AUA
Association of University Anesthesiologists

Update

Spring 2008

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FAER

Academy of Research Mentors in Anesthesiology

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"The Academy plans to expand its activities in the coming year in the hope of educating mentors in successful approaches and techniques, educating trainees about opportunities to obtaining appropriate mentoring and continuing to increase the value and recognition accorded to successful mentors."

There is a widespread perception that academic anesthesiology is struggling to maintain a robust research enterprise, in part because it is failing to attract and successfully mentor potential young investigators. In 2004, the Foundation for Anesthesia Education and Research (FAER) responded to this perceived deficiency by establishing the FAER Academy of Research Mentors in Anesthesiology (FARMA). The stated objective of the Academy was to *"recognize those individuals who through their activities as mentors have contributed importantly to the development and advancement of academic anesthesiologists in the area of research, and have promoted the activities of mentoring among others in the specialty, thus increasing academic research activities and promoting the academic image of Anesthesiology."* John P. Kampine, M.D., Ph.D., the Academy's founder and first president, oversaw the election of the initial 24 members.

Alex S. Evers, M.D.

While the Academy initially provided professional recognition for the mentoring contributions of its members, it was recognized that the Academy should also be a resource for the development of new mentors and role models in academic anesthesia and should take an active role in assisting faculty who are beginning in a mentoring role and in helping trainees to identify appropriate mentors. The Academy's second president, Simon Gelman, M.D., Ph.D., sponsored the first annual FARMA workshop at the ASA 2007 Annual Meeting, titled, "Finding the Right Mentor." This workshop featured brief personal descriptions by 17 anesthesiologists about how they had successfully mentored and/or been mentored to successful careers as NIH-funded physician scientists.

The Academy plans to expand its activities in the coming year in the hope of educating mentors in successful approaches and techniques, educating trainees about opportunities to obtaining appropriate mentoring and continuing to increase the value and recognition accorded to successful mentors. Planned activities include creation of a Web site with educational materials

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Advocacy:

Not for the Faint of Heart

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

While anesthesiologists carry out vital medical procedures and research in universities across the country, important decisions are being made in Washington, D.C. that will affect how future generations of anesthesiologists will do their jobs.

Rather than being passive observers of the legislative process, all in academic anesthesiology must strive to ensure the future of patient safety in our specialty.

Our involvement is absolutely essential since most members of Congress and members of the Administration do not have medical backgrounds. This means lawmakers and other decision makers must hear from us about the nuances of health care issues that affect our profession and our patients. As physicians and as constituents, we have a unique opportunity to provide input in the decision-making process.

Advocating for the profession may seem daunting. However, once you learn the issues, you are ready to jump in. Right now on Capitol Hill and throughout Washington, lawmakers are crafting legislation and making decisions that will affect many aspects of anesthesiologists' practice. Current examples of such issues include:

- Medicare annual payment updates (sustainable growth rate [SGR] reform)
- Medicare anesthesiology teaching rule reform (H.R. 2053/S. 2056)
- Rural pass-through (H.R. 1866)
- Health Care Truth and Transparency Act (H.R. 2260)
- Pain care policy (H.R. 2994)

Jeffrey L. Apfelbaum, M.D.

This list represents an important sampling of current issues affecting the medical specialty of anesthesiology. More information about each of these topics and bills can be found on the ASA Web site www.asahq.org/government.htm. At the

"We must stay actively involved to ensure full passage of teaching rule reform legislation this year. If you have been actively involved, we are all grateful to you for your efforts. If not ..."

Web site, you will find bill language, summaries and cosponsor lists, in addition to links for action alerts. The action alerts provide entre into the next step of active participation: responding to calls for action in a quick, easy-to-reach manner. The ASA CapWiz Action Center provides a one-stop avenue for you to contact your representative and senators in support of legislation affecting our specialty. After you provide your name and ZIP code, with the click of your mouse you can find your legislators, choose and edit a pre-written message, and become an active advocate for anesthesiology.

Once you personally familiarize yourself with the issues and begin to take action supporting the legislative interests of our specialty, you should become an ambassador to your colleagues in academia both at the faculty and housestaff level. Help inform those physicians who are uninformed and help motivate those who are apathetic or ignorant. Ignite their passion in our specialty. Encourage your residents to become involved in the public policy and political processes. If you don't do it, who will? Again, the ASA Web site www.ASAhq.org provides a number of resources to help others get involved.

Your efforts won't go unnoticed. Though we are only at the "childhood" phase of development of our advocacy efforts, this work to date has resulted in a number of successes.

Most notably, for 2008 the Medicare anesthesia conversion factor rose to $19.97 — up from $16.19 in 2007. This increase was the direct result of ASA's work to successfully develop a consensus with other medical groups through the AMA/Specialty Society Relative Value Scale Update Committee process. Further, more than 4,000 anesthesiologists nationwide responded to an urgent action alert and submitted comment letters to the Centers for Medicare & Medicaid Services (CMS) in support of the conversion factor increase.

Another top ASA priority in Washington is Medicare anesthesiology teaching rule reform legislation, which continues garnering co-sponsors and gaining momentum. More than one-quarter of all representatives and senators — 139 in all, to date — are co-sponsors of legislation, H.R. 2053 and S. 2056, to remedy the unfair Medicare anesthesiology teaching rule. As you know, this unfair CMS policy cuts payments to academic anesthesiologists *in half* when they supervise two resident physicians. When we achieve reform of the Medicare anesthesiology teaching rule, 100 percent of the projected $36 million will be returned to academic departments ***annually***.

Our progress to date is due in no small part to the hard work of grassroots anesthesiologists who write letters, make phone calls and schedule meetings to explain the issues to representatives and senators. We must stay actively involved to ensure full passage of teaching rule reform legislation this year. If you have been actively involved, we are all grateful to you for your efforts. If not…

Regarding Medicare payments in general, all physicians face a 10.6-percent cut beginning July 1 this year unless Congress acts to fix the SGR formula. For years, the medical community has fought against the misguided payment mechanism that would cut payments each year unless Congress intervenes to prevent the cuts.

Because of the advocacy efforts of organized medicine — including ASA — SGR cuts have largely been minimized. Although Congress' favorite solution of payment freezes or modest updates is hardly adequate, SGR cuts would have been much deeper without strong action by physicians and other health care advocates. Since Congress only chose to implement a six-month SGR patch this year, rather than its typical one-year fix, we must join forces again to stave off payment cuts for mid-year 2008. Please stay updated on the latest legislative happenings (www.ASAhq.org), and be prepared to take immediate action against SGR cuts when called upon.

As an academic anesthesiologist, you can be a strong voice for our specialty. There are certainly plenty of voices speaking out against our priorities, so academic anesthesiologists must remain diligent in our efforts to educate lawmakers about the medical specialty of anesthesiology. Together we have a wonderful opportunity to make a difference in the future of our profession. But it will take active participation from **all** in academic anesthesiology to ensure that future generations of patients have the benefit of a medical specialist in anesthesiology.

Emeritus Faculty: An Underutilized Resource

Fredrick K. Orkin, M.D., M.B.A., S.M.
Adjunct Professor of Anesthesiology
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A mini-tsunami! That's how some of our colleagues have referred to the growing numbers of increasingly elderly patients that will arrive in our operating suites and critical-care units in the coming decades as the U.S. population continues to gray. As hackneyed as that observation has become, there has been remarkably little recognition of a similar, albeit reversed, demographic phenomenon just beginning to affect academic anesthesiology: our increasing faculty attrition due to retirement.

Even before growing faculty cohorts retire, academic anesthesiology is already experiencing crisis and devolution. The signs include very low investigator-initiated research funding[1] amid minimal scholarly activity in supposedly academic environments, departments that increasingly resemble service departments in community settings, and increasing difficulty recruiting and retaining highly-qualified physicians who espouse scholarly interests.

Possible Remedies

The proposed remedy is a strong focus on enhancing prospects for obtaining external funding for research by two linked initiatives: research training for highly selected individuals early in their careers coupled with close mentoring by independent investigators (syn: those who have received competitive federal or major foundation funding).[1] Although critically important for developing new investigators, this strategy is focused on augmenting our specialty's meager ranks of "physician scientists" and offers limited benefit beyond the selected trainees who are preoccupied developing their careers and securing highly competitive funding and grant renewals. The reality is that the many other scholarly activities of an academic clinical department do not benefit much for years, until the new investigator's career is successfully under way.

A more comprehensive fix for those other activities requires recognizing the fundamental resource that all of academic medicine has lost. As the distinguished medical historian-internist Kenneth Ludmerer has noted in a seminal book,[2] the increasingly competitive health care marketplace engendered by 20 years of managed care has severely eroded our discretionary time. We have lost the time to teach; read; learn new approaches to care, teaching and research; undertake preliminary research; and, sadly, improve care. In short, the time to do scholarly activities has been squeezed out by unrelenting pressure to maintain personal income by raising clinical revenues.

Emeritus faculty can provide a modicum of relief in this devolution by participating in myriad activities that support the department's academic mission and that have two important characteristics: they take time but generate little or no revenue. In effect, emeriti can replace some of the lost discretionary time at no cost to the department. These activities include educational endeavors (e.g., residency-applicant interviews, case discussions, didactic lectures, grand rounds lectures, mock orals, journal club, mentoring), service functions (e.g., medical school interviews), research (e.g., clinical studies), and even some clinical work (e.g., preoperative clinic). Since retirees volunteer their time and typically have specific interests, the particular activities in which they participate are tailored to their preferences. However, emeriti supplement, assist and even mentor, but not replace, regular faculty, as the latter develop their own academic careers.

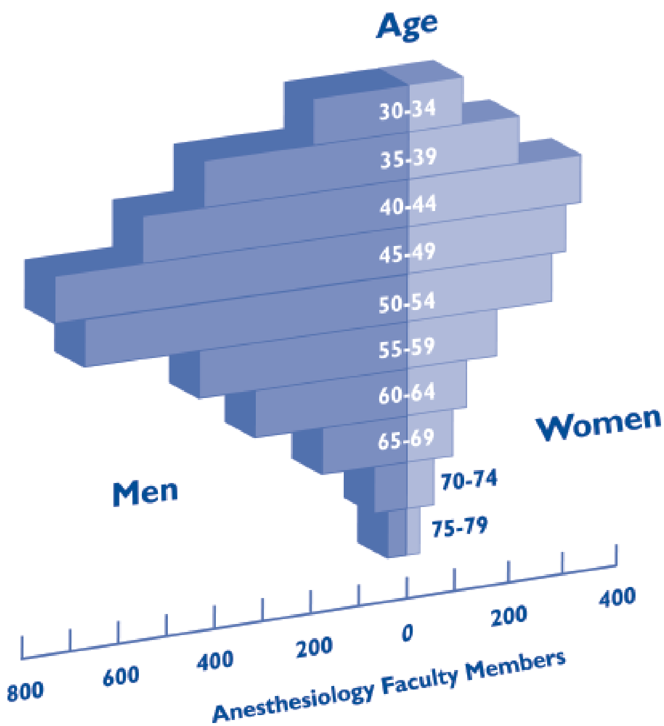
Fredrick K. Orkin, M.D., M.B.A., S.M.

In the Numbers

How many potential emeritus faculty are available to participate? This number is a function of the dynamic interplay between demographic variables — including recruitment into the specialty and recruitment into academia, reduced by attrition due to death, severe disability and career changes – and externalities such as societal trends in retirement timing, changes in economic markets that affect perceptions of personal wealth, among other diverse considerations that may influence an individual's readiness for retirement at a particular time. Thus, without much more information, the actual number of emeriti at any time is speculative. However, a suggestion of several hundred emerges from noting the numbers of anesthesiology faculty approaching customary retirement ages in academic anesthesiology's demographic pyramid [see figure]; this graphic was constructed from annual faculty data collected on December 31, 2006 and kindly furnished by the Association of American Medical Colleges. The graphic documents that our academic workforce (as the specialty generally) is rather young, with the largest numbers of faculty in their forties, in large part because these individuals entered the specialty during the latter 1980s and early 1990s, including when recruitment was at its historic high about 15 years ago. As time marches on, the numbers of potential emeriti will probably increase; then, beginning perhaps in 15 years, gradually decrease, unless recruitment into academic anesthesiology grows.

At a time when academic anesthesiology is challenged to recruit and retain faculty, why might retirees be interested in staying on as emeriti? After a long career, it is likely that many

Academic Anesthesiology's Demographic Pyramid



might want to maintain some meaningful connection to the specialty. (Although this discussion has focused on those retiring from an academic department, many retirees from community settings may also be similarly interested in becoming emeriti faculty.) By participating in some activity of interest in retirement, these individuals gain a valued sense of "giving back." Such sentiments are especially consistent with why one became a physician.

The Solution Is Before Us

Although the notion of retirees serving as emeritus faculty may seem innovative, if not fanciful, the phenomenon has actually existed informally in many departments for many years, albeit with very small numbers of participants. Typically, these individuals have had distinguished careers in their departments and informally just continued activities of special interest in their retirement. However, the phenomenon can be expanded as a faculty model with many more participants. Many retirees are probably quite willing to participate but may not see a path. Chairs should break the ice by broaching an emeritus-faculty role with senior faculty who are planning retirement, especially if they have special interests and/or skills of particular value to the department. With a little creative planning, augmenting the ranks of emeritus faculty offers another option for keeping academics in academic anesthesiology.

References:

1. Schwinn DA, Balser JR. Anesthesiology physician scientists in academic medicine: A wake-up call. *Anesthesiology*. 2006; 104: 170-178.
2. Ludmerer KM. *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. New York: Oxford University Press, 1999.

"At a time when academic anesthesiology is challenged to recruit and retain faculty, why might retirees be interested in staying on as emeriti? After a long career, it is likely that many might want to maintain some meaningful connection to the specialty."

Social Networking Sites

Keith Ruskin, M.D.
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I was stuck in an airport lounge a few weeks ago with nothing to do. Over the past few days, I had been thinking about social networking sites and how we as academic anesthesiologists might use them. You've heard about some of these companies – MySpace (www.myspace.com) for high school kids, LinkedIn (www.linkedin.com) for corporate executives and Facebook (www.facebook.com) for just about everybody else. With two hours to kill until my next flight, I decided to create a page for myself on Facebook. I picked Facebook because it seems to be the one that everyone seems to talk about, and also because I thought that I could hide for a little while I figured out how people used it to interact. I selected the option to create a new profile, entered my professional information and uploaded a picture of myself that was sitting on my laptop. Total time: 15 minutes.

Ten minutes after I created my profile, I received a message from an old college classmate who found me on Facebook. I added him to my "Friends" list and went back to my e-mail. A few minutes later, one of the faculty members in my department found my profile, so I added him to my Friends. Almost immediately, two of the residents in my department found me. By the time I got back home, another faculty member and 10 more residents had added me to their "Friends" and asked me to do the same. By the next morning, I had most of our current residents and several of our recent graduates in my network. So much for anonymity… I shouldn't have been surprised: In mid-2007, Facebook had 64 million users who had uploaded 1.7 billion photographs, and it was the most popular photo-uploading site in the world.

How does Facebook work? Each user creates a profile with some basic contact, educational, professional and personal information. Access to this information can be open to everyone or restricted to one's friends or members of a network. It's also possible to add topics such as favorite music, quotes or activities. There's a status feature that tells people what you're doing right now, an area for photographs and a "Wall." The Wall is one of the more interesting features of the site and allows any one of your Friends to leave a brief message there for all to see. You're notified by e-mail whenever anyone leaves a message for you, and, of course, you can remove messages from your own Wall. The Wall is used for short conversations or a single comment; a Messages section can be used to have a private discussion. In mid-2007, Facebook launched a framework that software developers could use to create applications which would interface with its core features. This platform attracted a considerable amount of attention, with Stanford University offering a computer science class on Facebook Web applications. It also spawned a venture capital firm that specializes in funding software developers working on Facebook applications.

Keith Ruskin, M.D.

Social networking sites fundamentally change the way people keep in touch. Many Facebook users share news and pictures with friends and acquaintances, using it as a kind of continuously updated "Family and Friends" newsletter. Others (like me) use it to keep in touch with professional colleagues. It's intriguing to occasionally find that two people whom I work with have some other connection and already know each other. Joining Facebook has subtly changed the way I interact with the residents. A physician in training who may be reluctant to ask a senior faculty member for advice in person might have an easier time writing something on my Wall or sending me an instant message. If a critical mass of anesthesiologists were to join a single social networking site, we might improve our ability to find others with similar research or academic interests, essentially creating our own society. At the very least, it's much easier to share my vacation pictures with my family and friends.

There are some important things to remember when creating a profile on a social networking site. Once you begin to add coworkers to your list of Friends, they have access to your entire profile, blurring the division between your professional and personal life. For this reason, it's important to create a profile that is appropriate for a physician working in an academic medical center. There is nothing on my page that my

chair doesn't already know about me. I keep my interactions with coworkers (especially residents) professional, too: I won't write something on Facebook that I wouldn't say in the operating room. Because I don't know who might be looking at my profile, my contact information lists only my office telephone number and work e-mail address. Patient care issues (or any confidential information) should not be discussed because of the obvious lack of privacy. Facebook does not provide a way to close an account, meaning a user cannot remove his or her profile once it has been created, although it is, of course, possible to remove nearly all of the information associated with that profile.

Are social networking sites potentially useful tools to academic anesthesiologists? My own experience leads me to believe that the answer is a qualified "yes." Any technology that improves our ability to communicate with one another is certainly worth trying. If nothing else, a growing proportion of our colleagues are using these sites to keep in touch with each other. I chose Facebook because it was the easiest to join and because I knew that several of my department's residents and faculty were already members. (I just didn't know how many of them were already members!) If enough anesthesiologists were to join Facebook, we could use it to recreate the networking that occurs during social events at the annual meetings of AUA and ASA.

Editor's comment: *It strikes me that one unintended consequence of my learning more about this will be learning more about my young adult children by finally gaining access to their social network…*

— W.A.K

FAER Academy of Research Mentors in Anesthesiology

Continued from page 1

for mentors and establishment of a national mentoring award. In addition, the second annual FARMA workshop will be held at the ASA 2008 Annual Meeting in Orlando. It will be titled "Being a Successful Mentor" and will be organized by Zeljko Bosnjak, Ph.D., and Paul Knight, M.D., Ph.D. A major role of FARMA remains providing appropriate recognition for the mentoring accomplishments of its membership who are listed below. New members can be nominated by current members or academic department chairs with election by a majority of the Academy membership.

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