



AUA

Association of University Anesthesiologists

Update

Summer 2007

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54th Annual Meeting — Chicago

Advocacy

Regulation And Legislation Affect EVERY Aspect Of Our Profession

The Power of ONE

7:1:1 42,000



Education

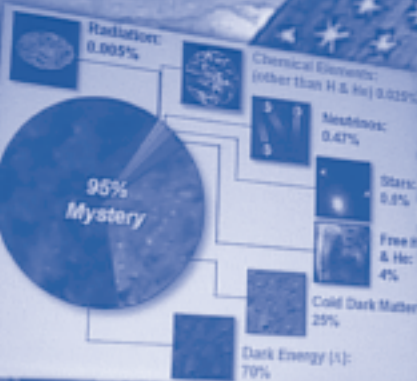
Isoflurane induces caspase-3 activation detectable changes in APP process and Aβ generation in naïve H4

Isoflurane induces cytotoxicity by activation of IP₂ receptor
Haocheng Wei, MD, PhD
Assistant Professor
Department of Anesthesiology and Critical Care



Mystery ...

Cosmology 1000 Years Ago (and Present-Day)



Big Bang Theory, You've Got To Be Kidding -God

EAB Panels 2007 Annual Meeting

Robert E. Shangraw, M.D., Ph.D., Professor
Department of Anesthesiology and Peri-Operative Medicine
Oregon Health & Science University
Portland, Oregon

The Educational Advisory Board (EAB) sponsored two panels at the AUA 2007 Annual Meeting on April 26-29 in Chicago. The first, moderated by **James R. Zaidan, M.D., M.B.A.**, of Emory University, was titled “Resident Issues That Affect Every Training Program.” The second, moderated by **William E. Hurford, M.D.**, of the University of Cincinnati, was called “Entrepreneurial Strength as a Goal of an Academic Department.”

“Resident Issues That Affect Every Training Program”

Steven J. Barker, Ph.D., M.D., Chair of Anesthesiology at the University of Arizona, discussed the matter of disruptive resident (or potentially staff) behaviors and provided three examples encountered in his own program. In confronting these problem behaviors, Dr. Barker introduced the “OODA Loop,” originally described by fighter pilot John Boyd and recently chronicled by Robert Coram in his 2002 book *Boyd: The Fighter Pilot Who Changed the Art of War*.

OODA is an acronym for the sequence “observe, orient, decide and act.” Boyd used the OODA loop principle in air combat where its success was reflected in his nickname “40-second Boyd,” given to him because he had won so many

practice dogfights. Dr. Barker suggested using the OODA loop in managing problem behaviors. In the observe mode, Dr. Barker suggested getting the viewpoint of all sides, including independent witnesses. Orient mode refers to taking steps to understand the motivations underlying the disruptive behavior(s), including possible psychiatric consultation. Once a

reasonable amount of information is at hand, it is time for an outcome decision and consequent action. The loop, for which Dr. Barker illustrated a diagram, recycles with further observation of effects secondary to the initial corrective action. Dr. Barker emphasized the importance of seeking expert psychiatric opinion early during the orient phase

rather than risk-making decisions based on faulty interpretation of the available data.

Dr. Zaidan discussed the appropriate rubric for dismissal of a resident from a program, which involves record keeping, counseling and necessary due process. Dr. Zaidan noted that, regardless of the problem, it is not possible to summarily fire a resident without due process but that it is possible — if justified by the circumstances — to expeditiously remove a resident from clinical responsibilities. Broad corrective steps start with initial individual assessment and mentoring by faculty working with the resident on a day-to-day basis.

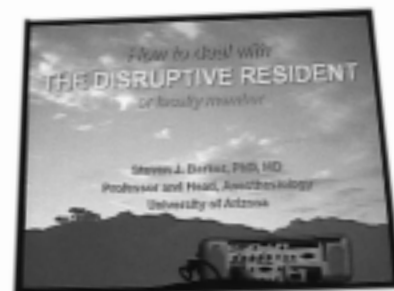
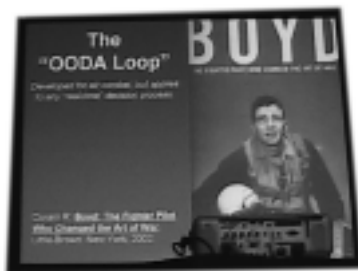
Feedback through the clinical competence committee (CCC) and the program director is the next step, at which time it is important to provide counseling and written documentation of its content. Elements of counseling include 1) explaining the problematic issues to the resident with documentation, 2) opening a review of the departmental and institutional policies, 3) presentation of goals and processes to correct the deficiencies and 4) describing the next steps — a warning letter and possible subsequent probation.

Dr. Zaidan indicated that a resident in remedial process should only be discussed within the context of regularly scheduled CCC meetings and that decisions of the CCC, while depicted as consensual, should be presented to the resident by a single identified individual. He also detailed suggested components of a warning letter and that the resident sign the letter to demonstrate understanding of the remediation plan and later consequences in the setting of unmet goals. Probation is a step that must be used with extreme caution because, at least in some states, its use becomes a permanent part of the individual’s record.

Once the program director and the CCC determine that a warning letter will be issued, Dr. Zaidan suggested, the institutional graduate medical education (GME) representative — known as the designated institutional official (DIO) — should be contacted. He further advised that the DIO be contacted regularly to facilitate a fair and reasonable institutional response to the problem. He concluded, based on observations as DIO at Emory



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



University, that strictly adhering to formal institutional and departmental guidelines will in the long run reduce the workload associated with the problem.

The third panelist was **Catherine K. Lineberger, M.D.**, Duke University, who discussed the possible mechanism for return to residency after an episode of substance abuse. Dr. Lineberger first reviewed the problem of chemical dependence, for which anesthesiology as a specialty is over-represented. Estimates of the diagnosis of chemical dependence among anesthesiology trainees range from 0.5 percent to 2 percent annually with a lifetime risk of 8 percent to 10 percent. Treatment centers handle many former anesthesiology trainees on a national basis — a successful completion of which leaves individuals in professional limbo.

The main foci of Dr. Lineberger's presentation were 1) how to determine who should be allowed to return to anesthesiology residency and 2) how this should process be accomplished. She showed excerpts from the North Carolina Physicians Health Program, which stratifies candidates for returning to anesthesiology practice into three categories: those for whom immediate return was possible, those to be reassessed in one to two years and those for whom return to anesthesiology practice was not recommended.

The criteria for stratification are acceptance and understanding of addiction, bonding with alcoholics anonymous or its opioid-addiction counterpart, relapse prevention skills, other active psychiatric comorbidity, quality of family relationships and lifestyle, presence of a supportive department and commitment to a five-year monitoring program. Of note she said that prevailing local expert opinion regarding former anesthesiology trainees, in contrast to established specialists, has consistently been the last option: not to recommend return to our specialty.

A major problem with regard to returning trainees is the mechanism by which a successful return must be conducted. A returnee should return to work gradually, initially part-time and with no night-time responsibility. He or she also requires flexible scheduling, both in terms of time commitments and the type of clinical work to be re-introduced. The needs of the individual and those of the department, including other trainees, are not easy to reconcile. Further, the role of supervising faculty can be murky because the role of the faculty is not to be the resident's physician but the *patient's* physician. A returnee must be judged according to professional performance standards applied within the rest of the program. Dr. Lineberger suggested, given that the returnee's number-one priority is sobriety, that the program electing to allow a return should be prepared to dedicate a high level of support and also to craft a re-entry contract from the outset. The re-entry contract must contain specific goals and detail consequences for unmet goals.

Dr. Lineberger concluded the discussion by showing that the relapse rate for opioid addiction is estimated at 25 percent to 60 percent and, although most recidivism occurs in the first three months, it can occur after years of abstinence.

The final speaker was **M. Christine Stock, M.D.**, Northwestern University, who discussed the legal aspects of handling a disruptive resident. She focused on the Family and Medical Leave Act (FMLA) of 1993 and the Americans with Disability Act (ADA) in 1990. She summarized the FMLA as:

“Covered employers must grant an eligible employee up to a total of 12 work weeks of unpaid leave during any 12-month period for one or more of the following reasons: 1) birth and care of the newborn child of the employee, 2) placement with the employee of a son or daughter for adoption or foster care, 3) care for an immediate family member with a serious health condition and/or 4) medical leave when the employee is unable to work due to a serious medical condition.”

Dr. Stock made it clear that our academic organizations are large enough to satisfy the 50-employee size to qualify as FMLA-covered employers. She indicated that an eligible employee is someone who has had 12 months previous employment with the organization, although it could be discontinuous service. Nevertheless, strictly speaking, this provision generally excludes all interns and — unless the internship year occurred at your institution — your CA-1 residents. The FMLA does not prevent a program from offering coverage to employees who are not technically covered, but a program must be consistent in how it provides coverage from one resident to another.

The American Board of Anesthesiology (ABA) provides its own regulation with regard to absence from work. ABA allows a maximum of 12 weeks total during the three-year CA-1 to 3 continuum for leave, not including medical meeting attendance. Absences of longer cumulative duration will lengthen the resident's training time by a commensurate amount. Extension of a resident's training beyond the expected three years creates an unfunded position, what Dr. Stock referred to as a GME budget anomaly. Further, there is no simple provision for return to training on a part-time basis, and this arrangement must be coordinated between the program director and the ABA Credentials Committee. Dr. Stock lastly dealt with how the ADA impacts resident training. She noted that the active use of illegal drugs is not covered by the ADA and discussed what constitutes limitations to a “reasonable accommodation” that an employer might use to enable an employee resident to continue working with regard to health care providers.

Discussion at the end of the panel centered on the practical difficulties of re-entry of substance-addicted former trainees into training programs. It also clarified that behavior problems caused by personality disorders are generally refractory to medical therapy and as such not covered by ADA provisions. Finally, there was discussion of the assertion that optimal patient care cannot be compromised for any reason.

Continued on page 4

“Entrepreneurial Strength as a Goal of an Academic Department”

The first panel speaker was **Franklin Dexter, M.D., Ph.D.**, who instituted and now directs the Division of Management Consulting within the anesthesia department at the University of Iowa. Dr. Dexter described the mechanism by which his group set up a management consulting group that handles both internal issues within his local institution and external queries from around the country. The division consists of two professionals, computer programmers assigned on an ad hoc basis and a small support staff. He is the professional most responsible within his group for external consulting, and he has access to two

extramural consultants through a contractual agreement. The department of anesthesiology bills for Dr. Dexter’s consultant time, and he has no incentive reimbursement.

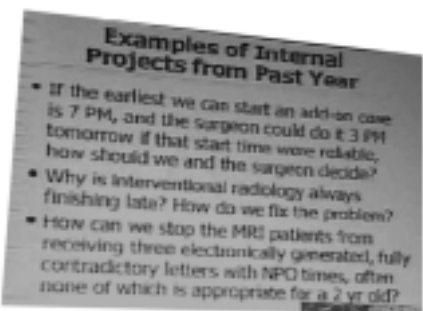
Dr. Dexter noted that the position involves a great deal of travel, with short notice such that it would be difficult to work concurrently in clinical practice. As for internal consulting, he provided examples of consulting questions that presented in the past year, including questions on staffing deployment, surgery scheduling and institutional support mechanism. He suggested that departments act as small businesses with a small group of consulting, information technology experts on staff to develop rational solutions to practical problems.

Warren M. Zapol, M.D., Massachusetts General Hospital, spoke about the process toward implementation of inventions and patents based on the example of the inhaled nitric oxide (INO) delivery system that he has brought to market. Dr. Zapol shared his personal journey with respect to INO that extends back to the late 1960s, with his background in pulmonary circulation research. He noted that the successful translation of INO from a theoretical concept to a real device took 30 years. Elements underlying the ultimate success required the confluence of a 1) great idea, 2) a passionate scientist, 3) effective institutional technology transfer

office, 4) an excellent patent attorney and 5) a strong-minded industry champion. Dr. Zapol mentioned that one must walk a tightrope with regard to public disclosure of intellectual property in that one has to file a patent application before publishing one’s data. He emphasized the importance of early and continued communication with your institutional technology transfer office and lawyers. Dr. Zapol detailed the hard work and pitfalls associated with negotiating with industry — what must be carefully surrendered to obtain the mutual goal of a marketable device. Finally he recounted that, even with industry cooperation, it took nine years of sequential clinical trials to convince the Food and Drug Administration to approve the INO apparatus for clinical use. The message was that even with a great idea, and with pieces that ultimately came into place, the process was long and tedious. There is no guarantee of success; in fact, a large majority of ideas fail to come to fruition as a business enterprise for a variety of reasons.

Michael J. Breslow, M.D., executive vice-president for research and development at the health care solutions company VISICU, Baltimore, Maryland, was the third speaker.

Dr. Breslow described a situation in which his group of entrepreneur anesthesiologists at Johns Hopkins University moved outside the academic environment to establish a business, one that developed software for intensive care unit (ICU) telemedicine. Dr. Breslow and his Johns Hopkins group initially considered that they would market themselves as consultant ICU experts who, after connection to a remote ICU via telemetry, could advise a remote ICU staff on medical decisions. The process of setting up a business, however, was something that the institution was reluctant to embark upon, suggesting that the principals set up an independent company (VISICU) and seek their own venture capital. In this way, Dr. Breslow contrasted his entrepreneurial tack from that of Dr. Zapol. Pilot studies funded by the initial venture capital showed that the VISICU system did lead to reduced mortality and morbidity, which led to further capital investment. Dr. Breslow re-iterated the importance of protecting intellectual property and shared how important it was to hire the right CEO. In their case, the CEO guided them to concentrate on marketing the software for ICU telemedicine rather than their own clinical expertise as consultants and concomitantly provided them with keys to better operational efficiency. He concluded by emphasizing that the mission can change (software versus consulting) but the core value (telemedicine-assisted



outcome improvement) should not. He noted that one has to make a very serious commitment to transform an idea into actual business.

The final panel speaker was **Alex S. Evers, M.D.**, Washington University, St. Louis, who discussed how to combine the strengths of a well-organized academic department

with the positive economic margin of local community practice. Dr. Evers told how many surrounding hospitals in the St. Louis area have approached him to improve care in their anesthetic environments. This was a department-specific outreach rather than university-wide.

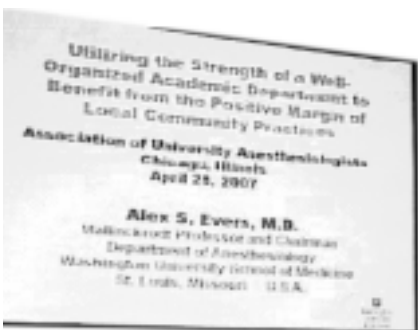
Dr. Evers noted that academic departments have essentially four potential income streams

beyond what is generated by their own clinical care: hospital/group plan subsidy, intellectual property sale, endowment and community clinical ventures. He noted, though, other reasons for reaching out into the community, such as having a positive reputation in the community, providing employment opportunities for trainees, reducing overhead through economy of scale and continuing surgeon/anesthesiologist relationships at hospitals where academic surgeons operate. The reasons why a community hospital would want to align itself with an academic practice, he said, are to tap into the larger financial infrastructure, maintain health system availability, benefit from the negotiating power of an academic department and participate in the outstanding care reputation.

Dr. Evers' department has a 15-year track record of these clinical ventures and now has four satellite locations with another to open in July 2007. He detailed his system for maintaining the relationship, which starts with giving community physicians clinical track faculty positions, including a noncompete clause in the contract, and employing directly all nurse anesthetists by the academic department. There are some risks to the venture, such as distraction of the academic department from its primary missions and the potential for intradepartmental conflicts.

Dr. Evers finished his talk by presenting some solutions to minimizing these risks and added that one has to be very selective in determining which community practices make good fits as collaborators.

Discussion at the end of the talk centered on how to ensure that a noncompete clause is legal and enforceable in the real world.



“Elements underlying the ultimate success [of an invention or patent] required the confluence of a 1) great idea, 2) a passionate scientist, 3) effective institutional technology transfer office, 4) an excellent patent attorney and 5) a strong-minded industry champion.”

Treasurer's Update

W. Andrew Kofke, M.D., M.B.A.
AUA Treasurer
University of Pennsylvania

As of December 31, 2006, total Society Assets were \$438,994, with the distribution of assets summarized in Figure 1 and the income versus expenses for the year summarized in Figure 2.

The more detailed breakdown of income and expenses is summarized in Figures 3 and 4.

Investments are managed by Merrill Lynch with instructions to use a conservative strategy. The resulting distribution of investment assets are summarized in Figure 5. The performance of the investments is shown in Figures 6 and 7. Note that the sudden jump in May 2006 was after the Council decided to add another \$50,000 to the portfolio. Since we chose to diversify our investment portfolio in 2005, the Society has earned about \$30,000 from investment income.

Overall the Society continues to be in good financial condition.

Figure 1: Balance Sheet Feb 2007

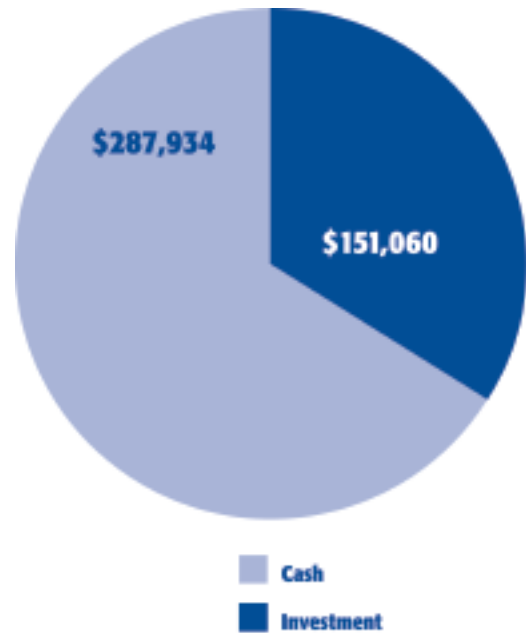


Figure 2: Income/Expense Dec 2006

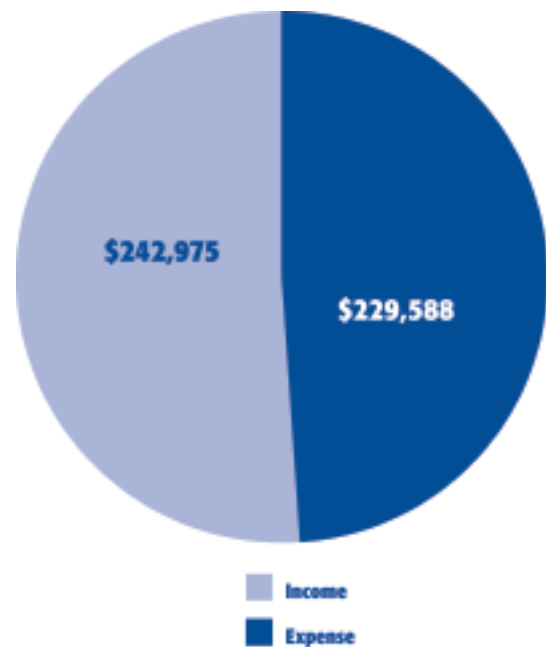


Figure 3: Income 2006

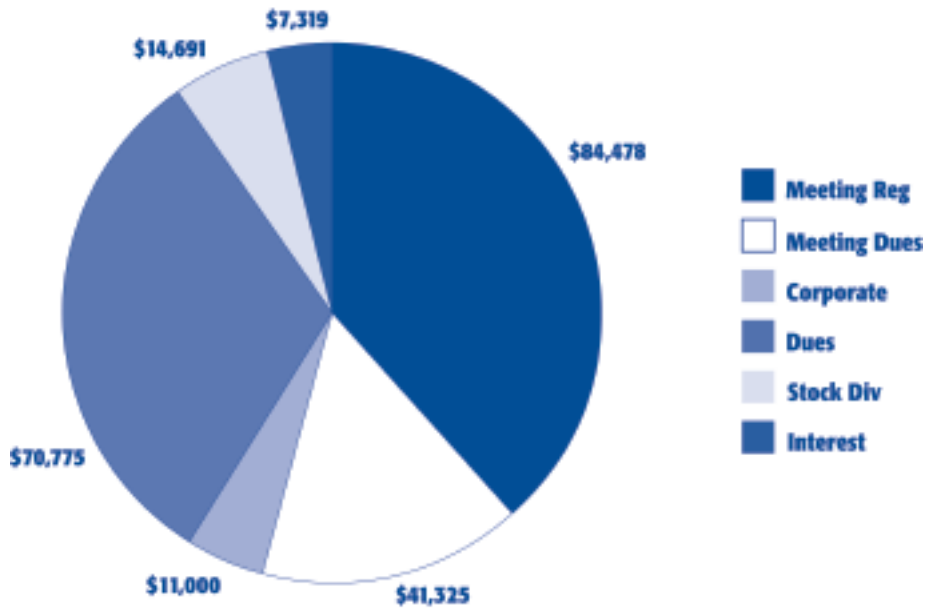


Figure 4: Expenses 2006

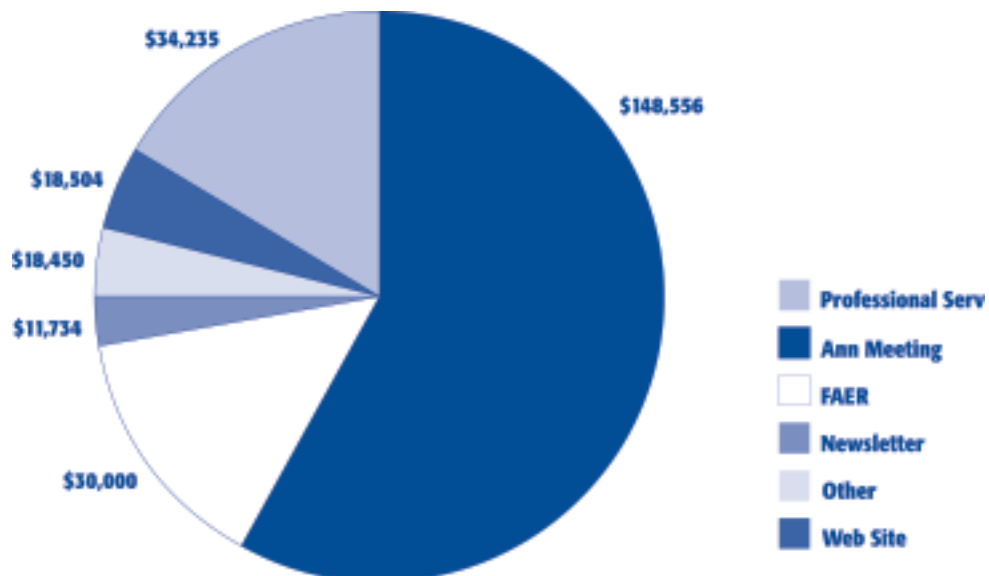
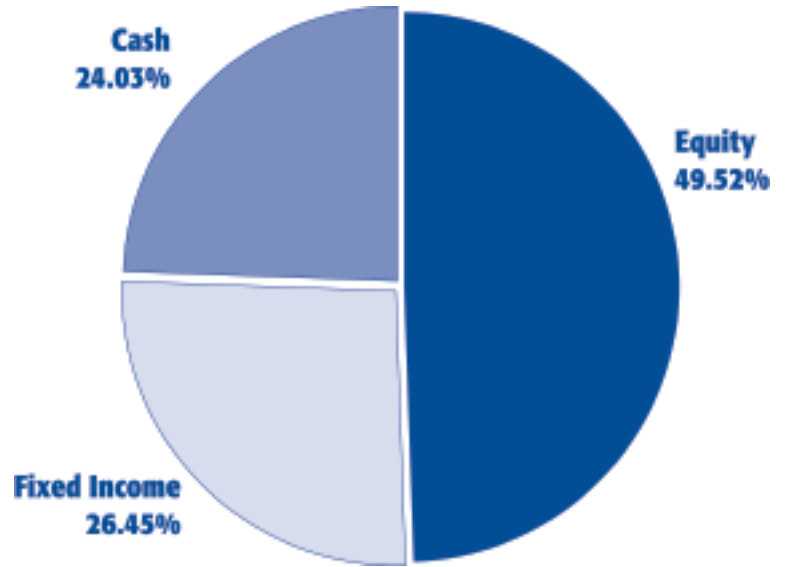


Figure 5:

Asset Class Analysis - Summary
 As of close of business: April 18, 2007



Asset Class	Current Holdings		ML Holdings(\$)
	Total Holdings(%)	Current(%)	
Equity	49.52	49.52	145,679
Fixed Income	26.45	26.45	77,820
Cash *	24.03	24.03	70,710
Total of Analyzed Assets			294,209
Other			1,279
Total Assets			295,488

* Total represents the sum of all cash and cash equivalents including short positions with associated credit balances.

Figure 6: Rate of Return 2006

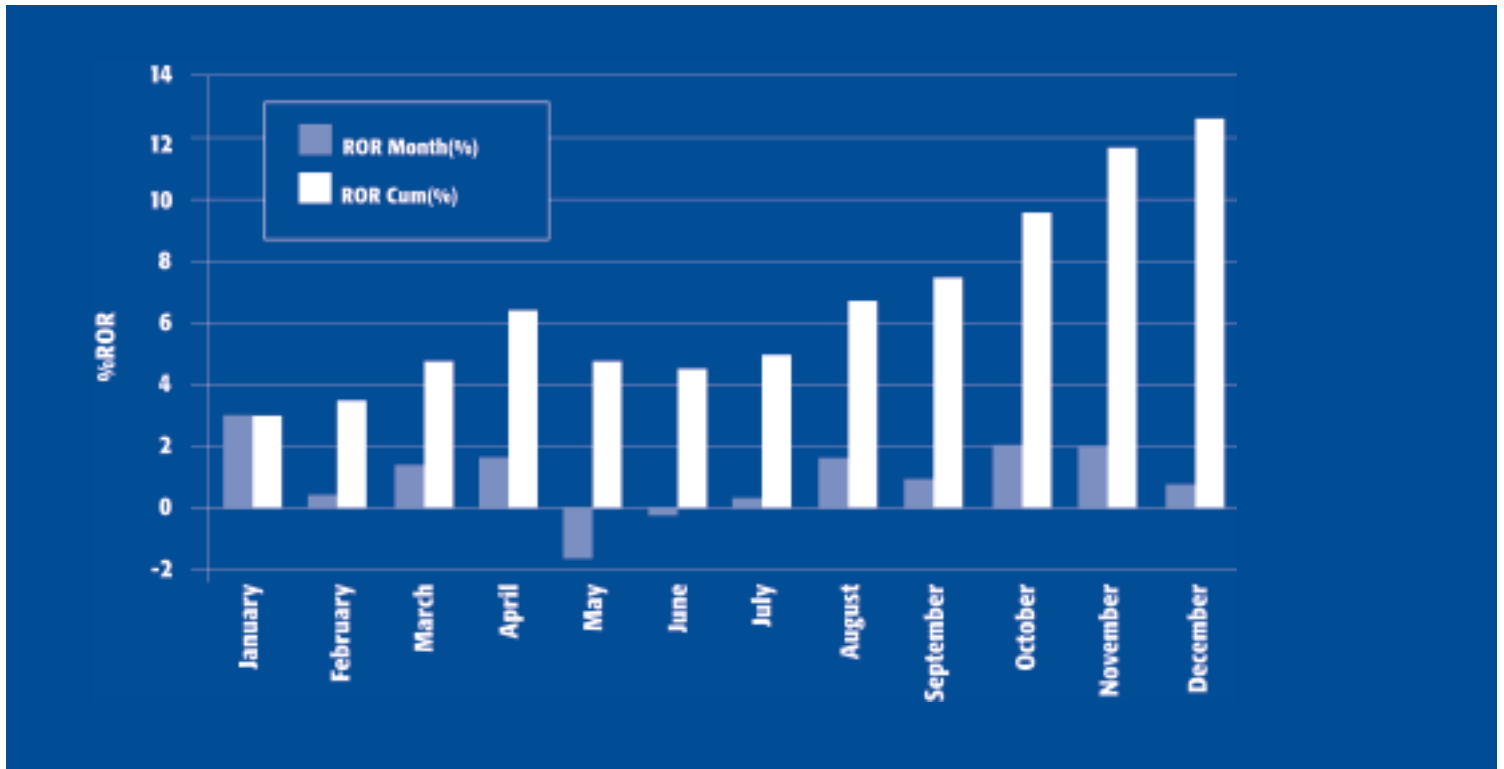
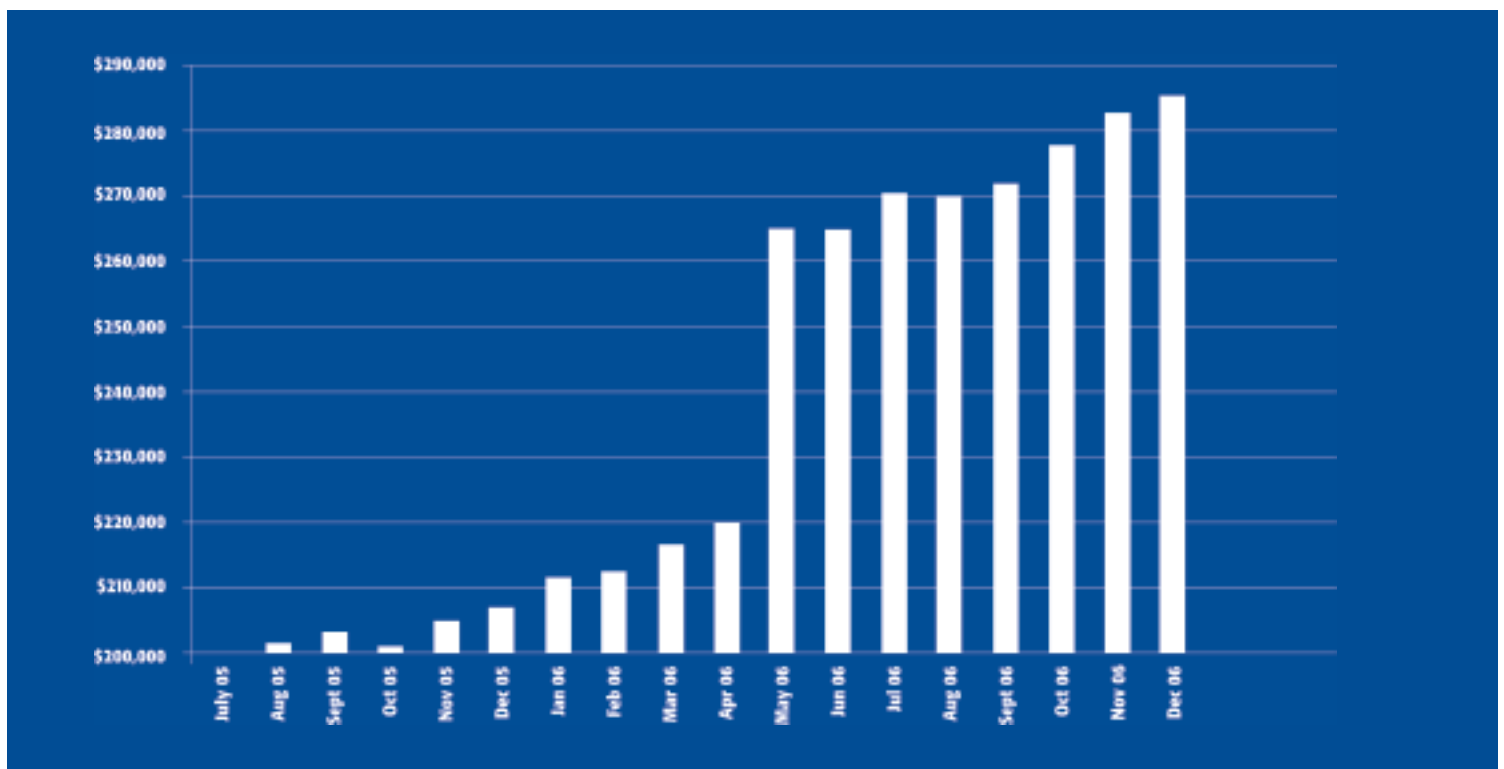


Figure 7: Closing Balance



Annual Meeting Report

Scientific Advisory Board

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



*Michael Crowder, M.D.,
Ph.D.*

The scientific program for this year's Annual Meeting in Chicago on April 26-29 featured some changes instituted by the Scientific Advisory Board (SAB) and the AUA Council. First, four additional oral presentations were given. This allowed us to showcase more science to the general AUA audience than in previous years. The talks were grouped topically. Five talks on general anesthetic mechanisms began the oral presentations. The final three talks in the first oral session examined the divergent effects of isoflurane on cytotoxicity. Two talks provided evidence for promotion of cell death by isoflurane in human neuroglioma and avian lymphocyte cells. The final talk presented data implicating a particular enzyme in the renal protective effects of isoflurane. The Sunday oral session was more topically diverse. Two human clinical studies were presented on genetic determinants of hypertension and the importance of functional status in outcome after vascular surgery. Development of a pig model of ischemic optic neuropathy was presented. Three distinct models of cell injury by ischemia, sepsis or ethanol in rat, mouse and human embryonic stem cells, respectively, illustrated the general interest of our specialty in cell death mechanisms. Two talks, one on vascular remodeling and the other on cytochrome P450-mediated drug metabolism, rounded out the Sunday oral presentation session.



In addition to the 16 talks, 51 posters were presented in a one-hour poster session moderated by SAB members. Posters were grouped by broad topics:

Clinical/Educational: 22
Ischemia/Cardiac/Neuroprotection: 6
Neurobiology/Pain: 16
Physiology/Pharmacology/Inflammation: 7

The poster session was very well attended and allowed for extensive discussions of the findings in a way not feasible after the oral presentations.

A new addition this year to the SAB program was the presentation of AUA-sponsored travel awards to the two residents judged by SAB to have the best abstracts. The 2007 awardees were **Claudia Benkwitz, M.D.**, and **Renyu Liu, M.D.**

Dr. Benkwitz presented her work, performed with Dr. Robert Pearce at the University of Wisconsin-Madison, on mice expressing a mutant GABA_A receptor that is insensitive to etomidate. Dr. Benkwitz will be



2007 AUA Travel Award Winners



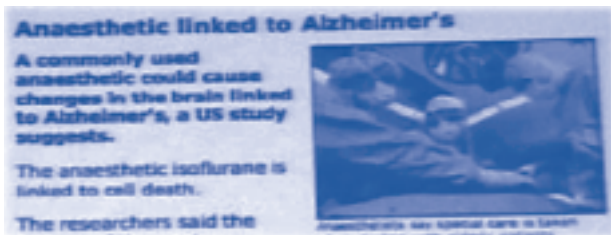
Claudia Benkwitz, M.D.



Renyu Liu, M.D.

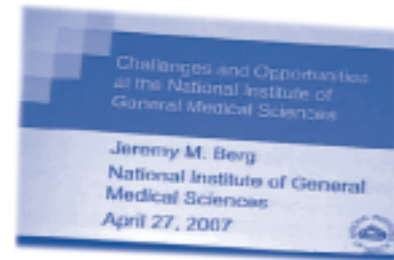
a CA-1 resident at Massachusetts General Hospital this fall. Dr. Liu presented his work, performed under the supervision of Roderic G. Eckenhoff, M.D., that measured binding affinities of general anesthetics to a peptide model of helical protein domains. The anesthetic affinities to a single site within the helix of the peptide follow the Meyer-Overton relationship. Dr. Liu is a CA-2 resident at the University of Pennsylvania.

The plenary talk this year was given by **Charles B. Berde, M.D., Ph.D.**, the Sara Page Mayo Chair in Pediatric Pain Medicine, Chief of the Division of Pain Medicine of Children's Hospital Boston and Professor of Anaesthesia at Harvard Medical School. Dr. Berde has made important contributions to our understanding of the mechanisms of local anesthetics and their use in pediatric regional anesthesia and pain management. The lecture provided a refreshing mixture of basic and clinical research along with a discussion of the basic man-



agement of pediatric pain. Dr. Berde began with a review of the molecular mechanisms of local anesthetics. Some promising work on the development of ways to prolong the action of existing local anesthetics and on new local anesthetics derived from paralytic shellfish also was discussed. The lecture turned then to more practical clinical matters such as ways to improve the efficacy and duration of local anesthetic regional and peripheral blocks and the logistics of a pediatric pain service. Primary take-home points were that local anesthetics are useful but limited and that new drugs need to be developed to supplement or replace them.

The SAB was honored to have **Jeremy M. Berg, Ph.D.**, Director of the National Institute of General Medical Sciences (NIGMS) as our National Institutes of Health (NIH) session speaker. NIGMS provides the largest portion of NIH dollars to anesthesiology research of any institute. Dr. Berg reviewed the broad mission of NIGMS, which basically is to support research outside the purview of any other single NIH institute. NIGMS has been extremely successful in this mission as it has supported more Nobel Prize winners (64) than any other institute. Dr. Berg reaffirmed the single-investigator-driven R01 grant as the largest mechanism for support of research at NIGMS, with 60 percent of the NIGMS budget and 86 percent of the grant funds devoted to R01s. NIGMS does, however, support some large-scale collaborative research programs. Dr. Berg highlighted three of these, the Pharmacogenetics Research Network (PGRN), the Protein Structure Initiative (PSI) and the Centers for Systems Biology. Each of these programs should benefit anesthesiology-related investigations. Dr. Berg ended with the good news that the NIH budget and, in particular, the NIGMS budget will be increased in the next fiscal year. Because of this budgetary increase, success rates of R01 applications to NIGMS in the next fiscal year are projected to rise from 26 percent to 29 percent. This is obviously welcome news and should encourage all of us to work toward maintaining or achieving NIH funding for our research programs.



Member Opinion: Medicare Funding and Nurse Anesthesia

Robert E. Johnstone, M.D.
West Virginia University
Morgantown, West Virginia

A bipartisan coalition of U.S. Representatives recently introduced a congressional bill to correct the 50-percent reduction in Medicare payments for overlapping anesthetics with resident physicians. Known as the Medicare Anesthesiology Teaching Funding Restoration Act of 2007, or H.R. 2053, it addresses only anesthesiology residency programs. This one correction, though, would provide approximately \$400,000 to each training program. Such funding is critical to keep them open. Since this payment penalty began in 1994, the number of anesthesiology residency programs has decreased from 160 to 129. Correcting this payment penalty is the top legislative priority of the American Society of Anesthesiologists (ASA).

Very annoying is that some nurse anesthetists are working to defeat it. They inspired the introduction of a competing bill, known as H.R. 1932, which includes direct funding of nurse anesthesia programs along with the teaching anesthesiologist payment reform. This bill was developed without the known involvement of any anesthesiologist. The nurse anesthetist programs would not seem to need additional support, having added 22 programs in the past six years and increased their number of graduates from 1,075 in 2000 to 2,035 in 2006. Also, when I visited my senators and representatives recently to talk about restoring full payments to anesthesiology programs, I found nurse anesthetists had been there a week before pushing a different agenda.

All of this makes me mad, except that the nurse anesthetists I know seem reasonable. They support anesthesiologists and policies that promote safety and quality. They appreciate the knowledge and medical direction of anesthesiologists and have no desire to practice medicine. The discontents and zealots among nurse anesthetists seem to be a small number, although they're particularly noticeable and disruptive.

It's difficult to craft a full response to nurse anesthetist misinformation because we're so conflicted over broader workforce issues. Many anesthesiologists practice in all-physician groups and champion the quality this brings to patient care, while many anesthesiologists prefer medical direction of nurses and anesthesiologist assistants (AAs) because it extends what they can do. It's the same with academic groups. Many employ nurse anesthetists, and some train them. Overall about one in five hospitals with anesthesiologists is a training site for nurse anesthetists. There is more demand for anesthesia care now than supply available to meet it, so everyone is busy, and using anesthesiologist extenders gets the work done. But that may not remain so, and this may be a good time to talk about what anesthesia practice should be and what workforce model should deliver it.

ASA has more than 42,000 members, the American Association of Nurse Anesthetists (AANA) 36,000 and the American Academy of Anesthesiologist Assistants nearly 1,000. One projection is that 100,000 clinicians will be needed to deliver all the anesthetics in a decade, reflecting the growing and aging U.S. population as well as the increasing demand for anesthetics outside surgical suites. Who will and should meet this need? As anesthesiology grows in the areas of perioperative care, critical care and pain medicine —

purviews of physicians — the demand for anesthesiologists will become increasingly acute. How can we accomplish this? What is the role for AAs?

AUA, an honorific society, may be the best group to organize a conference of anesthesiologists concerning these workforce issues. AUA members are broadly experienced in health care, dedicated to research and education, evidence-driven, outside the political process and nationally respected. AUA could help to reach a consensus among anesthesiologists. If united in vision, anesthesiologists could accomplish anything. If divided, someone else will determine the outcome.

In the meantime, I would urge AUA members to contact their senators and representatives to support H.R. 2053, the Medicare Anesthesiology Teaching Funding Restoration Act of 2007, to keep our training programs healthy and ensure the future health of our specialty.

Editor's note: The following can be found on the Webpage of my state society:

"On May 2nd, the Pennsylvania House Insurance Committee met for testimony on Governor Rendell's health plan. Representatives from the Pennsylvania Society of Anesthesiologists (PSA) and the Pennsylvania Association of Nurse Anesthetists (PANA) were present to testify.

Dr. Erin Sullivan, President, PSA and Dr. Joseph Answine, President-Elect, PSA testified that the anesthesia care team is time-proven and safe.

Furthermore, they testified that the anesthesiologist is an acute care physician that diagnoses and treats illness during the peri-operative period. Dr. Arthur Zwerling (Doctor of Nursing Practice, DNP), President-Elect, PANA stated that the PANA seeks independent practice for Certified Registered Nurse Anesthetists and he feels that an anesthesiologist is not necessary in most settings." See and hear excerpts of the testimony at www.psanes.org/HB_1256.html.

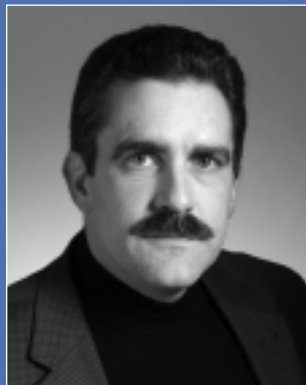
My personal opinion is that increased support of AAs could contribute to a long-term solution to the AANA problem. The presentation by 2006 ASA President Orin F. Guidry, M.D., at the 2006 AUA Annual Meeting was unambiguous on the threat posed to academic anesthesiology through this well-organized group of individuals attempting to practice medicine without undergoing the rigors of medical school or residency. One strategy in this goal apparently is to work to weaken or eliminate "MDA" programs. I encourage academic anesthesiology programs everywhere to support state legislation in support of AA schools and develop AA training programs.

— WAK



Robert E. Johnstone, M.D.

Duke to Host 55th AUA Annual Meeting



*Mark F. Newman, M.D.
Merel H. Harmel Professor
and Chairman
Department of Anesthesiology
Duke University Medical Center
Durham, North Carolina*

The Duke University Department of Anesthesiology will host the AUA 2008 Annual Meeting at the Washington Duke Inn in Durham, North Carolina, on May 15-18.

Duke University — known as the “Gothic Wonderland” — is an awe-inspiring campus year-round, and spring is a particularly splendid time to visit.

Duke University was established in 1924 by the family of tobacco entrepreneur Washington Duke. The total graduate and undergraduate population is approximately 13,000 students. Leading the world in education, research, medicine and basketball, Duke continues to epitomize Washington Duke’s dream and realization of success.

2008 AUA meeting participants are invited on a historian-led tour of Duke University, including the highlights described below as well as other planned events.

Duke University

Duke Chapel shines among Duke University’s many highlights. Built in 1930 and philanthropically financed with \$2.3 million, the Chapel not only serves as the heart of interfaith, spiritual and sacred music life on campus but also stands as a monolith of excellence in all we do, personally and professionally.

Cameron Indoor Stadium is a landmark in its own right. Home to the Duke men’s and



Cameron Indoor Stadium



Sarah P. Duke Gardens



women's basketball teams, Cameron boasts 9,000 seats and a bleacher-styled section reserved for students known as the "Cameron Crazies." The front lawns of Cameron, known as "Kryzewskiville," become a city of tents pitched by students who camp out during basketball season in hope of getting access to highly coveted tickets to home games.

A jewel of the Southeast, the Sarah P. Duke Gardens is one of the premier gardens in the country with more than 300,000 visitors each year. The month of May is one of the most remarkable times to tour Duke Gardens, especially its Asiatic Arboretum and Garden of Native Plants.

The Nasher Museum of Art houses three large gallery spaces, a gift shop and a gourmet café, totaling 65,000 square feet. Built in October 2005, the Nasher is a major new center for the arts at the heart of the Duke campus and the region at large.

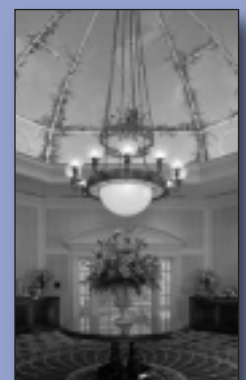
We are proud to be hosting an exclusive dinner at the Nasher for 2008 Annual Meeting participants. You can find more information about the Nasher's compelling current exhibitions at www.nasher.duke.edu.

The Washington Duke Inn

The Duke University Department of Anesthesiology will host the meeting at the Washington Duke Inn.

The 300-acre site features a championship golf course, gorgeous views and renowned fine dining, plus numerous amenities. The Washington Duke Inn was the winner of the AAA Four Diamond Hotel award for its Southern charm and exquisite hospitality. Our AUA group rate is \$170 per night.

The 2008 Annual Meeting Program will feature compelling speakers selected for their insight into modern issues. Our prospective speaker list includes Johnny Dawkins, former Duke player and longtime assistant coach for the Duke men's basketball team; Jim Goodnight, CEO of the SAS Institute; Peter Agre, M.D., winner of the 2003 Nobel Prize in Chemistry; and Dr. Stan Hauerwas, named "America's Best Theologian" by *Time* magazine.



The Washington Duke Inn

Duke University Medical Center

Durham's official title is "The City of Medicine," with Duke University and Health System the largest employers in the city and county. While big tobacco was on the decline by the 1980s, Durham's conversion into a health care and research community was well positioned, thanks to the establishment of the School of Medicine, the School of Nursing, and Duke University Hospital by James Buchanan Duke and other forward-thinking philanthropists. Health care, research and education now drive Durham's economy.

Duke medicine conceptually integrates the Duke University Hospital System, School of Medicine and School of Nursing. We are committed to quickly translating advances in technology and medical research into improved patient care. The Duke medical campus now comprises 90 buildings on 210 acres and employs almost 20,000 people, including 1,500 faculty physicians and researchers.

Learn more about Duke medicine online at www.dukehealth.org and about our Department of Anesthesiology at anesthesia.mc.duke.edu.

Durham

The city of Durham is a cornerstone of American history. Big tobacco made its debut here when Civil War soldiers from both sides camped at Bennett Place (approximately one mile from Duke) during the surrender. After liberally sampling Durham's Brightleaf tobacco, they remained loyal lifelong patrons, leading the exponential growth of tobacco companies like Bull Durham and Washington Duke's Duke & Sons to become industry giants. Durham became "Bull City," a modern city with small town charm. Furthermore, known in the 1920s as "The Black Wall Street," Durham is where big businesses like NC Mutual Insurance Co., the oldest and largest insurance company with roots in the African American community, began. M&F Bank has operated continuously and profitably since opening in 1908. Durham remains a thriving business center and is home to four of the top 25 businesses in *Black Enterprise* magazine's top-100 lists. As a monument to this spirit of innovation and entrepreneurialism, Historic Parrish Street is being redeveloped as a National Heritage Area.

Durham boasts diverse attractions and events. You can attend a Durham Bulls baseball game, shop at Brightleaf Square and other districts, tour the Duke Lemur Center (home to the largest group of lemurs outside of Madagascar) or visit the Carolina Theatre. Chapel Hill and Raleigh are near enough to offer countless activities involving any inclination.

Durham's rich history is preserved by the conversion of old tobacco mills into commercial and corporate enterprises such as the American Tobacco Historic District in Downtown Durham. Visitors can shop, eat and enjoy live music in the complex that houses companies like Motricity and the local NPR affiliate.

Visit the Durham Convention and Visitor's Bureau at www.durham-nc.com for further information on the area.



The Triangle

Durham is one corner of North Carolina's "Triangle" region, which also includes Raleigh and Chapel Hill. Together these three cities (each with a flavor of its own) provide all the attractions of a major metropolitan area minus the hustle. Raleigh is the capitol of North Carolina, while Chapel Hill is Tarheel Country — home to the University of North Carolina at Chapel Hill, Duke's arch rival in basketball. Durham's population totals just over 450,000 residents, while the Triangle approaches 1.5 million.

Home of the best hospitals, living communities and school systems in the Southeast, the Triangle is the number-one resettlement point for outgoing New Yorkers and boasts the highest number of Ph.D.s per capita in the country. The Research Triangle Park (RTP) was created in 1949 by business, academic and industrial leaders to attract economic development and foster excellence in the health care, research and education sectors. RTP's 7,000 acres of business development is home to GlaxoSmithKline, IBM, Lenovo, SAS and other giants.

2008 AUA Annual Meeting participants will fly into Raleigh-Durham (RDU) International Airport, known for its world-class passenger care, speed, safety and security. Co-owned by the cities of Raleigh and Durham, RDU is one of the fastest-growing airports in the United States, serving 10 million passengers each year.

We at Duke Anesthesiology welcome you as our guests for the 2008 AUA Annual Meeting.

Call for Abstracts

The Scientific Advisory Board (SAB), chaired by C. Michael Crowder, M.D., Ph.D., invites you to submit an original research abstract for presentation at the 55th Annual Meeting, May 15-18, 2008, at the Washington Duke Inn & Golf Club in Durham, North Carolina. **The abstract submission site will go live in early August 2007.**

As is tradition, all submitted abstracts will be accepted. Only one abstract per member (*authored or sponsored*) will be accepted. SAB peer review will assign abstracts to oral and poster sessions. Individuals whose abstracts are selected for oral presentation will be asked to not be overly technical in their presentations and to provide adequate background and context for their work. Oral presentations are not intended for postdoctoral fellows or senior faculty. To maintain the traditional high quality of abstract submissions, it is essential that member authors and sponsors critically review their submissions. Members are encouraged to consider submission of clinically-oriented abstracts, for there has been a decline in the numbers of such submissions for recent meetings.

The Association has made it easy to submit abstracts for presentation at the AUA Annual Meeting. We encourage you to submit an abstract by visiting the Society's online submission form at www.auahq.org; review the layout and format instructions, complete the submission form and upload your blinded and unblinded abstract as a Word document. It is that simple. **Please note:** ONLY electronic submissions will be accepted for consideration.

Abstracts selected for viewing at the 55th Annual Meeting will not be published, allowing members to submit essentially the same abstract to the American Society of Anesthesiologists 2008 Annual Meeting.

Resident Travel Awards

Abstracts submitted by residents within one year of residency/fellowship at the time of the Annual Meeting should be marked accordingly by checking the respective box on the online submission form. In order to be considered for the award, you must attend the meeting. The top two scoring abstracts judged by SAB will be awarded a \$1,000 travel award.

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The chair is wondering if maybe this is one of those OODA moments Dr. Barker was talking about.

(See EAB Report on page 2 if you don't get it.)