



# AUA

Association of University Anesthesiologists

# Update

Fall 2008

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## Medicare Anesthesiology Teaching Rule Fixed — Senate and House Pass Veto-Proof Legislation

Jeffrey L. Apfelbaum, M.D., President  
American Society of Anesthesiologists

With the 2008-09 academic year well under way, anesthesiology residency programs now operate with a different hope for the future: ASA has secured passage of Medicare anesthesiology teaching rule reform legislation! This means that beginning in 2010, Medicare will restore full payment to anesthesiology teaching programs, ending more than a decade of an unfair 50-percent payment penalty.

As those in academia are acutely aware, anesthesiology teaching programs have faced a crippling 50-percent payment penalty from Medicare when overseeing two residents on overlapping cases. The ramifications of this irresponsible policy have been severe. Since the 50-percent payment penalty took effect, 28 of our specialty's residency programs have closed, due in part to financial constraints caused by the penalty.

ASA first secured introduction of teaching rule legislation in 2006. Since then, thousands of dedicated ASA members reached out to their representatives and senators for support of the bills. For two years, ASA staff, leaders and members have worked strategically and relentlessly within Congress to ensure eventual passage of Medicare anesthesiology teaching rule reform language. We have collectively sent thousands of e-mails, made thousands of phone calls, and held countless meetings with members of Congress, advocating for full payment for our teaching programs.

In 2008 alone, we secured 127 bipartisan cosponsors in the House and 30 bipartisan cosponsors in the Senate. Our strong sponsors — Reps. Xavier Becerra (D-CA) and Pete Sessions (R-TX)

in the House, and Sens. Jay Rockefeller (D-WV) and Jon Kyl (R-AZ) — helped ensure that the proper bill language eventually became law.

It should be noted that, on average, a typical piece of legislation takes seven years to be passed by Congress, according to the American Society for Association Executives. Through hard work and determination, we were able to secure passage of Medicare anesthesiology teaching rule reform legislation in just two years.



Jeffrey L. Apfelbaum, M.D.

Long before we began our legislative battle, ASA worked with the Centers for Medicare & Medicaid Services (CMS) for more than a decade to rectify the payment penalty through the federal rulemaking process. Most recently, in 2005, ASA — along with thousands of individual anesthesiologists, the American Medical Association, the Association of American Medical Colleges, the Medical Group Management Association, numerous House and Senate members, and other interested parties — contacted CMS urging elimination of the 50-percent payment penalty. Despite this overwhelming support for a change to the policy, CMS held fast to the penalty.

With that, ASA began its path toward legislative victory by working with members of Congress to secure introduction of

*Continued on page 5*

### Plan to Attend the AUA Annual Meeting in Galveston - April 2-5, 2009

Although Galveston sustained major damage in Hurricane Ike, the meeting site at Moody Gardens had only minor damage. The Moody Gardens Hotel (and the spa), the Aquarium Pyramid, and the Discovery Pyramid are already open. The golf course will open October 15, and the Rainforest Pyramid and IMAX 3D Theater will

open January 1. The medical school and hospital anticipate resuming normal operations by that time as well. Please plan to attend the AUA meeting and show your support for Galveston, which by April will again be a beautiful resort destination.



## Anesthesiology Research at Brookhaven National Laboratory & Stony Brook University

Helene Benveniste, M.D., Ph.D.

Professor

Department of Anesthesiology

SUNY Stony Brook

Scientist, Brookhaven National Laboratory

**Editors note:** I visited Brookhaven National Laboratory (BNL) a few years ago on the invitation of Dr. Benveniste and left impressed with it as an excellent and unusual collaboration of an academic anesthesiology research group with a large federal government research enterprise. Because of this unusual arrangement, I have asked Dr. Benveniste to describe what they are doing there. Much of the following introductory material is taken from the BNL Web page:

[www.bnl.gov/bnlweb/about\\_BNL.asp](http://www.bnl.gov/bnlweb/about_BNL.asp).

Established in 1947 on Long Island, Upton, New York, BNL is a multi-program national laboratory operated by Brookhaven Science Associates for the U.S. Department of Energy (DOE). Six Nobel Prizes [www.bnl.gov/bnlweb/history/nobel](http://www.bnl.gov/bnlweb/history/nobel) have been awarded for discoveries made at the lab. One of 10 national laboratories overseen and primarily funded by the Office of Science of the DOE, BNL conducts research in the physical, biomedical and environmental sciences as well as in energy technologies and national security. BNL also builds and operates major scientific facilities available to university, industry and government researchers. Brookhaven is operated and managed for DOE's Office of Science by Brookhaven Science Associates, a limited-liability company founded by the Research Foundation of the State University of New York on behalf of Stony Brook University (SBU), the largest academic user of laboratory facilities, and Battelle, a nonprofit, applied science and technology organization.

Brookhaven has a staff of approximately 3,000 scientists, engineers, technicians and support staff and more than 4,000 guest researchers annually. The department of anesthesiology has three faculty who conduct their research at BNL in the BNL medical department. Working in a venue such as this affords them a remarkably diverse intellectual environment.

BNL's role for the DOE is to produce excellent science and advanced technology with the cooperation, support and appropriate involvement of our scientific and local communities. The fundamental elements of the laboratory's role in support of the four DOE strategic missions are the following:

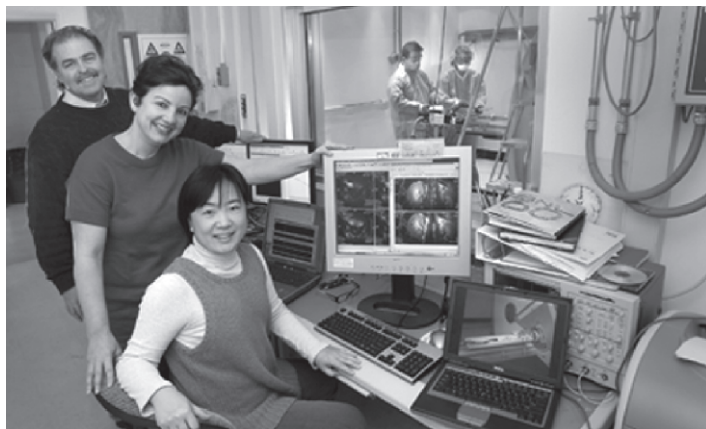
- To conceive, design, construct and operate complex, leading-edge, user-oriented facilities in response to the needs of the DOE and the international community of users.
- To carry out basic and applied research in long-term, high-risk programs at the frontier of science.
- To develop advanced technologies that address national needs and to transfer them to other organizations and to the commercial sector.

- To disseminate technical knowledge, to educate new generations of scientists and engineers, to maintain technical capabilities in the nation's workforce and to encourage scientific awareness in the general public.



Helene Benveniste, M.D., Ph.D.

BNL physicians in its medical department work with chemists in the Center for Imaging & Neurosciences to explore the human brain using medical imaging techniques based on medical radioisotopes. Other research projects in the medical department are



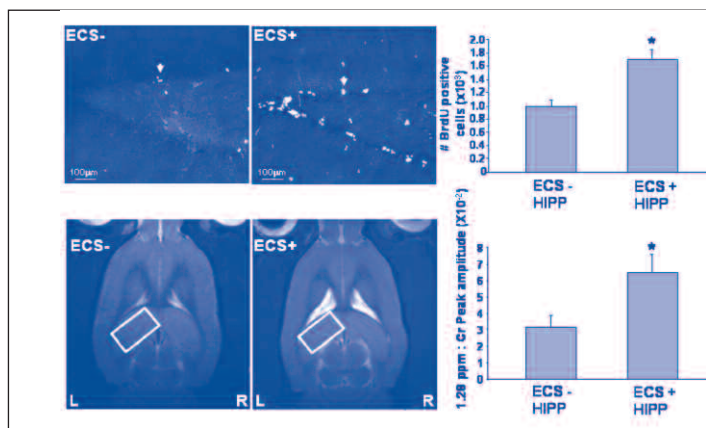
aimed at developing new nuclear medicine treatments and diagnostic agents, producing medical isotopes for clinical use, and understanding and treating cancer and heart disease.

Over the last five years, researchers in the department of Anesthesiology at SBU have been tightly connected with scientists in the Medical Department at BNL. In 2001, as a joint BNL-SBU faculty member, Dr. Benveniste initiated and created a 9.4T MRI laboratory, which today is tightly linked with other imaging modalities such as microPET and optical diffusion fluorescence imaging at BNL. The 9.4T/20 MRI instrument was originally purchased with combined funds from New York State (New York State Foundation for Science, Technology and Innovation), or NYSTAR, the Office of Drug Control Policy, the Office of Science, Department of Energy and also with support from SBU. The facility was inaugurated in October 2003, and the 9.4T horizontal MRI instrument was declared operational in February 2004. The 9.4T MRI laboratory is the first, and remains the only, one of its kind on Long

Island, and over the last three or four years, a solid and growing group of users has developed. The current research projects include phenotyping of transgenic mice models of human diseases, in vivo  $^1\text{H}$  magnetic resonance spectroscopy ( $^1\text{HMRS}$ ) of neural stem cells, cardiac and fluid flow dynamics, stroke and drug addiction studies. We will highlight some of these in the following.

### Biomarker Discovery Using $^1\text{HMRS}$

The first study in this area has focused on defining a biomarker of neuronal stem cells using proton magnetic resonance spectroscopy, or  $^1\text{HMRS}$ . Dr. Maletic-Savatic a pediatric neurologist at SBU in collaboration with Dr. Benveniste's microMRI group and investigators from Cold Spring Harbor



Laboratory (CSHL), designed a series of studies from the "bench to the bedside" to characterize the metabolomic signature of NSC. First, in vitro studies demonstrated a unique metabolite present in significant quantities in NSC at 1.28ppm, which was barely detected in oligodendrocytes and not at all in neurons and astrocytes.<sup>1</sup> Second, using the 9.4T microMRI instrument and singular value decomposition (SVD) analysis, we were able to demonstrate the same signature in vivo in the rodent hippocampus (where NSC reside) but not in the cortex. Additional preclinical microMRI experiments in rodents exposed to electroconvulsive shock (ECS), which is known to increase dividing NSC four-fold, further demonstrated that the amplitude of the 1.28 ppm peak measured by  $^1\text{HMRS}$  increased correspondingly in the ECS rats [Figure 2]. The 1.28 ppm peak has also been demonstrated in the live human brain in the hippocampus.<sup>1</sup> This project may have broad consequences for understanding a variety of neurological diseases from multiple sclerosis, autism spectrum disorder and post-operative cognitive deficits to Alzheimer's dementia.

1. Manganas, et al. *Science*; 2007.

### Systemic Lidocaine Does not Block Physiological Pain Pathways in Acute Pain

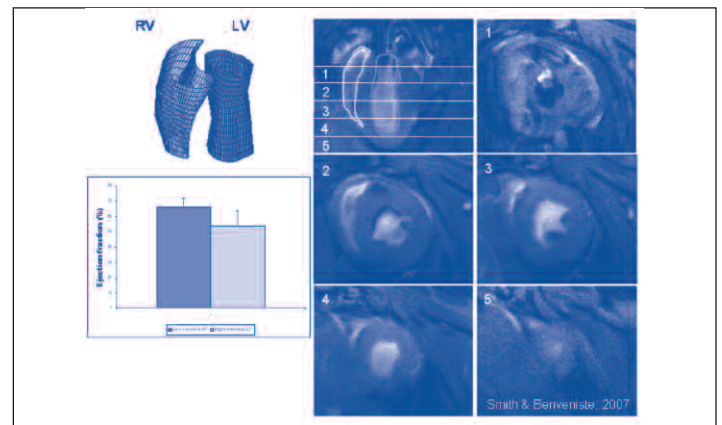
Preclinical results with functional brain imaging in the rodent suggest that lidocaine's analgesic efficacy when given systemically is unlikely to be through an action on normal physiological pain pathways. In addition, lidocaine was observed to enhance brain responses to acute noxious stimulation, which was unexpected because lidocaine is known to

block sodium channels and propagation of action potentials. We recently showed that both cocaine and lidocaine cause increases in the intracellular calcium concentration  $[\text{Ca}^{++}]_i$  in somatosensory cortex,<sup>1</sup> and we now propose that lidocaine's ability to increase  $[\text{Ca}^{++}]_i$  in the brain could underlie the enhanced cortical activation to noxious and non-noxious stimulation, which we observed. The increase in  $[\text{Ca}^{++}]_i$  in somatosensory cortex by lidocaine may also be relevant for its analgesic effects since studies have proposed a decrease in neuronal calcium currents in somatosensory neurons as the mechanism underlying neuropathic pain.<sup>2</sup>

1. Du et al. *J Neuroscience*. 2006.
2. Luo et al. ISMRM proceedings, 2008 and presented at the 2008 AUA meeting.

### Cardiac Phenotyping of Vasoactive Intestinal Peptide-Deficient Mice

New studies on mice with deletion of the gene for vasoactive intestinal peptide (VIP) have demonstrated spontaneous pulmonary arterial hypertension (PAH) and vessel remodeling in the absence of hypoxemia with pathology showing thickened pulmonary vessels (Said, et al. *Circulation*. 2007). The



microMRI group lead by MR physicist Dr. S. David Smith in the 9.4T MRI laboratory has developed hardware and software that allow accurate estimation of cardiac function in vivo in mice. It was hypothesized that VIP-deficient mice with known spontaneous PAH would also develop a decreased functional capacity of their right ventricle. This hypothesis was tested using MR microscopy to evaluate right and left heart ventricular volumes and corresponding ejection fractions in VIP-deficient and wildtype (WT) control mice. First, cardiac volume changes were estimated over the cardiac cycle in normal mice; the figure shows typical short axis views of the mouse heart and the resultant segmentation of the left and right ventricle (LV and RV). From these dynamic images, end-systolic and end-diastolic volumes could be determined in normal and VIP-deficient mice. Analysis demonstrated that RV end-systolic volumes of VIP-deficient mice were significantly larger than normal control mice. Studies are under way to characterize the development of RV pathology in VIP mice over time and to examine the effect of VIP therapy on the RV functional capacity in VIP-deficient mice.



# Update on Post-Katrina Recovery and Academic Anesthesia, July 2008

*Alan David Kaye, M.D., Ph.D., DABPM  
Professor and Chairman  
Department of Anesthesiology  
Professor, Department of Pharmacology  
LSU School of Medicine  
New Orleans, Louisiana*

Much has happened in the region and the state of Louisiana since Hurricane Katrina hit in August 2005. Though there are some positive things in the recovery of the city, there are unfortunately more negative consequences in the field of academic anesthesia. As the last surviving tenured professor and anesthesia chairman in the state, and as final member of the AUA relative to 2005, I offer this synopsis for our members.

Many of you probably have memories of the excellent history of academic anesthesia in New Orleans. John Adriani, M.D., was the first Chairman of Anesthesia at LSU School of Medicine in New Orleans. Alan Grogono, M.D., developed a powerhouse department at Tulane for nearly two decades until his retirement in 1998. Many of the people and things that were built are no longer in place. The two national CME anesthesia courses operating through Tulane have been closed. Charity Hospital, the flagship hospital of the LSU School of Medicine anesthesia department, was destroyed because of Hurricane Katrina, along with half of the hospitals in this region. More recently, the leaders of academic anesthesia at the time of the hurricane were faced with many decisions and strains. They had enormous challenges and made heroic efforts. Unfortunately, most of them are no longer here. Thus, Mel Gitlin, M.D., former chair at Tulane, is now in Miami; Alan Santos, M.D., former chair at Ochsner, is now in New York; Randy Cork, M.D., former chair at LSU Shreveport, is now in Alaska. I know and have worked with each of them, and it is a significant loss to the state that they have left this region.

Many observers around the country have assumed that there has been a great rebuilding here. Sadly, most damaged houses and critical structures have remained in an identical condition from 2005. I mostly see the same molded and decimated streets of uninhabited houses. Approximately half of the old population is living elsewhere. There is massive post-traumatic stress and depression in many of the survivors, with limited to nonexistent psychiatric facilities or personnel. On our own block, I have seen exactly one house being built since 2005, and it is finally nearing completion. In the chaos we all experienced, we see the world very differently. My family was relocated to Texas for nearly 10 months until schools could function and they could come back to New Orleans — and we consider ourselves the lucky ones. Many people did not even have insurance, and most insurance companies blamed flooding for housing devastation and refused to pay repair bills. Flood insurance is federally funded and is limited to only approximately \$200,000;

therefore, most people have never received adequate compensation to rebuild. Lives and jobs have been lost in significant numbers. Imagine the consequences of a check for \$200,000 on a property you owe more than \$1 million on, and you have nowhere to live but a temporary trailer.

Thousands of health care workers also left the state when they lost their jobs related to the closing of approximately half of the hospitals in this region. Having been a former residency director at Tulane during my nearly nine-year stay there, I received more than 150 resumes of colleagues and friends looking for jobs post-Katrina. All three of our clinical facilities were closed, and to this day, only one (University Hospital) has reopened. The salvation of the LSU School of Medicine at New Orleans (located across the street from Tulane Medical School) was the opportunity to move to private practice and the very rapid recruitment of excellent private practitioners, most of whom had worked closely with me at Tulane Medical Center in the 1990s. We currently oversee services at three hospitals and a surgery center. Our LSU department has helped train residents from Tulane Ochsner and LSU Shreveport, which each have independent training sites, and has provided many lectures in the last three years. We have been amazingly stable with our staff and recently received very positive news for a new independent residency from the RRC. Our offices have been moved five times since 2005, and we are headed to a final place with a new John Adriani Library, which many of you have donated books toward (if anyone is interested, contact me at [akaye@lsuhsc.edu](mailto:akaye@lsuhsc.edu)). Our NIH-funded simulation center has been rebuilt and recently opened. We expect the start of construction of a new joint LSU-VA 488-bed, \$1.2 billion facility across from the old Charity Hospital. Our very productive pulmonary vascular laboratory has been unable, related to significant vivarium issues, to perform a single experiment since 2005. We have been moving forward in recent months with collaboration with a number of our basic scientists to continue the excellent tradition of academic scholarly pursuits at LSU School of Medicine in New Orleans.

Tulane's anesthesia department does not have a single staff left from the 1990s and was recently taken over by a very large private practice group. Tulane's group had expanded after the storm with the closing of Tulane Medical Center until February 2006 to Lakeside Hospital (now known as Tulane Lakeside Hospital). The residency was pared down from approximate-



*Alan David Kaye, M.D.,  
Ph.D., DABPM*

ly 40 before Katrina to 14. The Tulane group has extensively collaborated with our department toward academic publications, didactic resident teaching, and clinical residency training at our level one facility, University Hospital. The private group with new leadership was to begin by June 2008.

Ochsner's anesthesia department serves its main campus at Ochsner Hospital. It never shut down related to Hurricane Katrina. However, in an extraordinary consolidation in October 2006, Ochsner purchased three additional hospitals: Baptist, Kenner and Meadowcrest. The residency has been stable, and we have worked closely with each of the Ochsner residents while they complete a trauma rotation with us at University Hospital. At present, an expedited search is under way for a new leader of the department.

Having worked at Tulane, Ochsner and LSU School of Medicine in New Orleans, I will say that there is no sugar-coated happy ending in sight. The city has seen a consolidation down to essentially three very capable anesthesiology groups. We are excited with the opportunity to restart the LSU School of Medicine in New Orleans anesthesia training program, and

this has been my greatest focus each day. The report on academic anesthesia progress may either be a sign of the times or directly reflective of the consequences of Hurricane Katrina. Each anesthesiologist practicing in this region has been affected by a number of extraordinary professional and life stresses. For our group, in the last three years, we have started up four new hospitals and a surgery center! It is true that I have less time to review and write manuscripts, but I am sure that I am here in New Orleans at this time for a reason, and I have been grateful to positively impact our community by raising clinical standards and moving forward our academic missions. We are very grateful for the support and understanding the country has had in helping us rebuild, albeit slowly, as in the case of book donations to our John Adriani Memorial Library. Volunteers come to our region regularly and help restore houses, schools and infrastructure. History tells us that years from now, the region will have been updated and improved through rebuilding. As mentioned early in this article, we intend to do it one book, one trainee and one patient at a time.

## Medicare Anesthesiology Teaching Rule Fixed — Senate and House Pass Veto-Proof Legislation

*Continued from page 1*

Medicare anesthesiology teaching rule reform legislation. Two years later, the bill became a law.

Medicare anesthesiology teaching rule reform legislation (S. 2056/H.R. 2053) ultimately passed the House and Senate as part of H.R. 6331, the Medicare Improvements for Patients and Providers Act, or MIPPA. Also included in H.R. 6331 was a provision to avert Medicare payment cuts to all of Medicine in 2008 and to provide a positive 1.1-percent update in 2009, rather than a 10.6-percent cut that took effect on July 1, and a projected 15-percent cut that had been slated for January 1, 2009.

Indeed, this monumental legislative victory did not happen overnight. It was the direct result of tireless efforts within CMS and Congress as well as coalitions within the federation of medicine.

Paramount to these efforts was the involvement of our academic anesthesiologists. Their firsthand testimony to the need for anesthesiology teaching rule reform provided Congress with compelling reasons to overturn the 50-percent payment penalty. Many AUA members contributed time, energy and talent to ensure passage of this legislation. I applaud you, congratulate you, and thank you for your dedication to the future of the medical specialty of anesthesiology.

There is an important "take home" message for those of us in academic medicine. "Academic Anesthesiology" is no longer a "three-legged stool" (i.e., research, education and clinical care). The lesson from our success with the anesthesiology teaching reform legislation is that we must take a leadership role in advocacy and groom future generations of anesthesiologists to understand the importance of doing

so as well. We can (and *must*) take action to effect regulation and legislation that will advance our specialty and improve patient care. The "three-legged stool" has indeed become a "four-legged chair" (i.e., research, education, clinical care and **advocacy**).

Without a doubt, the passage of S. 2056/H.R. 2053 is a huge victory for the medical specialty of anesthesiology, organized medicine and America's patients. The new law will correct the anesthesiology teaching payment inequity, strengthening our residency programs in the process. This means that our nation's most vulnerable patient populations will have continued access to expert anesthesiology medical care at academic hospitals throughout the country.

We applaud Congress for responsibly restoring full Medicare payment to anesthesiology teaching programs by including S. 2056/H.R. 2053, legislation that will address the payment disparity without unwittingly expanding non-physician scope of practice in the process.

In the Senate, we are very grateful for the leadership of Sens. Rockefeller and Kyl, who introduced S. 2056, which garnered bipartisan support from 29 additional Senate cosponsors. In the House, we appreciate Rep. Becerra, who introduced H.R. 2053, which gained 127 bipartisan cosponsors. Our strong sponsors helped ensure that the proper bill language eventually became law. Their provision will bring one-half billion dollars to anesthesiology teaching programs over 10 years.

This profound legislative victory is significant to me not only as the president of ASA, but also as an academic anesthesiologist. I am proud to have colleagues who are active, involved and determined, and who fight hard for sound policy even in the face of significant adversity.



## Medical Student Anesthesia Research Fellowship

### FAER MSARF Symposium

As part of the FAER Medical Student Anesthesia Research Fellowship, FAER offers students the opportunity to make a research presentation during the American Society of Anesthesiologists Annual Meeting at the FAER Medical Student Anesthesia Research Fellowship Symposium. The symposium is moderated by Donn Dennis, MD, FAHA. Dr. Dennis is a FAER Director, the Joachim S. Gravenstein, MD Professor of Anesthesiology and Director of Nanomedicine at the University of Florida College of Medicine, and Vice President of Pharmacology at ARYx Therapeutics, Inc. in Fremont, California. Dr. Dennis' research interests focus on translating fundamental science findings in the areas of cardiovascular biology and nanotechnology into medically useful, commercially viable products (e.g., new chemical entities, nano-based drug delivery systems and sensors).

The symposium is held in October during the ASA Annual Meeting. MSARF students make a 3- to 5-minute presentation on their MSARF research project. After each presentation, a brief question and answer period takes place. Mentors of the medical students are also strongly encouraged to attend.

FAER offers a \$1,000 grant to the student's MSARF host department to defray the costs for the medical student to attend the ASA Annual Meeting and this symposium. Medical students submit expenses to the host department for reimbursement.

In addition to the symposium, students and their mentors are invited to the Tuesday night FAER/Abbott - Volwiler & Tabern Resident Scholar Program. As part of the symposium program, students are required to attend these additional research-related activities on the Monday during the ASA Annual Meeting: Celebration of Research Luncheon  
FAER Honorary Research Lecture  
FAER Panel

Students who plan to attend the ASA Annual Meeting and present at the symposium must complete a MSARF Symposium Registration through FAER. Registration forms will be distributed to all MSARF Fellows during their fellowship.

Additionally, students must register for the ASA Annual Meeting by going to <http://www2.asahq.org/web/index.asp>. ASA Annual Meeting registration fees are free for medical student members. While visiting the registration website, students may also make hotel reservations.

**View the abstracts from the 2008 FAER MSARF Symposium to be held on October 21, 2008 at: [www.faer.org/programs/students/msarf.html](http://www.faer.org/programs/students/msarf.html)**

**MSARF Questions:** Please contact the FAER office at (507) 266-6866 with any questions.

**The FAER MSARF program is sponsored in part by grants from:**  
The Ronald L. Katz Family Foundation and Merck & Co., Inc.



# What Do You Want Your Society to Be?

Ronald Pearl, M.D., Ph.D.  
AUA President

AUA was established in 1953 by Henry Beecher, Manny Papper, Robert Dripps and Austin Lamont. At that time, there were only about 50 physicians in the United States with special expertise in anesthesiology, and the goal of the Society was to foster anesthesia research to address critical unanswered questions. The maximum number of members was limited for many decades, and the AUA meetings provided an opportunity for the leaders in academic anesthesia to address problems in a retreat-like setting.

AUA today retains many of these components, but it is a dramatically different Society. We have grown to more than 800 members. In an attempt to represent academic anesthesia, and not simply anesthesia research, the Society has expanded its membership criteria to include educational contributions and academic leadership. Although the annual meeting does allow opportunities to meet with old friends and make new ones, the agenda is packed with the Scientific Advisory Board, Educational Advisory Board, the NIH and host programs, as illustrated by the superb annual meeting at Duke University this spring.

At the time of such success, it is appropriate to ask what we want the Society to be. Many of our members actively participate in ASA, ABA, SAAC-AAPD, FAER and multiple subspecialty and research societies. Each of those societies has a well-defined and somewhat unique mission. In contrast, many of our own members, as well as anesthesiologists outside the Society, question the purpose of AUA. Our bylaws state that our mission is the advancement of the art and science of anesthesiology by encouraging our members to pursue original investigations in the clinic and in the laboratory by developing new methods of teaching anesthesia and by promoting the free and informal interchange of ideas.

The overlapping relationships between AUA and other societies can be a source of strength for academic anesthesia. The recent legislation that will repeal the anesthesia teaching rule penalty (half pay for double coverage) was successful only because ASA recognizes the critical importance of maintaining the strength of the academic anesthesia departments. Although many members of AUA played important advocacy roles in the process, AUA as a Society has traditionally not been active in advocacy, whether related to research, education, reimbursement or clinical care. In general, we have relied on our other societies to advocate for or against changes that may markedly impact academic anesthesia.

During the next year, the AUA Council will begin a discussion on the mission of the Society. In particular, we will address whether AUA should have an expanded role in representing academic anesthesia and whether any changes are required in the Society in order to do so. As part of that process, I welcome comments and suggestions from each of our members.



Ronald Pearl, M.D., Ph.D.

**“During the next year, the AUA Council will begin a discussion on the mission of the Society. In particular, we will address whether AUA should have an expanded role in representing academic anesthesia and whether any changes are required in the Society in order to do so.”**

# 56th Annual Meeting

*April 2-5, 2009  
Moody Gardens Hotel  
Galveston, Texas*

## Program Highlights

### **Thursday, April 2**

Welcome Reception

### **Friday, April 3**

Oral Presentations  
Poster Viewing  
President's Panel  
EAB Sessions  
NIH Session  
Evening Reception at Aquarium Pyramid, Moody Gardens

### **Saturday, April 4**

Host Program

- Global Health/Pandemics
- Alzheimer's Disease: Current Concepts
- Breaking Down Barriers to Health: Telehealth and Access to Care
- Health Resources Allocation

SAB Session  
Poster Viewing and Discussion  
Reception and Dinner at Moody Gardens

### **Sunday, April 5**

Oral Presentations

Jointly sponsored by the University  
of Texas Medical Branch and AUA





## Call for 2009 Annual Meeting Abstracts

The Scientific Advisory Board (SAB) invites you to submit an original basic or clinical research abstract for presentation at the AUA 56th Annual Meeting, April 2-5, 2009 at the Moody Gardens Hotel in Galveston, Texas.

As is tradition, all submitted abstracts will be accepted. Only one abstract per member (authored or sponsored) will be accepted. The SAB will review all abstracts and assign them to either oral or poster sessions. SAB will work with authors of the oral presentations to organize the content of their talk for this general audience and to emphasize clinical relevance of basic science studies. Members are encouraged to consider submission of clinically oriented abstracts, since clinical abstract submissions are down in recent years.

We encourage you to submit your abstracts for presentation at the AUA Annual Meeting by visiting the Society's online submission form at [www.auahq.org](http://www.auahq.org); review the layout and format instructions, complete the submission form and upload your abstract. Please note: ONLY electronic submissions will be accepted for consideration. The abstract submission site will go live in late October 2008.

Abstracts selected for the AUA 56th Annual Meeting will not be published, allowing members to submit the same work to the ASA 2009 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 appropriate box on the online submission form. In order to be considered for the award, the resident author must attend the meeting. The top two scoring abstracts judged by the Scientific Advisory Board will be awarded a \$1,000 travel award.

We look forward to a lively scientific session in 2009 based on your abstracts.

### **Marie Csete, M.D., Ph.D., Chair SAB**

Helene Benveniste, M.D., Ph.D.  
David Eckmann, M.D., Ph.D.  
Stuart Forman, M.D., Ph.D.  
Michael Gropper, M.D., Ph.D., F.C.C.P.  
Howard Gutstein, M.D.  
Judy Kersten, M.D.  
Lucy Waskell, M.D., Ph.D.  
Zhiyi Zuo, M.D., Ph.D.

## EAB Call for Nominations

The AUA Educational Advisory Board (EAB) helps to develop programs for the Annual Meeting. These programs are oriented toward the educational mission of our specialty. The EAB also contributes articles to the AUA newsletter. The full committee meets during the AUA Annual Meeting.

Committee members are expected to attend the AUA Annual Meeting and the EAB committee meeting as well as actively participate in all committee activities. AUA members who are interested in serving on the EAB, who plan on attending AUA Annual Meetings and who are willing to help undertake the work of the committee are encouraged to submit their names or those of other members with a brief resume by December 1, 2008 to: Robert E. Shangraw, M.D., Ph.D., EAB Chair [shangraw@ohsu.edu](mailto:shangraw@ohsu.edu).

The AUA Council and the EAB chair will choose three candidates who will then be contacted to confirm their willingness to serve. The three-year term begins after the AUA Annual Meeting.

## SAB Call for Nominations

The AUA Council would like to invite AUA members to nominate another member or apply themselves for service on the Scientific Advisory Board (SAB). The SAB determines the scientific content of the Annual Meeting and provides input to the AUA Council on issues pertinent to the scientific mission of AUA. SAB has three responsibilities:

1. grade abstracts for the AUA Annual Meeting and organize accepted abstracts into sessions;
2. attend the Annual AUA Meeting to help poster and oral discussion sessions, and attend the SAB working luncheon for discussion of issues relevant to the SAB; and
3. contribute a 500- to 1,000-word article to the AUA newsletter once during the three-year term on the SAB. Articles might be short reviews of some recent scientific advance or pertinent topic, a meeting review or an opinion piece.

To nominate a member or to apply for service on the SAB, please e-mail curriculum vitae by March 1, 2009, to: Marie Csete, M.D., Ph.D., SAB Chair [mcsete@cirm.ca.gov](mailto:mcsete@cirm.ca.gov).

The AUA Council and the SAB chair will choose three candidates who will then be contacted to confirm their willingness to serve. The three-year term begins after the AUA Annual Meeting.

## AUA Member Tod Sloan Receives ASNM Lifetime Achievement Award

At this year's meeting of the American Society of Neurophysiological Monitoring (ASNM), the ASNM Board presented the Richard Brown Lifetime Achievement Award to Tod Sloan, M.D., Ph.D., M.B.A., FASN, University of Colorado, for his continuing service toward the improvement of intraoperative monitoring and his dedicated service to ASNM.



# AUA Membership Nominations Available Soon

## Submission Deadline January 9, 2009

### *How Do I Nominate Someone?*

All AUA members are invited to nominate candidates for membership in the association beginning on Thursday, November 6, 2008. 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 an 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 anesthesiology.

The Council recommends for election by the general membership those candidates who seem best qualified. In the Council's deliberations, great emphasis is placed on excellence in areas of pertinence to the goals of the Association. The Council is requesting that the nominator identify — from among the areas of teaching, research and administration — 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 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 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 AUA. The reason for such Honorary Membership should be clearly stated by the nominators, emphasizing how such recognition would benefit 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.

Only electronic submissions via the AUA Web site will be accepted, beginning **Thursday, November 6, 2008**. Paper nominations will not be considered by the Council and will be returned to the nominator.

Nominators can access the online nomination process by visiting **www.auahq.org** and clicking on the "Membership Process" section. You will need the AUA username "auamember" and password "papper." Please have the following information available before you begin the submission process. *You will not be able to save your information during this process. All information must be completed at one time in order for the submission to be completed. Please allow approximately 30 minutes to complete the following steps needed to submit your nomination.*

The following information is needed in order to complete the nomination process:

1. Nominator contact information (full name, title, institution, address, phone, fax and e-mail address).
2. Nominee contact information (full name, title, institution, address, telephone, fax and e-mail address).
3. Nomination letter (this information can be copied and pasted into text boxes).
4. Seconding nominator information (full name, title, institution, address, telephone, fax and e-mail address).
5. Seconding nominator letter (this document must be in a Word or PDF file).
6. Five references (full name, title, institution, address, telephone, fax and e-mail address).
7. Curriculum vitae (this document must be in a Word or PDF file).
8. Peer-reviewed grant funding (this may be copied and pasted into a text box or uploaded as a Word or PDF file).

If you have questions regarding the new process, please contact the AUA office at (847) 825-5586 or e-mail **c.dionne@asahq.org**.



# AUA

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## Annual Meeting Hosts

The AUA Council is looking for Host Institutions for April 2012. For more information, review the Annual Meeting Guidelines for Host Institutions posted on the AUA Web site at [www.asahq.org](http://www.asahq.org).

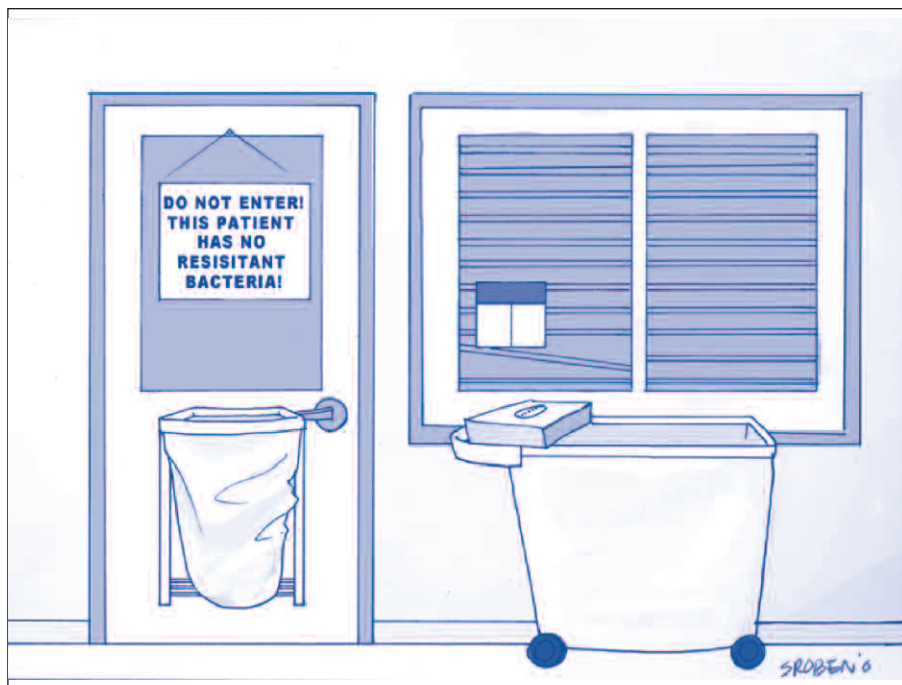
## Future Meeting Dates and Locations

### April 8-10, 2010

AUA 57th Annual Meeting  
Grand Hyatt Denver – Downtown  
Denver, Colorado

### May 11-15, 2011

AUA 58th Annual Meeting  
Loews Philadelphia  
Philadelphia, Pennsylvania



**A new clinical problem: the patient without MRSA. Notify the government! Inform the patient! Isolate! Quarantine!**