



AUA

Association of University Anesthesiologists

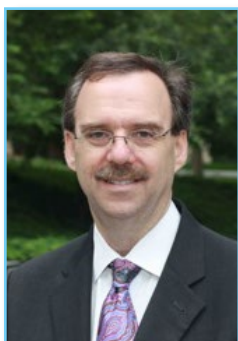
Update

Fall 2013

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President's Message



Lee A. Fleisher, M.D.

It is a very exciting time in medicine with substantial challenges that can create large opportunities. The current economic and legislative environment has added pressure on all of our missions with decreasing reimbursement for clinical care, new models of clinical care, decreasing federal funding for research and many unfunded mandates in the realm of resident and fellow education. There are several societies and associations within anesthesiology that attempt to address different aspects of the mission of our academic departments

and the faculty within them. Within that context, the mission of the Association of University Anesthesiologists is

- the encouragement of its members to pursue original investigation in the clinic and in the laboratory
- the development of the method of teaching (anesthesia)
- free and informal interchange of ideas.

As we move forward in this new normal of healthcare, it is important to determine the relevancy of a group and how best to utilize our opportunities to work across University boundaries to ensure the success of the specialty into the future. In the first issue of the journal *Anesthesiology*, an editorial remarks that "The specialty of anesthesia is finally becoming interpenetrated with the scientific attitude. This attitude, joined with resolute action, will be an answer to its problems". It is my belief as I trust it is of the AUA membership that continuing and, in fact, expanding that scientific attitude is critical to our continued relevance in the future.

This has been an exciting year of transition within the AUA. Council has finalized a letter of agreement to contract with the International Anesthesia Research Society for its management

services, but more importantly to develop a relationship in which the IARS and the AUA look for opportunities of synergy to advance academic anesthesiology. As has previously been discussed, one of the goals is to align the two meetings so that there is an opportunity for each society to maintain its separate identity and missions but opportunities to leverage each other's strengths. The discussion at the last Annual Meeting and subsequent emails have highlighted both the enormous opportunities available and the potential concerns and challenges for such a plan. I have asked the President-elect, Dr. Thomas Blanck, to form a committee to develop plans for the first aligned meeting which will occur in 2016.

We are also looking to a strategic plan developed under the leadership of Dr. Ron Pearl during his Presidency for additional opportunities to advance the agenda related to research and education. In particular, we are continuing to look for opportunities for faculty mentorship and through our relationship with the Foundation for Anesthesia Education and Research and its two academies. Additionally, Dr. Larry Chu and the Stanford Media Lab are currently working to update our website and include information of relevancy to our academic mission. The new website should be unveiled shortly. I am grateful to Larry and his department for allowing him to undertake this important effort.

While these may be challenging times for medicine in general and anesthesiologists specifically, there are also many bright spots. Anesthesiologists have continued to explore new areas of science and are asking many fundamental questions in the area of neurobiology and cardiovascular medicine to name just a few. The impact of pharmacogenomics and proteomics on perioperative care will be a critical issue with regard to the best management of our patients in the future and many anesthesiologists are leaders in this growing field. The implications of long-term anesthesia outcomes after surgery are being recognized as a growing area of importance.

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President's Message

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With the support of AUA, FAER and IARS, a group of health services researchers had their first meeting at the 2012 ASA Annual Meeting and there is now an Interest Group within Academy Health (www.academyhealth.org) devoted to this topic. We are aligning with our surgical colleagues to utilize the power of data and new statistical methodologies to pose new hypotheses and demonstrate important associations that need further study. Next year's presidential panel at the AUA will focus on this topic of big data.

As Albert Einstein said: "the significant problems we face cannot be solved at the same level of thinking we were at when we created them." I believe that anesthesiologists can apply innovative thinking in those areas in which we can make an impact. I also believe that the AUA can continue to evolve as a forum to foster the "free and informal exchange of ideas" that is required to make that happen.

Save the Date!

AUA 61st Annual Meeting

April 24-26, 2014

Stanford University School of Medicine
Stanford, California

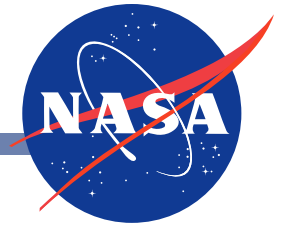
SAB Call for Nominations

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 program and provides input to the AUA Council on issues pertinent to the scientific mission of AUA. The SAB has three responsibilities:

1. Grade abstracts for the AUA Annual Meeting and organize accepted abstracts into sessions;
2. Attend the AUA Annual Meeting to assist at 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 email curriculum vitae by Thursday, January 16, 2014 to: Charles W. Emala, M.D., SAB Chair at cwe5@columbia.edu. The AUA Council and the SAB Chair will choose two candidates who will then be contacted to confirm their willingness to serve. The three-year term begins after the AUA Annual Meeting, April 24-26, 2014 in Stanford, California.

Massachusetts General Hospital Anesthesia Scientist to Join NASA



for Astronaut Candidate Training



*Mazen Maktabi, M.D.
Chief, Division of
General Surgery Anesthesia
Department of Anesthesia,
Critical Care and Pain Medicine
Massachusetts General Hospital*

Her name is Jessica Meir, Ph.D. She is Assistant Professor of Anesthesia at Harvard Medical School and the Department of Anesthesia, Critical Care and Pain Medicine at Massachusetts General Hospital in Boston, Massachusetts. Last June, through an enormously competitive process, she was selected by NASA to be one of eight NASA astronaut candidates from a pool of over 6,100 highly qualified applicants with outstanding credentials. The general astronaut training will last for two to two and a half years. At the conclusion of training, if proficiency is demonstrated by the astronaut candidate a mission may be assigned to her/him, followed by mission-specific training.

Dr. Meir is a comparative physiologist and her research focuses on studying the physiology and adaptations of vertebrates in extreme environments. She graduated with a Ph.D. degree in marine biology from Scripps Institution of Oceanography at the University of California, San Diego (UCSD) in 2009. At UCSD, the focus of her Ph.D. was to research the physiological mechanisms that enable emperor penguins and elephant seals to dive and tolerate hypoxic conditions for prolonged periods of time on one breath of air. During her postdoctoral studies at the University of British Columbia in Vancouver, Meir researched high altitude physiology, focusing on the bar-headed goose. In flying between its breeding and wintering grounds, this bird's remarkable migration takes it through the oxygen poor atmosphere over the Himalayan Mountains. She arrived in Boston in September 2012 to work with Warren Zapol, M.D. in researching at the genomic and molecular level the adaptation of Weddell seals during diving for prolonged periods of time under Antarctic ice. Weddell seals can dive down over 3,000 feet (900 meters) below the ice for durations over 80 minutes on a single breath before they need to surface to breathe. This exciting career plan was placed on hold when she became an astronaut candidate. Embarking on an astronaut career is a major change "... I have to leave (MGH). I am leaving here and starting my new job ... Being an astronaut becomes your full-time job so I move to Houston in two weeks. I won't be

at MGH any longer." Meir said that she may have to work on her pending projects on her own time. She is not quite sure why she was selected from a pool of outstanding applicants. However, when one looks at what she has accomplished in her life, we understand the reason for her selection. Meir has a set of unique skills and achievements that made her competitive in the NASA application process: success in her scientific training, understanding the physiology during extreme conditions of great depths under Antarctic water and at high altitudes, being diverse and operationally minded, having a private pilot license, doing extreme scuba diving under the ice in the Antarctic, and understanding decompression physiology. Having the right personality, emotional stability and ability to



get along with others are especially important since astronauts will have to be confined for prolonged periods of time in small spaces with other crew members from different countries and cultures (such as on the International Space Station). Meir previously applied for a similar opportunity at NASA in 2009 but did not make the final cut. She has been dreaming of becoming an astronaut since she was five years old. She is a native of the town of Caribou, Maine and the daughter of international parents, a retired nurse from Sweden and a retired general surgeon from Israel. Her parents were very supportive of her career goals and dreams and they are used to her doing all sorts of adventurous activities. I asked her if she had any advice

for colleagues. She said "It seems quite trite but it is really amazing to be able to say that your dreams can actually come true ... I am extremely lucky. Still, a lot of people probably deserve it ... Unfortunately there aren't just opportunities (like this) for everybody. I am pretty lucky."

(Directive to reader: click on images to see videos online)

› Watch Jessica Meir's video portrait

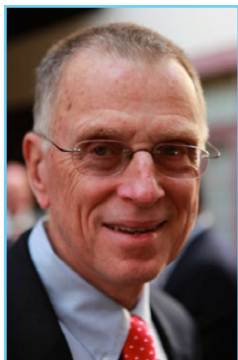


› Watch In Their Own Words: Jessica Meir



Videos courtesy of ReelNASA via YouTube. Center page image courtesy of NASA.

EAB Report: Educating Residents to Succeed in a Post-ACA* Era



*Robert E. Johnstone, M.D.
Member, Educational Advisory Board
Professor and Interim Chair
Department of Anesthesiology
West Virginia University*

Anesthesiology residency programs are undergoing major transformations with the implementation of the Next Accreditation System (NAS), an outcomes-based process of the Accreditation Council for Graduate Medical Education (ACGME). The NAS requires measuring the competencies of resident physicians to perform the essential tasks necessary for a safe clinical practice. The ACGME is also encouraging programs to engage residents in patient safety, quality improvement, health disparity reductions, care transition improvements, fatigue avoidance, enhanced professionalism and the concept of life-long learning.

Practicing anesthesiologists view this transformation positively, and perceive many additional skills that will be needed to succeed in the future, as the delivery models for health care change. The NAS transformation is thus driving discussions of what these needed skills are, and how programs can teach them. In addition to the science, technology and administration of anesthesia, many academic leaders perceive a need for more skills in teamwork, communication and departmental management, as well as understanding of healthcare organizations, practice financing and societal responsibilities.

Driving the future now is the roll-out of the Affordable Care Act, potentially replacing independent departments and fee-for-service payments with integrated systems, physician collaboration, payments for quality scores and incentives for cost reductions. For anesthesiologists perioperative medicine is growing into a surgical home model, where anesthesiologists assume responsibilities for surgical patients from admission to discharge, find cost savings, and are compensated from bundled payments to the hospital and all physicians. To succeed in this environment, future anesthesiologists will need to understand healthcare systems, care processes and business principles.

The need to educate residents in practice management extends back many years to the rise of managed care, which tied the delivery of healthcare to its financing. What had previously been a side issue for anesthesiologists became of greater importance as hospitals demanded efficient practices, groups merged and individuals sought non-traditional work arrangements. The adoption by Medicare of a fee schedule in 1992 that undervalued anesthesiologists while demanding compliance with many administrative rules introduced clinicians to the importance of government regulations, especially as Medicare payments to anesthesiologists increasingly lagged commercial payments, compared to other specialties. The

correction, after several years of trying, of half-payment rules for anesthetics administered by teaching anesthesiologists taught academic anesthesiologists the importance of legislative and regulatory advocacy. Many residents already understand this, with approximately two dozen programs set to achieve 100 percent participation this year in the American Society of Anesthesiologists (ASA) Political Action Committee.

Residency programs are innovating in many ways to teach relevant system, process and business skills. Some are inviting lectures from outside business leaders, particularly from health system administrators and business school educators. Department administrators and academic faculty with prior private practice experience frequently teach aspects of anesthesia revenues and expenses, workforce, and institutional citizenship. Law school faculty and practicing faculty at some programs talk on medical legal topics. Many academic anesthesiologists are acquiring business degrees themselves and teaching courses in their programs. Programs that have long encouraged scientific scholarship and research are finding opportunities for residents to investigate practice management challenges and present their findings, both locally and nationally. Many anesthesiology meetings now have sections devoted to practice management investigations.

Quality management is a requirement of institutions, accreditors and payers, and is expected by the public. Some programs are including residents in determining quality indicators and benchmarking performance beyond traditional case conferences. The University of Kentucky, for instance, assigns PGY1-4 residents and a faculty mentor each year to quality improvement teams that identify and investigate practice issues and then present their findings to institutional quality improvement experts.

Several programs find leadership opportunities for residents at departmental, institutional and national levels. National anesthesia societies often include residents on committees, looking to institutions for nominations. At a local level, West Virginia University assigns each senior CA3 resident to work for a couple of days with the surgical suite charge anesthesiologist to assign cases, monitor progress and communicate with surgeons.

Business and leadership skills are more limited than science and practice skills among academic anesthesiologists, so many programs are encouraging residents to attend national meetings focused on these areas. Mayo Clinic now requires, and pays, for each of its anesthesiology residents to attend the ASA Practice Management and Legislative Conferences, as well as an annual meeting of their state societies of anesthesiologists, at least once during their residency. Other programs are sending groups of residents to these meetings. Many state societies of anesthesiologists are helping to pay for resident attendance at these national meetings. The ASA Practice Management Conference has a whole day program for residents.

National practice management conferences are particularly useful because of resident exposure to highly qualified speakers and up-to-date information in an area where change is constant.

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EAB Report

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Scientific data generally remain fixed over time because they are defined by nature or physical-chemical processes. Examples include minimum alveolar concentrations of inhalational anesthetics and structures of ryanodine receptors. Practice data tend to change over time, because they are defined by political and regulatory processes. Examples include anesthesia payment conversion factors and the shared savings from accountable care organizations. This increases the importance of learning the processes by which practices function, what drivers change, and how regulations arise.

A classic long-term goal of residency education has been to transform medical students into independent practitioners

of anesthesiology. Although still true, this must be interpreted today in the context of most anesthesiology being delivered in a team mode, dependent on systems of care and grouped payments. Residents now have the breadth of anesthesiology skills, from the pre-anesthesia unit through intraoperative care and pain management to post-anesthesia care and critical care units. If they can organize and lead patient care through this process, and communicate it to others, their future will be robust.

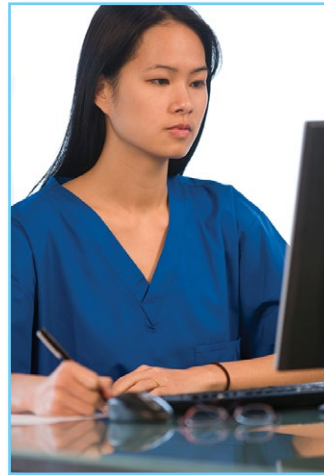
*Affordable Care Act

Academic Anesthesiology in the News



The August 13 *Washington Post* gave a first page story to a report by AUA member George Mashour's group: Borjigina, Jimo; Lee, UnCheol; Liu, Tiecheng; Pal, Dinesh; Huff, Sean; Klarr, Daniel; Sloboda, Jennifer;

Hernandez, Jason; Wang, Michael M.; and Mashour, George A.: Surge of neurophysiological coherence and connectivity in the dying brain *PNAS* <http://bit.ly/AcademicAnes> The investigators recorded EEG activity in rats undergoing cardiac arrest, and, before the onset of electrographic silence, observed a surge of highly synchronized brain activity with features associated with consciousness and visual activation.



The investigators describe their work in the context of better understanding anesthesia and altered levels of consciousness.

See also another article by an academic anesthesiologist in the *NY Times* about the drug shortage ...

NY Times: How a Cabal Keeps Generics Scarce

The critical shortage of generic drugs continues unabated.

<http://nyti.ms/1fvbVe8>

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 (April 24-26, 2014 in Stanford, California).

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 to attend AUA Annual Meetings and who are willing to help undertake the work of the committee are encouraged to submit their names and a brief CV. Alternatively, AUA members can submit the name of another member along with a brief CV. Nomination materials should be sent by Thursday, January 16, 2014 to: David J. Murray, M.D., EAB Chair, at murrayd@notes.wustl.edu.

The AUA Council and the EAB chair will choose three candidates who will then be contacted in the winter to confirm their willingness to serve. The three-year term begins at the 2014 AUA Annual Meeting in Stanford, California.

Anesthesiology Conference on Innovation and Entrepreneurship – Hosted by FAER

January 18, 2014 – Orlando, Florida



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

In January, the Foundation for Anesthesia Education and Research FAER is hosting an educational program that will empower and inform anesthesiologists in key aspects of successful translational research, product development, technology commercialization and entrepreneurship: the

Anesthesiology Conference on Innovation and Entrepreneurship (ACIE).

At ACIE, attendees will uncover ways to transfer discoveries from university labs, academic research and private practice into the marketplace through licensing and the creation of startup companies. ACIE will bring together physician-scientists and innovators with investors and members from industry.

The one-day ACIE “boot-camp” will feature a series of morning plenary sessions intended to provide education on such topics as innovation and entrepreneurship, intellectual property, business presentations, funding and regulatory pathways. During the afternoon, attendees will attend two of six workshops where they will put their foundational knowledge to use during hands-on, small group discussions. Workshops include: valuation of technology, small business innovation research grants (SBIR), patent law, regulatory pathways, entry and exit strategies, and the role of academic centers in translational research. The day will conclude with a keynote presentation by Warren Zapol, M.D., emeritus anesthesiologist-in-chief at Massachusetts General Hospital and current director of the MGH Anesthesia Center for Critical Care Research.

ACIE will be held January 18, 2014 at the Rosen Plaza Hotel in Orlando. The conference is the same Saturday as the Society for Technology in Anesthesia (STA) Annual Meeting, which will be held at the same location.

FAER’s goal is to make ACIE a low-cost, high-impact event. Members of the American Society of Anesthesiologists (ASA), Association of University Anesthesiologists (AUA) or the Society for Technology in Anesthesia (STA) may register at the early bird rate of \$100. Early bird rates expire November 15. Attendance is limited to the first 150 people who register.

Visit FAER.org/ACIE for more information and to register.



Morning Plenary Sessions

- **Innovation & Entrepreneurship:** Why is innovation important to anesthesiology and medicine? Presenter: Ted Stanley, M.D. (Upstart Ventures)
- **Intellectual Property:** What is it and how do I protect it? Presenter: Linda E.B. Hansen, JD (Foley & Lardner LLP)
- **Business Presentations:** What are the key features and how do I communicate an “elevator pitch?” Presenter: Edwin (Ed) Kania, MBA (Flagship Ventures)
- **Funding Your Ideas:** What are the key entry and exit strategies? Presenter: Thomas Bigger (Smart Biotechnologies)
- **Regulatory Pathways:** What are regulatory issues and pathways for drug, device and combination products? Presenter: Bill Burns (Piramal)
- **Physician Panel:** How do successful physician-entrepreneurs make it happen? Panelists: Donn Dennis, M.D. (Xhale, Inc.); Richard Melker, M.D. (Xhale, Inc.); Steve Shafer, M.D. (Stanford University); Ted Stanley, M.D. (Upstart Ventures); Warren Zapol, M.D. (Massachusetts General Hospital)

Afternoon Workshops

- **Valuation of Technology Presenters:** Bruce Gingles (Cook Medical); Steve Shafer, M.D. (Stanford University)
- **Small Business Innovation Research Grants Presenters:** Donn Dennis, M.D. (Xhale, Inc.); Tim Morey (University of Florida)
- **Patent Law Presenters:** Kirk Hogan, M.D., JD (University of Wisconsin School of Medicine and Public Health); Richard Melker, M.D., Ph.D. (Xhale, Inc.)
- **Regulatory Pathways Presenters:** James McLeod, M.D. (Galleon Pharmaceutical Corporation); April Lavender (Cook Incorporated)
- **Entry & Exit Strategies Presenter:** Brian Cummings (Technology Commercialization and Knowledge Transfer, The Ohio State University)
- **Role of Academic Centers in Translational Research Presenters:** Evan Kharasch, M.D., Ph.D. (Washington University in St. Louis); Jane Muir, JD (University of Florida); Nikki Zapol, JD (Partners Healthcare)

Visit FAER.org/ACIE to register to attend this inaugural event!

SAB Report: The Resuscitation Outcomes Consortium – a Model for Anesthesiology and Perioperative Medicine?



Peter Nagele, M.D., M.Sc.
Division of Clinical and
Translational Research
Dept. of Anesthesiology
Washington University
St. Louis, MO

Clinical practice requires the solid foundation of definitive evidence from clinical research for guidance. Clearly, our specialty has no shortage of important questions: perioperative β -blockade, the safety of hydroxyethyl starches, general vs. regional anesthesia for hip and knee replacement surgery, the safety of a single dose of etomidate for anesthetic induction, to name but a few. Even the effectiveness and safety of cricoid pressure during rapid sequence induction is unproven as is its quality of evidence at the anecdotal level. As a specialty creating solid clinical evidence, however, we do poorly. Why? Because the majority of our clinical decisions is not based on solid scientific evidence and as a specialty we do not engage in a joint effort to create the missing evidence.

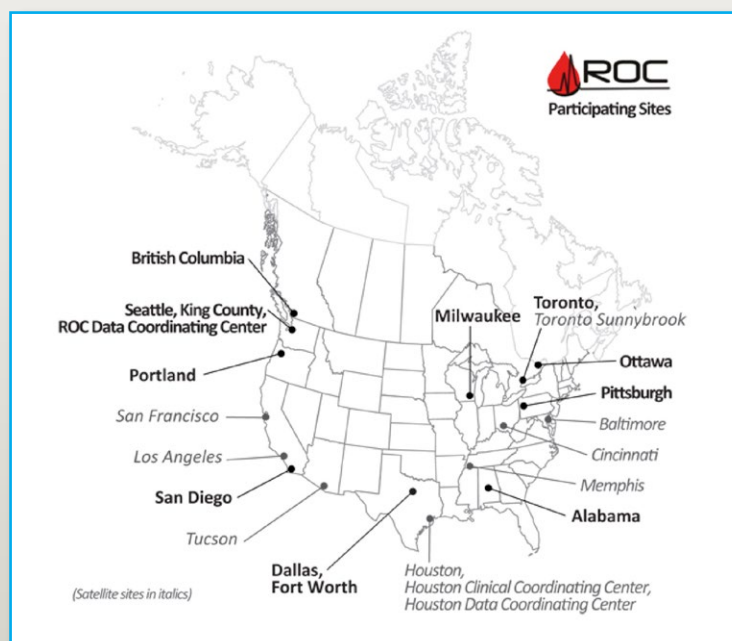
Here in this brief article, I would like to bring a successful model for creating important clinical evidence to the attention of the academic anesthesia community: the **Resuscitation Outcomes Consortium** (ROC; <http://bit.ly/ROCAbout>). The Resuscitation Outcomes Consortium is currently a group of 10 regional clinical centers throughout North America (7 U.S., 3 Canada) and one data coordinating center at the King County Center for Resuscitation Research at the University of Washington in Seattle, WA (see Figure 1), from where most of the studies are being coordinated. The participating centers are mostly situated within university emergency medicine departments.

Why was the Resuscitation Outcomes Consortium founded?

Clinical research in resuscitation from cardiac arrest is notoriously difficult: first, the rate of survival from out-of-

hospital cardiac arrest is small (~5%) requiring very large sample sizes, often reaching several thousand patients; second, prehospital emergency care is fragmented and often differs from county to county and state to state; third, prehospital research, in particular among incapacitated patients, requires many additional steps when obtaining ethics committee approval which makes a tedious process even more tedious and drawn-out. Leaders in emergency medicine were faced with two choices: either to continue business as usual and provide clinical care for cardiac arrest patients based on individual experience and opinion, or to radically transform the knowledge and evidence base of resuscitation by employing rigorous state-of-the-art clinical research methodology to answer the most important and most pressing questions in resuscitation. They chose the latter. They knew that no single institution, no single investigator could shoulder the load of the planned research alone and so they formed the Resuscitation Outcomes Consortium. One of the first trials ROC initiated was to investigate the role of hypertonic resuscitation. Does resuscitation with a small volume of hypertonic saline improve mortality after traumatic brain injury or hypovolemic shock? Initiated in 2006, the results were published three years later (Bulger EM, JAMA 2010, 304:1455-64 [it did not show a positive effect]). To date, ROC has published trial results in NEJM, JAMA, Lancet, BMJ, and Circulation that have changed clinical practice and directly influence the AHA guidelines for CPR.

Within the Resuscitation Outcomes Consortium each site agrees to contribute to the studies and clinical trials the consortium agrees to undertake. Typically, one or two principle investigators within ROC take the lead on a clinical trial and function as the overall lead PI whereas the coordination of the trial comes from the coordinating center in Seattle. Study proposals are critiqued by all ROC members before agreeing on a final binding study protocol. The involvement of 10 core centers with an additional variable number of study sites allows for swift enrollment and completion of trials within a fairly short period of time. At present, the Resuscitation Outcomes Consortium is funded by institutional funds, NHLBI (National Heart, Lung and Blood Institute, U.S.), the U.S. Army Medical Research and Materiel Command, the AHA (American Heart Association), the Canadian Institutes of Health Research (CIHR), the Defence Research and Development Organisation/Canada, and the Heart and Stroke Foundation/Canada. Annual funding levels are in the proximity of \$10 million.



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Why can't we do the same?

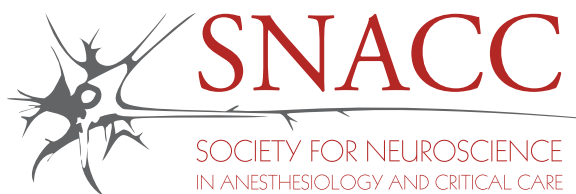
In theory, anesthesiology and perioperative medicine should be one of the most fertile grounds for clinical research and one of the easiest areas in medicine to conduct large hypothesis-driven clinical trials. Each year more than 30 million patients undergo non-cardiac surgery in the United States alone. 30 million! In the U.S., we have approximately 140 academic anesthesia departments (with residency programs) and a total of 40,000 operating rooms (academic and private setting). What if every academic anesthesia department would see it as a part of its core mission to support clinical trials that are prioritized by a national steering committee? This would allow us to spread the time, effort and cost over more than 100 study sites allowing for a rapid completion of each study. As an example, clinical trials in the area of perioperative myocardial infarction typically require close to 10,000 patients to show a statistically significant difference in 30-day mortality. If we have 100 study sites and

Don't we owe it to our patients to base our clinical decisions on a solid foundation of evidence?

each contributes 100 patients over 2 years (= 1 patient per week), this trial could be completed in 2 years. Naturally, trials of this magnitude require an experienced and adequately funded and staffed coordinating center, but shouldn't we be able to organize that? It is my strong belief that once the NIH or similar funding agencies see how serious we as a specialty are in answering these important clinical questions – questions of significant public health concern – they will be open to supporting our efforts.

Interestingly, the European Society of Anaesthesiologists (ESA) has recently implemented a comparable effort, the ESA Clinical Trial Network.

It has already produced some outstanding results such as the EuSOS study [Mortality after surgery in Europe: a 7 day cohort study, *Lancet*, 2012 (9847):1059 – 1065] – and this without huge funding. Isn't it about time that we do something similar? Don't we owe it to our patients to base our clinical decisions on a solid foundation of evidence?



The Society for Neuroscience in Anesthesiology and Critical Care (SNACC) will have two pre-meeting sessions on Thursday October 10, 2013 that may be of interest to AUA members.

SNACC Mentoring Session

Getting Started and Maintaining a Successful Academic Career

Moderator: Jeffrey J. Pasternak, M.S., M.D.

Experience with a Formal Mentoring Program

Michael M. Todd, M.D.

Getting Started and Staying Alive in Research

Gregory J. Crosby, M.D., S.M.

Academic Appointments and Promotions:

Philosophy and Application

William L. Lanier, M.D.

Work-Life Balance and the Enjoyment of Academic Medicine

Kathryn K. Lauer, M.D.

SNACC Basic Neuroscience Research Symposium

CNS Inflammation: Friend or Foe?

Moderator: William M. Armstead, Ph.D.

Physiology and Pathophysiology of Brain Inflammation

Edward R. Sherwood, M.D., Ph.D.

Role of Inflammation in POCD and Alzheimer's Disease

Roderic G. Eckenhoff, M.D.

Role of Inflammation in the Development of Chronic Pain Syndromes

Temugin Berta, Ph.D.

Role of Inflammation in Stroke

Midori Yenari, M.D.

What's New in Neuroinflammation from Our Research Group?

More information at <http://www.snacc.org/index.iphtml>

COMMENTARY: Suite Strife: Offing Older Anesthesiologists

by Robert E. Johnstone, M.D.
Reprinted from the May, 2013
issue of *Anesthesiology News*,
with permission



Intergenerational conflict is disrupting some surgical suites as anesthesia groups and hospitals begin testing their senior physicians – and eliminating those who fail. Others are considering cognitive and physical tests for their senior members. Young physicians extol this trend as a way to “weed out those who should no longer be practicing.” A young Johns Hopkins surgeon told the *Washington Post*, in December, that testing and weeding gives “those who are fully functional the freedom to practice without the stigma of ageism.” Seniors see age-based testing as ill designed, wrongly aimed and the epitome of ageism.

Ageism is, of course, the age discrimination that permeates our pop culture, which glorifies youth, sexual potency and athleticism. The British rock group The Who, famously sang, “I hope I die before I get old,” while country music star Toby Keith twanged, “I ain’t as good as I once was/I’ve got a few years on me now.”

The trouble with extending ageist thinking to surgical suites is that youth, sexual potency and athleticism don’t get anesthetics done, at least not well. Experience, wisdom and focus, all common traits of seniors, work better.

Marty Makary, M.D., the Hopkins surgeon and weeder wiz, related in an essay in the *Wall Street Journal* how students and residents once labeled a senior surgeon, “Dr. Hodad” – an acronym for “Hands of Death and Destruction” – to get rid of him. It is easier to weed out people if you first demonize them.

Running Out of Gas ... or Just Pacing Themselves?

Hodad vignettes, senior sophistries and weeding advice are easy to find now. The first talk at the American Society of Anesthesiologists Practice Management Conference this year was “Turning off the gas: The aging anesthesiologist.” The syllabus advised: “Aging ... is characterized by degenerative changes in the structure and functional reserve of cells and tissues ... Many of these changes can adversely impact an anesthesiologist’s ability to practice safely.” It further cautioned that “learning becomes slower and requires more effort; short-term memory is impaired; creative thinking and problem-solving abilities decline; and intellectual quickness, on the spot reasoning and reaction time slows.”

Providing a bit of gravitas to that cant, a recent editorial in *Anesthesiology*, titled “More than just taking the keys away,” warned ominously that “there are many studies that show associations between physician underperformance and increasing years” (2012;116:501-503).

It is, of course, easier to justify selective testing and weeding if it is based on physical attributes, not intergenerational biases.

After reading these senior denigrations, some anesthesiologists might prefer being run over by a manure wagon than suffering the humiliation and disgrace of aging. But that is already happening. Extrapolating individual examples of demented or dysfunctional seniors to disparage all of them is fodder for the wagon. Many studies show young doctors make more mistakes in practice and in life than older ones.

And there is no shortage of young ignoramuses to mock, even if derision is not the style of seniors, perhaps to their detriment.

One can only imagine tests designed by the currently young for weeding old physicians: *Born This Way* by L. Gaga is a textbook of obstetrics? MTV stands for Medical TeleVision? YOLO (“you only live once”) is appropriate medical advice? Answer “true” to any of these and get offed.

Enter the YIPer

One could lampoon young anesthesiologists preoccupied more with Facebook than patients, tweets than theories, social fluff than science fare. The youngest ones seem most likely to call in sick, to have styles characterized more by motion than progress. Could these young and inefficient practitioners (YIPers) be jealous of experienced and productive seniors, trying to achieve through selective tests what they cannot through work accomplishments? Studies show workers from 18 to 47 years old are more stressed and angry than those 48 and older. Perhaps their current stress is due to childhoods of trophies for just showing up, and to schools with no-fail marking systems.

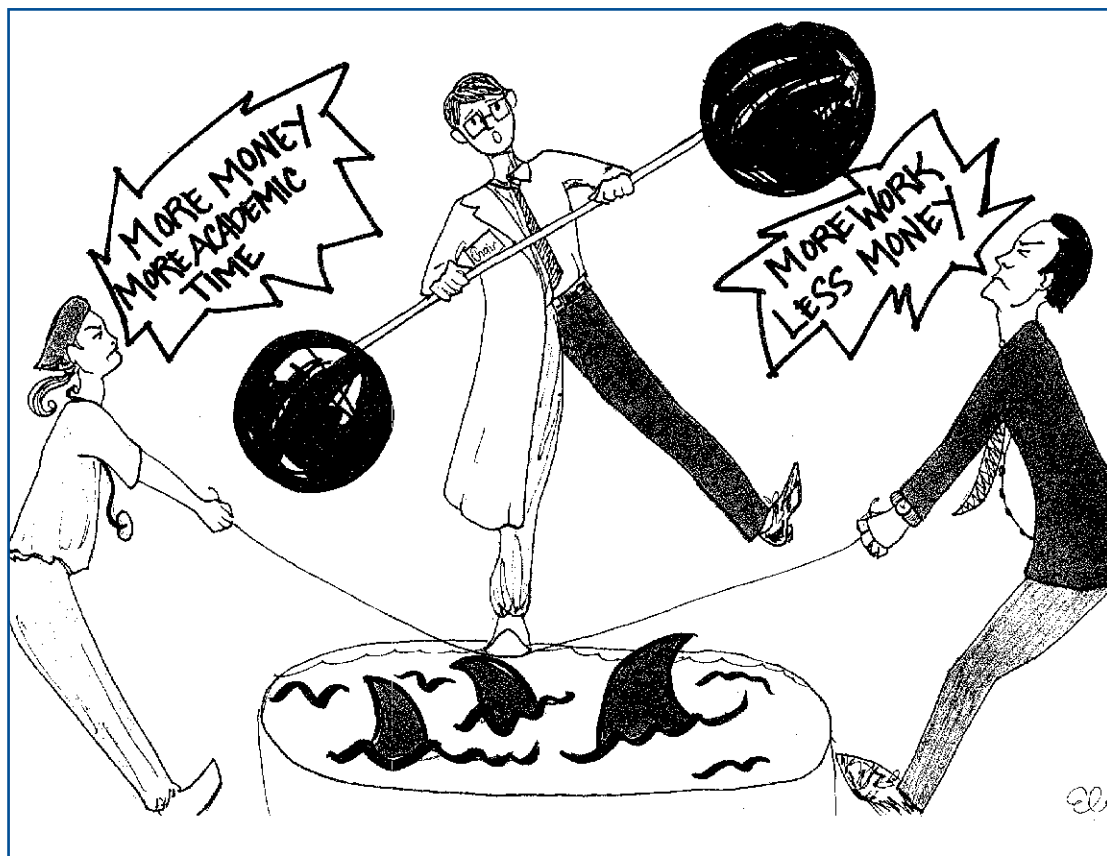
Maybe YIPers should have to pass special tests designed by seniors: If the Internet goes out, how can you get home? How did the ether screen get its name? Who is buried in Grant’s Tomb?

I hope the day of dueling tests does not come to pass, but I’m not opposed to a single test for everyone that measures what is needed to practice competently, to achieve good patient outcomes, for the privileges requested. Or maybe no written tests once in practice-just peer reviews and clinical outcomes. Standards are universal, age diversity desirable, sponsored knackery repugnant.

Anesthesia practices can benefit especially from experienced clinicians in this era of drug shortages. During a recent neostigmine shortage, seniors became the go-to experts on edrophonium, a classic and restocked reversal agent. Seniors can answer simple questions, such as why there are little hooks on the top of face masks, as well as significant ones like what to do if supraglottic airways are missing. Most senior anesthesiologists have more experience with face-mask anesthesia than their recently trained counterparts.

Clinician competence is certainly necessary for safe anesthesia and good patient outcomes. As competency tests are developed and authenticated, let’s hope they are universally applied. Singling out one generation to test, at the exclusion of others, is a sure way to miss incompetents. And if we get into intergenerational warfare YIPers might lose, as competitive and goal-oriented baby boomers defend themselves and the “Greatest Generation” teaches everyone how they earned their name.

The academic chair's
balancing act...



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