

Income



Expenses



Income exceeded expenses by $8,144.

Figure 3: Investments

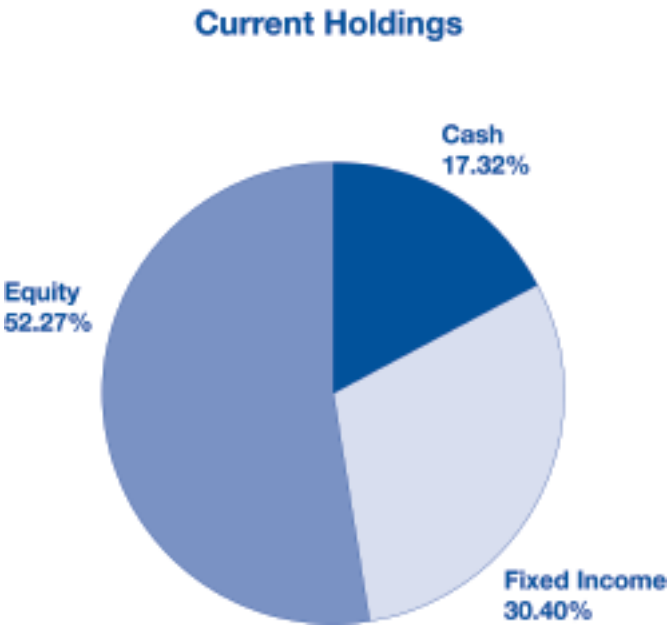


Figure 4: Asset Growth

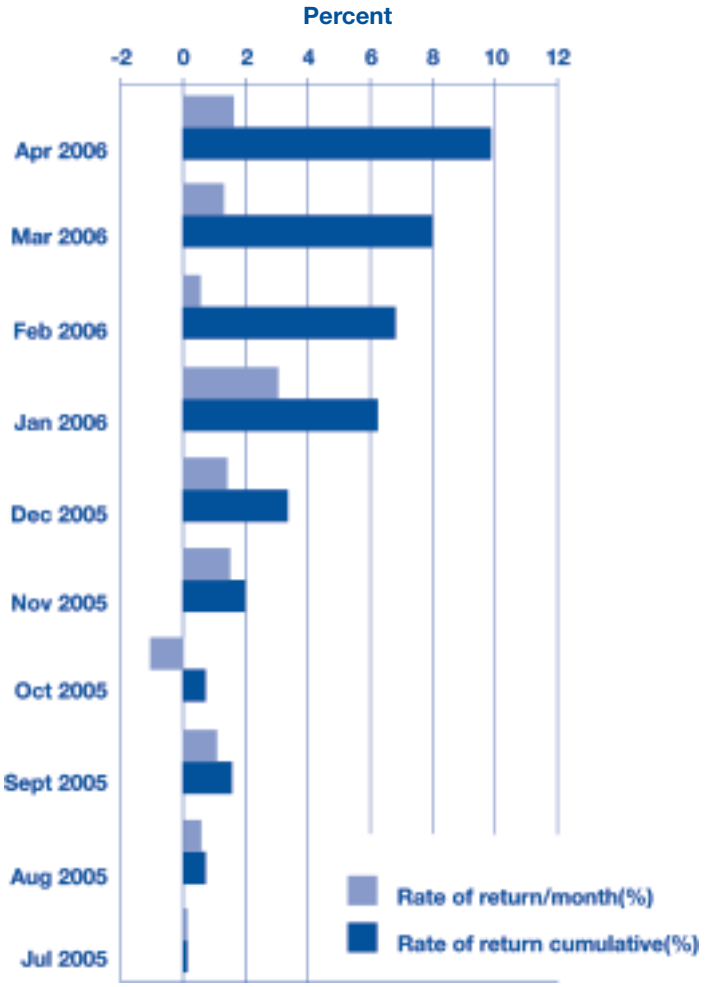
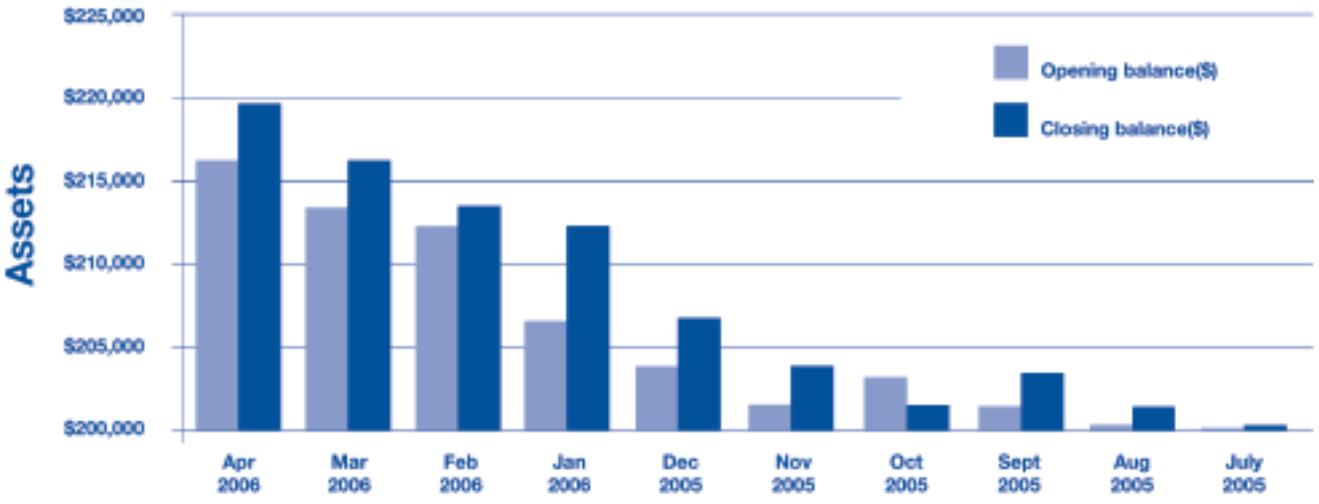


Figure 5: Investments

Asset growth after depositing $200,000 last year.



Recipes *for* Frying SPAM

Keith Ruskin, M.D.
Yale University
New Haven, Connecticut

Nigerian $26Mil Pays for Cut Rate Vi@gr@!!

To Whom It May Concern:

Greetings of the season to you. Please pardon the intrusive nature of this message, but I am in dire need of help and have found your name from a most reliable source. I have unearthed $26,000,000 (TWENTY-SIX MILLION) US dollars from a deceased client and wish to transfer it to the United States. I need a most reliable partner who can invest this money for me…

THIS STOCK IS ABOUT TO TAKE OFF!!! MONDAY WILL OPEN WITH A BANG FOR BJGN. TRIPLE YOUR MONEY WITH THIS STOCK NOW!

And after you've received your share of the TWENTY-SIX MILLION U.S. dollars and tripled it with BJGN, it's time to buy V!@G-RA and C:IA-L I S from an Internet pharmacy.

Spam, or unwanted commercial e-mail, is a huge problem, and it's getting worse: More than two-thirds of all e-mail is now thought to be spam. People who rely heavily on e-mail may receive more than 100 unwanted messages per day. If you have your own domain name, and you're really unlucky, you may become a victim of "spoofing." Being spoofed means that a spammer ran a program that found your domain name, either from its own spam lists or maybe by sniffing around databases or vulnerable e-mail services. The software then generates a series of fake addresses with that name on the end. This is used as the sender's addresses in the "From" and/or "Reply To" fields of their spam, which is then sent to unwitting strangers. For example, I've received spam that claims to be from <wyk1@ruskin.net>, <xpg@ruskin.net> or <steve@ruskin.net>. This is bad because you now get messages from angry people who think that you really sent them that advertisement about V1c0den.

What can you do? Although there is no perfect solution, a combination of software, mail services and common sense can make your electronic life much easier. Most importantly, don't reply to spam, and don't click the link that offers to remove your address from the list. This marks your e-mail address as being valid and increases its value for other spammers.

The first solution is to find an e-mail service provider that offers spam filtering. AOL, Verizon and Google's Gmail are just a few of the many low-cost services that filter e-mail before it even hits your inbox. Some medical centers and universities filter their employee's institutional e-mail. Most of the time, this works very well; but it's not a perfect solution. Some unwanted e-mail gets through, and if you happen to correspond with a company whose domain name has been used to disguise the true address of the spammer, important messages may be deleted before you even see them. Some services use their own filters, but many subscribe to commercial antispam services. The largest, Messagelabs <www.messagelabs.com>, is a leader in identification of new spam techniques and filters millions of messages per day. Messagelabs filters spam for large institutions (such as hospitals and medical schools) but others, like Peer to Peer <www.peertopeer.net, filter e-mail for people with a single mailbox, too.

Keith Ruskin, M.D.

"Whitelists" ensure that you receive e-mail only from people you want to hear from. Most e-mail providers offer this service, but whitelists are not a simple solution. Creating the whitelist initially requires a bit of work because it needs the e-mail address of every person from whom you wish to receive e-mail. The first time someone sends e-mail to an address protected by a whitelist, the sender receives a polite message asking for identification. This information is then forwarded to the recipient who can then decide whether or not to accept that message and all future e-mail. Once the whitelist is configured, it's only necessary to add new senders. In the beginning, though, there may be a delay while the sender of an important message is verified.

Your e-mail provider doesn't offer automatic spam filtering? You can still get good protection. Microsoft Outlook and Apple's Mail both offer automatic junk mail detection. Outlook's protection is automatic and works "out of the box" while Apple requires that you identify a message as junk. Similar messages are then automatically moved to a "junk" folder for review or deletion. I use the Apple product, and it marks between 30 and 50 messages per day. You also can install software on your computer to help manage the onslaught. The Norton Internet Security suite (available from <www.symantec.com>) comes with spam and spyware filters as well as antivirus protection. Qurb, from Computer Associates, blocks spam by creating a whitelist of recipients from whom you wish to receive e-mail. E-mail addresses in your address book, as well as e-mail addresses in sent messages, are automatically included. Messages from unknown recipients are analyzed, and if they do not appear to be spam, are placed at the top of a "quarantined" list. This

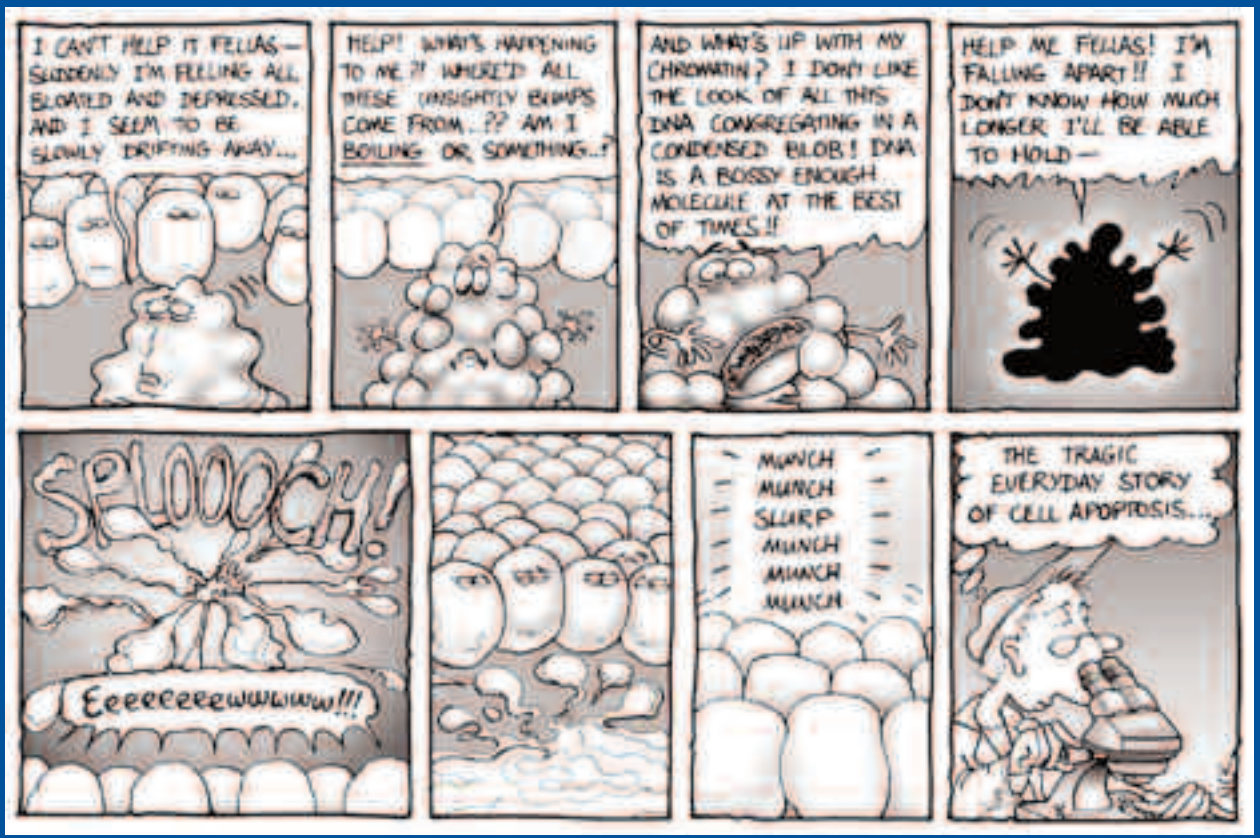
"Spam ... is a huge problem, and it's getting worse: More than two-thirds of all e-mail is now thought to be spam."

product was recently given the *PC Magazine* "Editor's Choice" award. You can download this program from <www.qurb.com>.

It's also important to be careful with e-mail that may appear to be legitimate. According to a recent survey, half of all adults in the United States have had direct personal experience with computer fraud. One common method called "phishing" is used to get credit card or bank account information. This scam involves sending an e-mail message that usually alleges that the recipient's bank account has been corrupted and then directs the computer to a realistic Web page with a login screen. As soon as the victim enters an ATM card number and PIN, the scammers use the information to withdraw money. Some Web pages also ask for identifying information such as driver license or Social Security numbers.

Some scams have been around for years, but con men are now using the Internet to recruit new marks. The "Advance Fee" fraud is the most common. Victims are asked to help move a fortune out of a war-torn country but are constantly asked to forward money for purported fees, bribes and the like. In fact, a recent article in *The New Yorker* tells the story a psychologist who fell victim to this scheme, was cheated out of hundreds of thousands of dollars, and spent time in jail for defrauding his patients. Needless to say, if a deal sounds too good to be true, it probably is, so just delete suspicious messages without answering them. Sending a reply will only result in more e-mail. If you'd like to know how a scam works, visit <www.bustedupcowgirl.com/scampage.html. The person who runs this site periodically responds to scammers' e-mail to see what happens, and the resulting exchanges are highly entertaining.

Unfortunately spammers are both dishonest and smart, and they've become experts at circumventing protection. Sending millions of messages doesn't cost much, and it only takes a few people to make spamming financially worthwhile. It is possible, though, to manage junk e-mail, and the techniques in this article will make your inbox manageable again.



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ASA President Delivers Stirring Talk at AUA Meeting

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bills would restore full funding to anesthesiology teaching programs throughout the country, and none would affect other medical or nurse education programs. The legislation wording can be found at <www.asahq.org/Washington/HR5246Shaw-Sessions.pdf>.

It seems this proposed legislation has caught the attention of AANA. AANA has launched a particularly fierce opposition campaign using nursing-oriented, and thus irrelevant, arguments against this legislation, which were reviewed by Dr Guidry in his talk. The bottom line is that legislation to end discrimination against teaching anesthesiologists would in no way change CMS's current payment policy for nonphysician anesthesia providers. I am thus frankly surprised and dismayed with their opposition to this legislation that is essential to the future health of academic anesthesiology and can only wonder about the motivation behind this opposition.

"If programs continue to close … the tradition of anesthesiologists creatively contributing to ongoing advances in medicine will be placed in jeopardy, to patients' detriment."

We at AUA continue to debate how best to resurrect our specialty to become competitive for research funds and to attract the most talented of our graduates to academics. But the 50-percent payment policy is severely hampering our efforts. It seems that this one event, normalizing reimbursement of teaching anesthesiologists, could be a very important and pivotal contributor to our achieving these goals. We must work together to ensure passage of legislation to restore full funding to anesthesiology teaching programs.

The ASA Web site includes a user-friendly mechanism to contact members of Congress in support of H.R. 5246, H.R. 5348 and S. 2990. Simply visit <capwiz.com/asa/home> to send a message to your representative and senators. Also do not forget to ask your parents, aunts, uncles and grandparents to do the same!

For further information, please contact Ronald Szabat, J.D., LL.M., ASA Director of Governmental Affairs and General Counsel, or Manuel Bonilla, ASA Associate Director of Governmental Affairs, at (202) 289-2222.