



# AUA

Association of University Anesthesiologists

# Update

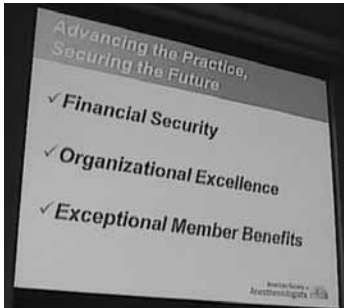
Summer 2012

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## AUA 2012: ASA President's Message Financial Security, Organizational Excellence, Exceptional Member Benefits

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



John M. Zerwas, M.D., ASA President Elect, presented the ASA's president's update at the 2012 AUA Annual Meeting. He discussed the goals of the ASA, which included financial security, organizational excellence and exceptional member benefits. He reviewed some of the ASA finances. He indicated

that half the operating revenue was based on dues income, indicating that this really should be less. He pointed out that the AMA operates totally independently of dues income, but that this is not a suitable goal, either. ASA reserves are around \$63 million. Non-dues operating revenue is about \$14 million. Operating expenses were indicated to be \$32 million, \$9 million for education, \$7 million for advocacy and \$6 million for governance of the ASA.

New financial processes and systems have been instituted, notably dating back to when Dr. Zerwas was ASA treasurer. He indicated that the ASA has hired a CFO, has instituted generally accepted accounting practices, created a more reasonable budget process and increased revenue. Moreover, a higher educational level is notable in new hires. Previously, there was a predominance of high school-educated support staff, whereas now it is predominantly bachelor's degree and higher.

The annual meeting has been expanded and made more exciting. Membership continues to grow.

There has been a strategic decision to focus on education. Thus, the ASA has provided substantial support for Maintenance of Certification in Anesthesiology, or MOCA™, and has a customized learning center opportunities for our members. ASA has expanded its education department and added a chief learning officer, Diane Gambill, Ph.D.

ASA also has been advancing the journal *Anesthesiology*, which is the premiere journal of anesthesiology in the world. There is consideration that it may go to an every-two-week publication schedule.



John M. Zerwas, M.D.

Dr. Zerwas previewed the upcoming meeting in Washington, D.C. this October, before a presidential election, indicating that notable political consultants James Carville and Mary Matalin will give a presentation and that it should be very exciting indeed.

There has been a communications strategy to significantly enhance the image of anesthesiology among the general public. ASA has been working on access to media and improving general awareness of anesthesiology and what anesthesiologists do. They have a test ongoing in Michigan to teach the public through a public awareness campaign. The results of this initiative will then be analyzed and possibly generalized.

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# EAB Report: 2012 AUA Annual Meeting

David Murray, M.D., Chair  
Education Advisory Board (EAB)  
Washington University  
St. Louis, Missouri

The Education Advisory Board (EAB) included two themes at this year's AUA Annual Meeting in Cleveland. The first panel, "High Stakes Performance Assessment: During Residency and for Certification," was moderated by David Murray, M.D., from Washington University in St. Louis. Bob Gaiser, M.D., from the University of Pennsylvania, moderated the second panel that included three presentations about "Anesthesia Education: Impact on Global Health."

Dr. Murray provided an overview as well as the first presentation, "Performance Assessment: Assuring the Measures are Meaningful," which offered a perspective on performance assessment and the role of the expert in establishing meaningful measures of ability. The limitations of the quality measures used in practice and the retrospective peer-review processes of clinical outcomes to establish a measure of ability and performance were described in the presentation. The presentation described the differing limitations that exist when performance is assessed in various "non-clinical" testing environments such as during a simulation, task training or standardized patient assessment. The role of the expert in establishing a performance standard is the common requirement in determining expectations for many of the complex management decisions required in clinical practice.

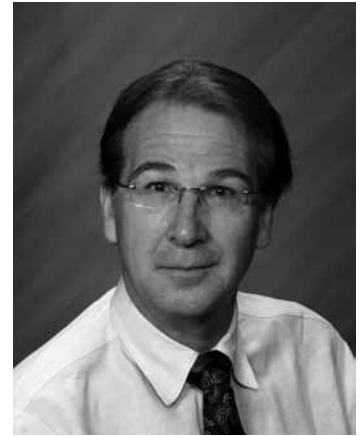


Dr. Keith Baker, Residency Director of the Massachusetts General anesthesiology program, described a daily resident evaluation program. His presentation "Resident Evaluation: What to Measure and How to use the Measures" included the practical details and results from the evaluation program. Dr. Baker described the electronic evaluation form and various rating sections for absolute and relative-to-peers performance for each of the six ACGME core competencies, a set of clinical competency committee questions and a rater confidence section regarding the resident's overall ability. Dr. Baker described the analysis of data from 140 faculty members who returned 14,469 evaluations on 108 residents. The lecture outlined how these faculty ratings were used to effectively identify residents who required remediation.



Cynthia Lien, M.D., Professor of Anesthesiology at Cornell/Weill Medical Center in New York, discussed "Anesthesiology Certification: Beyond the Multiple Choice Examination." Dr. Lien is

Chair of the Joint Council on In-Training Anesthesiology Examinations. The Joint Council is responsible for all aspects of generating questions used on the in-training and Part 1 examinations as well as collating those questions for the examinations. Dr. Lien described the advantages of the multiple-choice format, particularly as related to the precision and reproducibility of an assessment that has a single correct answer. Dr. Lien described how other exam formats, such as the Script Concordance Test, computer-based simulation and simulation-based OSCE, may provide alternatives for exam formats that would better assess the competency of physicians.



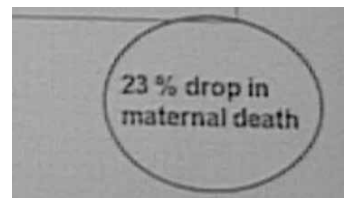
David J. Murray, M.D.



Robert Gaiser, M.D. moderated the second panel. During his introduction, Dr. Gaiser described the increasing medical student and anesthesia resident interest in global health initiatives and opportunities to participate during and following training. The panel included three speakers who described global education initiatives in obstetrics, trauma care and the practical aspects of resident involvement in global education initiatives.



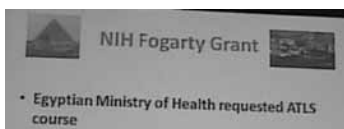
The first panelist, Medge D. Owen, M.D., a Professor of Obstetric Anesthesia at Wake Forest School of Medicine and Director of Maternal & Infant Global Health Programs, described the role of Kybele, a nonprofit 501 (c)(3) organization to promote safe childbirth worldwide through medical education partnerships. Dr. Owen is president of Kybele, Inc. She identified many of the factors that contribute to maternal and infant mortality in low-income countries. The practical on-site delivery of care was described as were a number of the simple initiatives that Kybele has



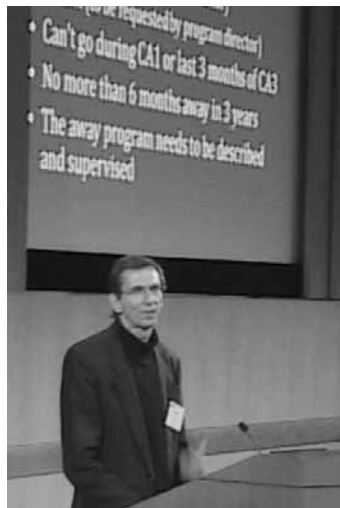
undertaken to improve maternal and neonatal outcomes in Ghana. The organization's role in Ghana was described as well as their activities in other countries where obstetricians and anesthesiologists conducted site visits and have improved childbirth safety through educational partnerships. One of the key examples was the role of the organization in helping improve and increase more effective and safer regional anesthesia practice.



Maureen McCunn, M.D., M.I.P.P., F.C.C.M., Assistant Professor of Anesthesiology and Critical Care at the Hospital of the University of Pennsylvania, Attending Physician, Department of Anesthesiology and Critical Care, began a presentation about the global impact of trauma. Trauma is the leading cause of death in all age groups less than 45 years.



Global anesthesia outreach in education and local training of anesthesia providers in trauma care is a short-term strategy supported by the World Health Organization to improve the quality and quantity of providers in countries with insufficiently met needs. Dr. McCunn described the burden of disease caused by trauma and injury and poor access to surgery/anesthesia. Her presentation described some of the available solutions in training, education, policy and advocacy in low- and middle-income countries. Dr. McCunn provides some specific examples of the type of training that is effective and provided examples such as an NIH study in Egypt,



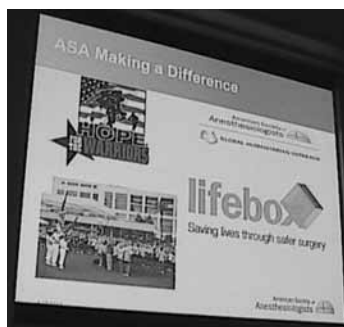
volunteerism in India, and trauma training in Ecuador and Tanzania.

In the third presentations, Marcel Durieux, M.D., Ph.D, Professor of Anesthesiology and Neurologic Surgery at the University of Virginia, described resident participation in global health projects in Africa. Dr. Durieux described the practical requirements for resident participation posed by the ABA and the training institution in terms of obtaining permission as well as coverage for residents to have a

global experience. He outlined a number of the direct benefits as well as the less-often described secondary benefits such as changes in perspective and attitude that occur after residents have these type of experiences and return to their residency programs. Dr. Durieux described the global experiences and some of the equipment challenges associated with the work in Tanzania. The requirement for more reliance on preparation, clinical skills and observation to conduct anesthesia and how to effectively teach anesthesia to a provider who has limited background in medicine were discussed as features of the rotation. The question-and-answer session indicated that these experiences are of increasing interest to the specialty and to residents and program directors.

## AUA 2012: ASA President's Message Financial Security, Organizational Excellence, Exceptional Member Benefits

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ASA has a track record of supporting foundations and related organizations and this is expected to continue. This includes support of such organizations as the Foundation for Anesthesia Education and Research, the Anesthesia Quality Institute, the

Anesthesia Foundation and the Wood Library-Museum of Anesthesiology.

ASA is also working on other things in the "making a difference" category, including the Lifebox campaign to provide pulse oximeters to underdeveloped countries around the world.



# SAB Report: 2012 AUA Annual Meeting

Charles W. Emala, Sr., M.S., M.D., Chair  
Scientific Advisory Board (SAB)  
Columbia University  
New York, New York

Marie Csete, M.D., Ph.D.

The AUA Annual Meeting, hosted by the Cleveland Clinic on May 17-19, was a smaller-than-usual but vibrant scientific exchange with attendance limited by an unfortunate schedule conflict with the IARS meeting in Boston and the International Liver Transplant Society in San Francisco.

The Scientific Advisory Board (SAB) program opened the meeting with a program titled “From Discovery to Product” with presentations that provided an overview of the opportunities and challenges of bringing pharmaceutical discoveries from the laboratory to clinical use. Douglas Raines, M.D., an anesthesiologist from Harvard Medical School, told the story of bringing a modified anesthetic induction agent from the laboratory to an interested pharmaceutical company. He described the initial invention disclosure and the expense of patent filing by his institution. Dr. Raines described the challenges of forming an initial start-up company that lacked several components, including the expertise to negotiate licensing with the institution, a business plan to present to external investigators and, most importantly, money to hire contract research organizations to do the development and legal work. The solutions were to hire a law firm on a contingency basis, provide the institution a one-year option for the license and hire a CEO paid with equity and a promise of future salary contingent on financing.

The next step toward pharma was supported by an internal venture capital fund with \$35 million to invest in small companies formed from within the institution. This arrangement provided mentorship, identified a CEO, performed a market analysis, provided seed money and established connections and credibility.

The project next progressed to an external venture capital company, and the invention is now with a medium-sized pharmaceutical company that retains the option to buy the company.

The second speaker in the session was Paula Bokesch, M.D., the Senior Medical Director at Cubist Pharmaceuticals, who provided a perspective of drug discovery from the pharmaceutical industry



Charles W. Emala, Sr.,  
M.S., M.D.



Marie Csete, M.D., Ph.D.

side. The estimated investment cost to bring a chronic oral medication to market is \$1.8 billion with a requirement for six-month toxicology trials, while an oral drug used intermittently requires an estimated \$500 million and two weeks of toxicology trials. The vast majority of drugs in development are lost in phase II (with only a 34 percent success rate in this phase). Dr. Bokesch emphasized several times during her presentation that identifying a human biomarker that correlated with a truth in concept of the intended drug effect was a huge asset in drug development. She also emphasized the importance of partnering with a pharmaceutical company that caters to the market relevant to the invention. She used the example of her own company, CUBIST, which has an established sales force in hospitals and markets IV formulations; they would not be the optimal partner for an orally used chronic medication. Dr. Bokesch provided several examples of development failures, including a long-acting local anesthetic for postop surgical pain that failed due to an overestimation of projected revenues; an investment of \$1.5 billion would be required for an estimated \$8 million market.

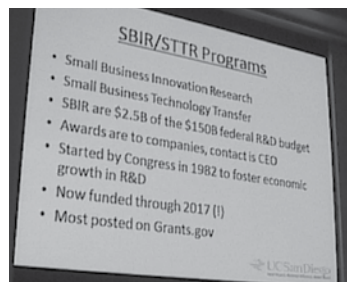
Dan Berkowitz, M.B., B.Ch., an anesthesiologist from Johns Hopkins, spoke on the ethical boundaries between academic and industry labs and opened with a reference to a recent editorial in *Nature* (“Traditional drug-discovery model ripe for reform” March 2, 2011; 47: 17-18) that spoke



of the changing relationships between academia and industry in drug development. The traditional model of big pharma looking for the blockbuster drug with all in-house research/development, from preclinical studies to manufacturing to sales, has proved unsustainable. Big pharma has a dry pipeline of novel drugs, looming patent walls, extravagant costs and public pressure to show benefits of high pharmaceutical costs.



Academia remains under high pressure from limited NIH funding and a strong public benefit pressure to show benefit from these public funds. A brief history of drug development regulation was then provided. Prior to the 1962 amendments to the Federal Food, Drug and Cosmetic Act, drug approval was the Wild West; drugs were tested in humans before animals with poor documentation and minimal reporting. The signing of these amendments by President Kennedy led to a significant increase in drug development costs and the need for clinical trials. The Bayh-Dole Act of 1980 transferred ownership of intellectual



property rights from the funding agency (e.g., NIH) to the funded institutions, which led to the development of offices of technology licensing at universities whose capabilities continue to evolve. Dr. Berkowitz then presented his personal story of drug development

of an arginase inhibitor to promote endothelial function. Initially a company formed by the inventors (Corridor Pharmaceuticals, Inc.) was able to present the invention at an “alliance meeting” at Johns Hopkins in which pharma hears presentations from academic inventors. Acidophil was the venture capital company that carried it forward.

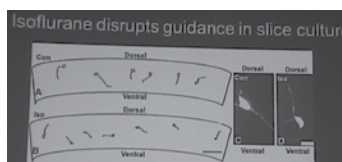
“The traditional model of big pharma looking for the blockbuster drug with all in-house research/development, from preclinical studies to manufacturing to sales, has proved unsustainable. Big pharma has a dry pipeline of novel drugs, looming patent walls, extravagant costs and public pressure to show benefits of high pharmaceutical costs.”

Dr. Berkowitz closed with the ethical issues that arise with inventions from academic labs. He suggested that full and even “over”-disclosure is the safest and ethical approach. He recommended full disclosure in presentations and publications, avoidance of involvement of graduate students and trainees in projects related to the company side of the invention, and not to suppress or delay the results or publications.

Marie Csete, M.D., Ph.D. closed the session with an overview of federal funding opportunities available for start-ups, beginning with an overview of the NIH Small Business Innovation Research/Small Business Technology Transfer (SBIR/STTR) funding opportunities ([www.sbir.gov](http://www.sbir.gov)). The SBIR program encourages domestic small businesses to engage

in federal research/research and development (R/R&D) that has the potential for commercialization. SBIR enables small businesses to explore their technological potential and provides the incentive to profit from its commercialization. Awards are provided in two phases. Phase I: establish the technical merit, feasibility and commercial potential of the proposal. SBIR Phase I awards do not exceed \$150,000 total costs for six months. Phase II: The objective of Phase II is to continue the R/R&D efforts initiated in Phase I and is based on the results achieved in Phase I and the scientific and technical merit and commercial potential of the project proposed in Phase II. Only Phase I awardees are eligible for a Phase II awards. SBIR Phase II awards normally do not exceed \$1 million total costs for two years. Awards are made to companies, not a principal investigator at a university. In addition to the NIH, 10 other federal agencies participate in SBIR, including NSF and the the Department of Defense ([www.dodsbir.net](http://www.dodsbir.net)).

Resident Travel Award winner presentations are always a highlight of this meeting. For the second year in a row, Columbia was represented in this group. David Mintz, M.D., Ph.D. presented work on a little-researched potential mechanism of general anesthetic toxicity, interference with axon guidance. Following individual primary murine cortical neurons, Dr. Mintz showed that isoflurane causes axons to wander randomly when presented with a guidance cue, while unexposed neurons are directionally focused by the cue. This defect is likely mediated via effects on semaphorin 3A, which promotes extension of axons. Further, the collapse (vs. extend) phenotype in axons induced by isoflurane was dose-dependent, and other anesthetics with known GABAA activity also promote the same phenotype (whereas non-GABAA-effective agents do not). Given the developmental importance of axon guidance in the brain, Dr. Mintz has characterized another potential mechanism of toxicity that can be quantified in vitro, for comparison with developmental effects of anesthetics in vivo.



For the third year in a row, a Vanderbilt resident received the travel award: Amanda Lorinc, M.D. Her work, “Identification and characterization of a novel compound that protects cardiac tissue from hERG-related, drug-induced arrhythmias,” also received a lot of attention during the poster sessions. The hERG gene encodes the potassium channel, IKr, essential for cardiac repolarization, such that its inhibition leads to (sometimes fatal) arrhythmias. A small molecule identified from a compound library screen (“601”) was examined in rabbit Langendorff

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# SAB Report: 2012 AUA Annual Meeting

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preparations for ability to reduce the incidence of arrhythmias promoted by dofetilide. Using elegant optical mapping techniques, Dr. Lorinc showed that 601 acts by decreasing the nodal line length and alternans gradient of Torsade, as opposed to other possible mechanisms (such as the magnitude and incidence of alternans).

This year, for the second straight year, outstanding junior faculty presentations were also highlighted in the SAB oral presentations. Renyu Liu, M.D., Ph.D., from Penn, described the work that led to synthesis and characterization of a water-soluble mu opioid receptor. Dr. Liu engineered the receptor, overexpressed, and purified the receptor, which retains native structure in molecular dynamic simulations and binds naloxone with normal kinetics. This water-soluble version of the mu receptor represents an important, easily tractable and manipulated tool for future structure-function studies as well as for mu antagonist and agonist drug discovery.

Ines Koerner, M.D., Ph.D., from Oregon Health and Sciences University, was the second junior faculty recognized for her outstanding research. Dr. Koerner focused on the role of microglia (resident immune cells of the brain) in mediating injury after global ischemia in a murine cardiac arrest/CPR model. She used fear conditioning as the behavioral assessment of memory loss. Animals with memory loss after global ischemia had activated microglia and elevated brain expression of pro-inflammatory cytokines, IL1 $\beta$  and TNF $\alpha$ . Intervention with a soluble epoxide hydrolase (sEH) inhibitor resulted in reduced CA1 neuron death, did not change the levels of pro-inflammatory cytokines or number of activated microglia, but significantly increased microglial production of the anti-inflammatory cytokine, IL10. Dr. Koerner's work identifies a potential therapeutic approach to switching microglial phenotype in the setting of ischemic brain injury to enhance neuronal survival.

A highlight of every year's SAB program is the plenary lecture, and this year was no exception. Roger Johns, M.D., M.H.S., from Johns Hopkins, closed the AUA meeting with a detailed overview of his research on basic cellular signaling mechanisms of vascular smooth muscle cells in pulmonary hypertension. The presentation focused on a gene identified by Dr. Johns' group that was highly upregulated in a hypoxia-induced model of pulmonary hypertension, which they named hypoxia-induced mitogenic factor (HIMF). Hypoxia and TH2 stimulation upregulated HIMF protein that is expressed in several cell types in remodeling pulmonary vessels. HIMF was shown to have mitogenic, angiogenic, vasoconstricting and chemokine-like properties in the lung. They have now proven a role for HIMF as a pleiotropic cytokine that mediates the vascular remodeling and induced hemodynamic changes of hypoxia-induced pulmonary hypertension. HIMF is also upregulated in some human forms of pulmonary hypertension and asthma. Large-scale human genomic and gene polymorphism studies are under way. HIMF is a member of the FIZZ/resistin/RELMbeta family of proteins, which have adipokine- and insulin-resistance properties, suggesting that HIMF may mediate vascular pathology associated with obesity and metabolic syndrome.

Again this year, the SAB program highlighted the great promise of our specialty's talented pool of young investigators. The wide variety of research topics under study and the quality of scientific inquiry promises a great future for anesthesiology research.



# AUA President's Panel: The Emergence of Consciousness

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

The AUA President's Panel, titled the "Emergence of Consciousness," was moderated by George Mashour, M.D., Ph.D. Participants were Michael S. Avidan, M.D., who discussed intraoperative awareness, Max B. Kelz, M.D., who discussed neural inertia, and Ken Solt, M.D., who discussed inducing emergence.

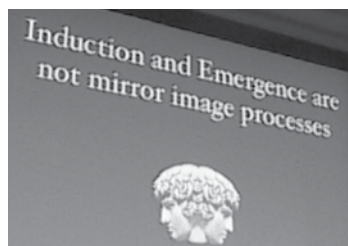


Dr. Avidan focused on intraoperative awareness and methods of its detection and prevention. He reviewed studies evaluating the efficacy of processed EEG in preventing awareness with explicit recall. The

Dr. Kelz reviewed the concept of neural inertia, indicating that the brain concentration when you go to sleep is significantly different from that at which arousal occurs. He intimated that state transitions are not explained just by pharmacokinetics and that induction and emergence are not mere processes...that hysteresis is an issue. He indicated that there may be a family of genes that affect resting membrane potential, and this requires some study. He stated that induction



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



"This study found no difference or effect of the BIS monitor, but there was a wide confidence interval. This then was followed in 2011 with a NEJM publication of 6,000 patients looking at awareness and comparing BIS versus end-tidal anesthesia monitoring, finding that the BIS was very unlikely to be superior."

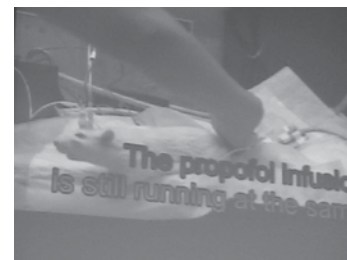
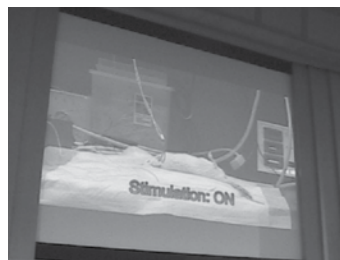
B-aware Trial seemed to indicate a compelling result. However, half were TIVA with a more or less nonhomogenous, anesthetic technique. Dr. Avidan then published an article in the New England Journal of Medicine in 2008 in which they hypothesized that the B-aware Trial simply indicated that there is a value of increased vigilance. They suggested that there was a low risk of awareness when volatile anesthesia was used with monitoring end-tidal concentration. This study found no difference or effect of the BIS monitor, but there was a wide confidence interval. This then was followed in 2011 with a NEJM publication of 6,000 patients looking at awareness and comparing BIS versus end-tidal anesthesia monitoring, finding that the BIS was very unlikely to be superior. The Chinese Medical Journal evaluated 5,000 TIVA patients, finding that BIS helped prevent awareness.

Dr. Avidan went on to discuss the notion that some patients are resistant, starting with the report that people with red hair have a 19 percent increased requirement for anesthetics. However, when such segregation was done, no difference has been found in awareness or anesthetic drug administration or end-tidal anesthesia concentration to BIS relationship. He then reviewed some notions on why processed EEG doesn't always work. He indicated that minimally trained anesthesiologists can estimate depth of anesthesia from inspection of the raw EEG and that they now have an EEG teaching website available ([www.icetap.org](http://www.icetap.org)).

sensitivity cannot predict emergence sensitivity.

Dr. Solt then reviewed the observations on how to induce emergence through drugs that manipulate neurotransmitter pathways. He said that there are arousal and sleep pathways in the brain with important neurotransmitters, those being acetylcho-

line, neuroepinephrine, dopamine, histamine and orexin. He presented studies where researchers specifically manipulated the dopamine axis, with some interesting observations. Methylphenidate blocks reuptake neuroepinephrine and dopamine, which are arousal neurotransmitters. Notably, in animals, this drug decreased the time to emergence with isoflurane by 72 percent, and it was very dramatic. It also decreases the time to emergence with propofol by 39 percent in rats. Dr. Solt noted EEG changes with MPH indicating the EEG changes from the anesthetized slow pattern to the fast awake pattern with MPH administration. He then presented a variety of studies indicating that the D-1 receptor appears to be the most significant dopamine receptor involved in these observations. Finally, he then presented data indicating that anesthesia is able to be reversed in animals with ventral tegmental stimulation under propofol infusion. Electrical stimulation of the SNPR produced no arousal response.



# New FAER Programs Emerging, and 2012 Grant Announcement

Denham S. Ward, M.D., Ph.D., President  
Foundation for Anesthesia Education and Research (FAER)

After the Foundation for Anesthesia Education and Research's spring board meeting, which was held in conjunction with the AUA Annual Meeting in Cleveland, I am excited to share with you information about new FAER programs emerging as well as some statistics from our 2012 grant awards. However, first I want to congratulate the AUA and its members for their successful meeting and thank them for their generous and consistent support of FAER. Without your help, the programs and research grants I describe below would not be possible.

## National Heart, Lung and Blood Institute T-35 Grant Application

In an effort to expand our programming for medical students interested in academic anesthesiology and research, FAER is planning to submit an application for a T-35 grant to the National Heart, Lung and Blood Institute. The NIH T-35 Medical Scholars Program will engage medical students in basic, clinical and translational research promoting the prevention and treatment of heart, lung and blood diseases. The program will complement FAER's highly successful Medical Student Anesthesia Research Fellowship program by providing more opportunities for medical students to work on research projects in a dedicated laboratory setting.

Anesthesiology departments interested in partnering with FAER can reply to the foundation's RFA for participating as host sites for the pending multi-institutional T-35 grant. Applications are due August 1. Information is available on FAER's website at [faer.org/NIHT-35GrantFAER.org](http://faer.org/NIHT-35GrantFAER.org), or please contact me directly at [denhamward@faer.org](mailto:denhamward@faer.org).

## FAER Visiting Professor Program (VPP)

Visiting professorships are an important and common way of increasing academic interchange between departments. The FAER VPP, conceived of by Simon Gelman, M.D., will help advance education in the specialty by promoting visiting professorships, while also providing financial support for FAER.

This summer, we are launching the VPP, which will serve as a central repository of visiting professors in anesthesiology. The web-based catalog will feature faculty members who serve as visiting professors and have agreed to contribute all or a portion of their honorariums to the foundation. The visiting professor database will be searchable by institution, individual and topic, and will include information on recent lectures and areas of expertise. If you are interested in becoming a FAER Visiting Professor, please contact Sara Lueders, Program Coordinator, at [SaraLueders@faer.org](mailto:SaraLueders@faer.org).

## 2012 Grant Funding Announcement

Summer is an exciting time at FAER, as our next cycle of grant recipients embark on their research projects. This year, out of 49 applications from 32 institutions, FAER awarded 16 grants to 13 different institutions. The breakdown of grants awarded is as follows:

### Mentored Research Training Grant – Basic Science:

Three of the 12 MRTG-BS applications were funded. This 25 percent funding rate is consistent with the past average funding rate of 27 percent for MRTG-BS applications.

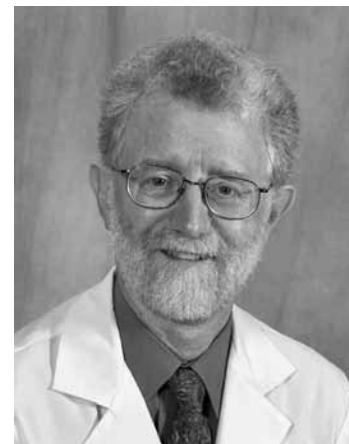
**Mentored Research Training Grant – Clinical and Translational:** Two of the 15 MRTG-CT applications received funding. This 13 percent funding rate is lower than the historical funding rate average of 22 percent.

**Research in Education Grant:** Seven out of 15 grant applications were awarded. This 47 percent funding rate was higher than the previous average REG funding rate of 33 percent and reflects a continued increase in the number and quality of REGs.

**Research Fellowship Grant:** Four out of seven grant applications were awarded. This 57 percent funding rate was higher than the previous RFG average funding rate of 47 percent.

Feedback from the ASA Committee on Research, which reviews the MRTG and RFG applications, indicates that overall, the grant applications need to provide better pilot data to illustrate that the project is feasible. In addition, the committee indicated that the career development and mentoring plans, a critical element of the FAER grant application, provided by the physician investigators and their mentors were often deficient. Because FAER grants are each viewed as training grants, these two elements (pilot data and mentoring plan) are taken quite seriously. The ASA Committee on Research and the FAER Board encourage AUA members to spend more time with their protégés in developing these parts of the grant. Over the coming months, and prior to the next grant cycle deadline of February 15, 2013, FAER will be providing additional resources to help grant applicants submit successful applications.

Full information about the funded grants, including a list of recipients and institutions, will be posted on [FAER.org](http://FAER.org) and will be announced in the August issue of the *ASA NEWSLETTER*.



Denham S. Ward, M.D., Ph.D.





# AUA

Association of University Anesthesiologists

**The following individuals were elected to AUA active membership status at the AUA Annual Business meeting on May 17, 2012 in Cleveland, Ohio.**

Sheila Barnett, MBBS, BSC  
Adrian Bosenberg, MBChB, DA(SA) FFA(SA)  
Ken Brady, M.D.  
Marek Brezinski, M.D., Ph.D.  
Maxime Cannesson, M.D., Ph.D.  
Mark Chaney, M.D.  
Lawrence Chu, M.D., MS  
Ronald Easley, M.D.  
Jesse Ehrenfeld, M.D., M.P.H.  
Thomas Grissom, M.D.  
Tomoki Hashimoto, M.D.  
Yandong Jiang, M.D., Ph.D.  
Stephanie Jones, M.D., Ph.D.  
Brian Kavanagh, MB, FRCPC  
Jae-Woo Lee, M.D.  
Edward Mariano, M.D.  
Lynne Maxwell, M.D.

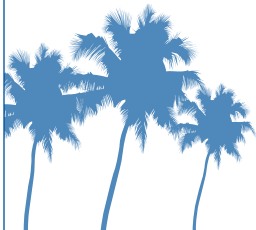
Jill Mhyre, M.D.  
Vivek Moitra, M.D.  
Stephanie Murphy, VMD, Ph.D.  
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## AUA 60<sup>th</sup> Annual Meeting

April 4-6, 2013

J.W. Marriott Marquis  
Miami, Florida

Hosted by  
Department of Anesthesiology  
Perioperative Medicine and  
Pain Management  
University of Miami, School of Medicine



# Proposed AUA Bylaws Changes

All proposed bylaw changes were approved by the AUA membership at the Annual Business Meeting on May 17, 2012 in Cleveland.

At last year's AUA Annual Meeting, potential changes to the AUA Bylaws were discussed. Based on the comments from the membership at that meeting, the Bylaws Committee (Ronald Pearl, M.D., Chair; Lee Fleisher, M.D.; Kevin Tremper, M.D.) has proposed the following changes. These require approval by a majority vote of the AUA members present at the Annual Business Meeting of the Association. This meeting took place on Thursday, May 17, 2012 at the InterContinental Hotel in Cleveland, Ohio.

Several of the proposed changes are based on the strategic plan for the society, which was developed several years ago. One key recommendation from that plan was that the society would be better served by increased continuity at the officer level. Currently, the President-Elect serves a one-year term and then serves as President for two years and as Immediate Past President for one year. Unfortunately, this often results in suboptimal understanding of how the society functions. Therefore, a change in the Bylaws is proposed so that an individual serves two years as President-Elect, two years as President, and then two years as Immediate Past President. This proposal results in corresponding changes in multiple sections of the Bylaws (a full copy is available at [http://auahq.org/AUA%20Final%20By-Laws\\_0506.pdf](http://auahq.org/AUA%20Final%20By-Laws_0506.pdf)). We also propose a formal standing Communications and Website Committee with the chair of the committee as a member of AUA Council (rather than the current ex-officio status as the editor of the newsletter).

The other major change is the elimination of the requirement that members have a faculty position in anesthesiology in the United States or Canada. The proposed changes now have no geographic requirement. This will also decrease the need for future new membership in the honorary category, but the Bylaws will continue to have such a category.

The following changes (and the associated rationales) are proposed:

## Current 3.10 Active Members

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 twenty-four months, following completion of residency training in anesthesiology and (b) whose work as an anesthesiologist, teacher, or investigator has demonstrated success in academic anesthesia or who has shown a continued productive interest in and contribution to academic anesthesia may be nominated for election to the Association. However, (c) individual exceptions to the above residency qualification shall be made at the discretion of the Executive Council when one of the following two conditions applies: (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 interest in and contribution to academic anesthesia.

**Proposal:** This section will be amended by deleting "in the United States or Canada". The section will then read:

An individual (a) who occupies and has occupied a faculty position in anesthesiology in a medical school or its affiliated teaching hospital for at least twenty-four months following completion of residency training in anesthesiology and (b) whose work as an anesthesiologist, teacher, or investigator has demonstrated success in academic anesthesia or who has shown a continued productive interest in and contribution to academic anesthesia may be nominated for election to the Association. However, (c) individual exceptions to the above residency qualification shall be made at the discretion of the Executive Council when one of the following two conditions applies: (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 interest in and contribution to academic anesthesia.

**Current 3.603 The Council shall have the power to designate as a former member any active member who is absent from three consecutive meetings without justifiable excuse in writing to the Secretary.**

**Proposal:** Delete this section since we no longer enforce an attendance requirement.

**Current 4.001 The Council shall consist of the President, an Immediate Past President or - alternating years - a President-Elect, a Secretary, Treasurer and three Councilors-at-Large.**

**Proposal:** The Council shall consist of the President, the Immediate Past President, the President-Elect, a Secretary, a Treasurer, the chair of the Communications and Website Committee, and three Councilors-at-Large.

**Current 4.002 The editor of the Association's newsletter shall serve as an ex-officio member of the Council.**

**Proposal:** Delete this section if 4.001 is amended as above since the editor will be a regular member of Council.

## Current 4.40 Officers

The officers of the Association shall be the President, an Immediate Past President or - alternating years - a President-Elect, a Secretary and Treasurer.

**Proposal:** The officers of the Association shall be the President, an Immediate Past President, the President-Elect, a Secretary and Treasurer.

#### Current 4.43 President-Elect (or Past President)

In the absence of the President, the President-Elect (or Past President) shall preside at all meetings of the Association.

**Proposal:** In the absence of the President, the President-Elect shall preside at all meetings of the Association. In the absence of both the President and the President-Elect, the immediate Past President shall preside at all meetings of the Association.

#### Current 4.71 President

The President shall be elected for a two-year term automatically following a one-year term as President-Elect.

**Proposal:** The President shall be elected for a two-year term automatically following a two-year term as President-Elect.

#### Current 4.822 Failure to attend three or more consecutive Council meetings may be considered cause for removal.

**Proposal:** Delete this section (same rationale as the deletion of 3.603).

#### Current 6.202 Nominating Committee

The committee shall consist of three members, including the President who shall serve as chair, the Immediate Past President or President Elect, and a member of the Council.

**Proposal:** This should be deleted since it conflicts with and is already covered by:

#### 4.501 A nominating committee, consisting of the past president, who shall serve as chair, the president, and the secretary, shall nominate candidates for offices three months prior to the Annual Membership Business Meeting. The terms of the candidates are to be included on the slate when presented. Additional candidates may be nominated from the floor at the annual meeting of the Association.

Proposal: Add the following section:

#### 6.203 Communications and Website Committee Composition

A. The Communications and Website Committee shall consist of ten members, one of which shall be chair and newsletter editor nominated by Council and appointed by the president. The chairs of the EAB and SAB will also be members of the Communications and Website Committee. The Communications and Website Committee chair shall serve for a period of five years subject to one renewal upon appointment by the president with approval by Council. The seven regular members of the Communications and Website Committee shall serve for a period of three years each with appointment staggered so that no more than three appointments are made each year.

B. The chair of the Communications and Website Committee will be a voting member of Council.

C. The president (after consultation with the Communications and Website Committee chair) shall appoint members to the Communications and Website Committee.

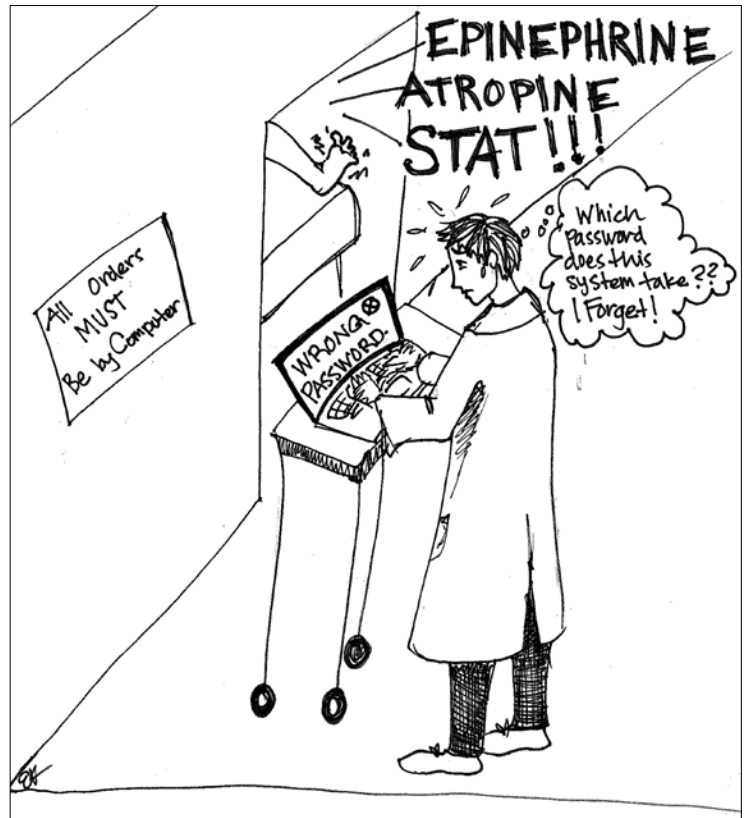
#### Duties

A. The Communications and Website Committee shall be responsible for production of the society newsletter and production and maintenance of the society website and other technological communications.

#### The Communications and Website Committee is presently composed of:

- W. Andrew Kofke, M.D., Chair, University of Pennsylvania
- SAB Chair, Charles Emala, M.D., Columbia University
- EAB Chair, David Murray, M.D., Washington University
- Alex Macario, M.D., Stanford
- Andrea Kurz, M.D., Cleveland Clinic
- Larry Chu, M.D., Stanford
- Lisa Faberowski, M.D., Stanford

We need three additional members. Please contact Dr. Kofke, if interested, at [kofkea@uphs.upenn.edu](mailto:kofkea@uphs.upenn.edu).





# AUA

**Association of University Anesthesiologists**

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