



# AUA

Association of University Anesthesiologists

# Update

Summer 2008

EAB Panels	
2008 Annual Meeting	2
AUA President's Panel	5
Medical Idiocracy	6
SAB 2008 Annual Meeting	7
Treasurer's Report: 2008	8
UTMB to Host 56th AUA Annual Meeting	10

# 55<sup>th</sup> AUA Annual Meeting



## Duke University



# EAB Panels 2008 AUA Annual Meeting

Robert E. Shangraw, M.D., Ph.D., Chair  
Educational Advisory Board

The Educational Advisory Board (EAB) sponsored two panels at the 2008 AUA Annual Meeting in Durham, North Carolina, on May 15-18. The first, moderated by **Wayne Jacobsen, M.D.**, University of Arizona, was titled “How to Create a Better Anesthesiologist: Transition of Anesthesiology Training Programs From ‘Apprenticeship’ to ‘School,’” and the second, moderated by **Robert E. Shangraw, M.D., Ph.D.**, Oregon Health & Science University, was titled “Role of Additional Graduate Degree Training for Faculty to Bolster an Academic Anesthesiology Program.”

## Creating a Better Anesthesiologist: Transition of Training Programs

The goal of this panel was to review steps taken, in individual programs and in oversight organizations, to optimize the quality of anesthesiologists in the country. It took the approach of evaluating methods used to select medical student recruits to training programs, composition of the training programs themselves, and proffering available to program graduates to maintain practice excellence in their careers.

**Randall Schell, M.D.**, department educational program director, University of Kentucky, discussed the process by which medical students are selected for entry into residency training programs. He started with the premise that selection of the “right” medical student is critical to not only finding people who can successfully complete a residency but who can then proceed to a successful career as a board-certified consultant in anesthesiology. Success within the programs themselves, unfortunately, is poorly predicted by the traditional criteria employed to select residents in the first place. Reviewed criteria include core data from the electronic residency application service (ERAS): 1) U.S. Medical Licensing Examination Part 1 scores, 2) core clerkship grades, 3) medical school dean’s letter and 4) membership in the national medical honor society, Alpha Omega Alpha. All of these parameters, using data published from several different medical specialties, proved to be poor predictors of subsequent performance during training. The personal interview, thought by many program directors to hold a critical role in selection decisions, also has major flaws. Dr. Schell showed that the interview score can be dramatically influenced by prior interviewer knowledge of the candidate’s ERAS values. This led to good correlation of interview performance with ERAS data but otherwise did not improve prediction of resident performance. On the other hand, ERAS-blinded interviews had only weak correlation with ERAS data. It appears that structuring the interview does help predict first-year resident performance. The weakness of almost all screening tools is that they emphasize cognitive abilities while ignoring interpersonal skills, motivational and affective parameters or quality of character. The de-emphasized qualities, however, may be very important in determining downstream professional success. Dr. Schell noted that better metrics are needed to define and predict success than those currently employed.

**Neal Cohen, M.D., M.P.H.**, vice chair for the Residency Review Committee (RRC) for Anesthesiology and vice dean of academic affairs at the University of California-San Francisco, spoke on the maturation of GME training from the perspective

of the RRC. Dr. Cohen reviewed the three-fold mission of the ACGME as: 1) improve health care via resident education and accreditation, 2) define standards and 3) ensure program compliance with these standards. One difficult ongoing task for the ACGME in general has been the change in emphasis of evaluating both residents and programs from a time-based system to a competency-based system. The mechanism for transition is to monitor outcomes rather than process. Dr. Cohen acknowledged that change can and will be difficult but asserted that it can be accomplished, especially in the area of assessment. One problem is defining endpoints, including what constitutes “better.” Dr. Cohen defined the goal of “...creating an environment that encourages creativity and scholarship” in training programs. He introduced the ACGME “learning portfolio” trial, an interactive Web-based program on the ACGME Web site ([www.acgme.org](http://www.acgme.org)). He talked of capitalizing on the educational sequence of “experience, reflect, learn, assess.” Dr. Cohen discussed specific changes in anesthesiology



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



training, too. These included integration of the PGY-1 (CA-0) year into the residency, dictating one to two months of emergency medicine/critical care experience and up to one month of anesthesiology. Refinement during the CA-1 to CA-3 sequence involves up to six months of electives, containing areas broadly defined by the term “perioperative medicine.” Such experiences could include research and even satellite or international experiences. All these considerations will have to work within the framework of the limitation on duty hours, which may become more restrictive, on the educational mission.

**Sunny Yoder**, executive secretary for the Group on Resident Affairs of the Association of American Medical Colleges (AAMC), discussed how AAMC is working to optimize the resident training experience in anesthesiology. She outlined seven goals on which the AAMC resident affairs group has focused. The first goal is recruitment and retention of high-quality faculty who employ teaching and evaluation methods based in



science. AAMC support initiatives, according to Yoder, include developing MedEdPORTAL, a "...free publishing and dissemination portal to foster and promulgate on-line teaching materials, assessment tools and faculty development resources," which is located on the AAMC Web site ([www.aamc.org](http://www.aamc.org)). The second goal is to create a sound basis for research in medical education. To support this effort, AAMC developed the Medical Education Research Certificate (MERC) program. MERC is designed for medical educators to improve their educational research skills. Enrollees take a set of six three-hour workshops from a menu of nine, which can be taken in any order except for the final "capstone" workshop. AAMC seeks rigorous research into teaching methods to give a backbone curriculum that can be incorporated into everyday educational practice. Her third goal is strong GME leadership at both the institutional and departmental levels. AAMC seeks coordination among institutional leaders (designated institutional official, or DIO) and individual departmental program directors. AAMC seeks, as its fourth and fifth goals, effective accreditation as managed by the accrediting agencies, and a resident duty environment that includes appropriate limits on duty hours and graduated responsibility over time. Yoder's sixth goal is a strong connection between resident education and clinical quality, and her final goal is sufficient public (financial) support for GME through Medicare and Medicaid.

**Charles Otto, M.D.**, University of Arizona, spoke on the role of postgraduate learning to maintain excellence. Dr. Otto is also Vice President for Scientific Affairs for the American Society of Anesthesiologists (ASA). He emphasized that striving for excellence does not end upon completion of residency training, and he reviewed mechanisms by which practicing anesthesiologists can maintain their abilities. Of these, the postgraduate refresher courses offered through ASA and other anesthesiology groups are only a sampling. Dr. Otto detailed the Maintenance of Certification in Anesthesiology (MOCA) program conducted by the American Board of Anesthesiology (ABA, [www.theaba.org](http://www.theaba.org)). MOCA occurs on a 10-year cycle, will be required for all diplomates of the ABA since 2000 to maintain board certification, and may be required in some fashion for earlier diplomates. The four-step MOCA process involves re-assessment in 1) professional standing, 2) cognitive expertise, 3) practice performance and 4) demonstration of lifelong learning. The first category is straightforward; essentially a report of what one has been doing over the past 10 years in terms of professional activity. Cognitive expertise involves a written examination. Practice performance consists of 1) case evaluations versus benchmark, 2) completion of patient safety education (20 hours), as listed on the ASA Web site ([www.asahq.org](http://www.asahq.org)), and 3) performance on a simulator, of which there is a registry of approved sites listed on the ASA Web site. Lifelong learning requires accumulation of 350 CME credit hours/10 years, of which 250 hours are category I, and no more than 70 hours credited in any one year. Postgraduate refresher courses factor into this category, along with electronic/print offerings such as *Anesthesiology*-based CME, other journal-based CME crediting and the ASA-based Self-Education and Evaluation (SEE) program.

Discussion at the end of the panel centered on possible ways to improve methods for assessment in terms of predicting resident performance among applicants, objectively evaluating performance during residency training (especially in the new competency categories), and extrapolating performance measures to that in subsequent practice environments. It appears to the group that the metrics used in anesthesiology have substantial limitations. It was suggested that perhaps we should even look outside of medicine into other professional groups to find more meaningful assessment tools.

### **Role of Additional Graduate Degree Training for Faculty to Bolster an Academic Department**

The goal of this panel was to evaluate degrees other than a clinical degree (e.g., M.D.) or a science-based degree (e.g., Ph.D) in terms of how they can strengthen the academic mission of a department. It examined the M.B.A., J.D., M.P.H. and M.S.Ed. degrees from the perspective of faculty members who have obtained them, doing so from the standpoint of the "costs" associated with obtaining them and the productivity benefits brought to themselves and their institutions.

**Timothy Gilbert, M.D., M.B.A.**, associate vice chair at the University of Maryland, described characteristics for the M.B.A. degree. Dr. Gilbert found the need for business training when he became division chief, with no previous business training, and was expected to develop a business plan for his division. He opted for an M.B.A. degree, but also mentioned that the Master's in Medical Management (M.M.M.) degree has similarities. Dr. Gilbert reported that about 5-7 percent of physicians hold an M.B.A. degree and that most of these are in routine medical practice. Medically focused M.B.A. areas of specialization include health care management, information technology, risk management, insurance management and operations research/efficiency. The programs for physicians can be completed in 1.5 years (full-time) or part-time, spanning usually 2.5 years or sometimes longer depending on time availability. Tuition can be steep at \$40-50,000 per year, but there may be remission programs at your home institution. The core curriculum consists of accounting, finance, economics, legal/ethical aspects, communications, strategy, human resources, marketing and statistics. Most (90 percent) interviewed physicians who have taken advanced management degrees report that the effort was worth it. Dr. Gilbert says that benefits to the department and institution, while not entirely comparable to traditional business settings, are real. They include better strength in negotiations for grants, contracts and facility support; more productive deployment of human capital; and expansion of the department beyond its traditional structure. In addition, new types of scholarship can be developed, examples of which were studies of anesthesia manpower in the U.S., clinical decision-making analysis and prediction of the need for mechanical ventilation in an at-risk population. Dr. Gilbert's personal gain has involved a professorial position at his institution's business school, medical directorship of its center for clinical trials, and as program director for the joint M.D./M.B.A. program.

*Continued on page 4*

**Kenneth Abbey, M.D.**, Oregon Health & Science University, discussed the value of legal training in an academic career. Dr. Abbey acquired his J.D. degree and was a practicing attorney before matriculation to medical school. But the sequence could easily be reversed, and often is among many physician-lawyers. Costs associated with legal training are three years for full-time education and about \$100,000 in the absence of tuition remission. He emphasized the markedly different approaches to education that have been adopted by the legal and medical communities. Dr. Abbey presented the difference in approach to problem-solving, using the example of motorcycle-helmet laws. The medical approach tends to be that helmets are essential to reduce the incidence of severe head injury among riders, whereas the legal approach takes the view that the individual has rights (freedom) that should not be breached. Advantages of an anesthesiologist trained in law include some clearly legal issues — litigation, contract negotiation, and legal or ethical issues observed in everyday practice (consent to trauma examination, consent to surgery and appropriate response to patient injury). The second group of advantages involves expertise in creation of hospital policy, e.g., institutional ethics and fine-tuning of clinical credentialing. It brings weight to resident and medical student education in ethics, and legal aspects and risk of anesthesia practice. Finally, in scholarship, Dr. Abbey notes the J.D. approach's value on writing on ethics, legal policy regarding drug handling, and research in both ethics and closed claims analysis.

**Karen B. Domino, M.D.**, University of Washington, described the M.P.H. and related public health degrees. She was a senior-level academic anesthesiologist at the time that she saw the need to acquire public health credentials, based on the direction of her own research and career development. But the interval for earning such a degree can occur before, during (joint) or earlier after attaining the medical degree than the timeline that Dr. Domino chose. Degree program choices in public health are the master's of science (M.S.), the master's of public health (M.P.H.) and the master's of health administration (M.H.A.). The M.S. degree, according to Dr. Domino, emphasizes statistical and research methods without the broader study of health care and public health policy. It can generally be completed more quickly than the other degrees (one to two years, depending on time commitment). The M.H.A. curriculum requires two years full-time study and resembles in many ways the M.B.A. degree, with a strong focus on health care systems such as hospital administration. Its curriculum emphasizes assessment of health status and risk factors in populations (communities, markets), performance of economic and strategic analyses, development and allocation of large-scale resources, and implementing strategies to deliver clinical services to populations. Many hospital administrators hold the M.H.A. degree, and in many ways, it provides a network of executives for individuals inclined to large-scale management careers. The M.P.H. degree is a blend of the M.S. and M.H.A. curricula and generally takes two years of full-time study to complete. Compared to the M.S. degree, the major conceptual difference is the scope of interest, adding a component of population health management (e.g., health policy decision-making). Dr. Domino said that the main functional difference was addition of a "practicum" to the curriculum. In the practicum, the student learns leadership and group process skills, political awareness and communication skills, understanding of financing mechanisms, and is introduced to hands-

on organizational behavior. One can specialize in epidemiology, health services, environmental/occupational health or global health. Her personal application of M.P.H. training has mainly been in the context of interpretation of the closed-claims project to identify risk factors for suboptimal outcomes in anesthesia and possibly advance organizational policies to minimize risk.

**Alan Jay Schwartz, M.D., M.S.Ed.**, University of Pennsylvania and Children's Hospital of Philadelphia, described characteristics for the M.S.Ed. degree. Dr. Schwartz developed his interest in the science of education very early in his post-residency career back in the late 1970s. In the early 1980s, he enrolled in the M.S.Ed. program at Penn, which at the time had a subcategory interest group for medical education. Since that time, Dr. Schwartz noted, the medical educator track has disappeared as an option of the Penn curriculum. It cannot presently be found at other major schools of education, including Columbia, Harvard or Stanford. Vanderbilt ostensibly has a five-year joint M.D./M.Ed. degree program, but Dr. Schwartz found it to be moribund. In general, the M.S.Ed. degree requires the equivalent of one year full-time study, 10 credit hours, and may include internship/field work experience. All these programs emphasize K-12-level education and omit medical education. But they do instruct principles of measuring individual learning achievement and program effectiveness. Dr. Schwartz presented data to indicate the large teaching load of U.S. academic anesthesiology programs for medical students, anesthesiology residents, other residents and allied health trainees. He shared results of his online survey of U.S. anesthesiology program directors to assess the teachers' credentials. Of 131 programs solicited, 70 responded (53 percent). In anesthesiology alone, the teaching load for these programs was 2,684 residents, 146 pain fellows, 73 pediatric fellows and an unknown number of cardiac fellows being taught by 3,081 full-time faculty. Among the 70 responding programs, 52 had faculty with master's degrees of all types (187 individuals), 50 had faculty with doctorate degrees (206 individuals) and only six had faculty with M.S.Ed. or equivalent degrees (nine individuals). The data indicate a dearth of faculty formally trained in education, despite current pressure to revamp educational programs to increase their effectiveness. Less formal approaches have also been developed. Dr. Schwartz described the efforts of the Society for Education in Anesthesia (SEA) ([www.seahq.org](http://www.seahq.org)). SEA is hosting a meeting on June 6-8, titled "Anesthesia Education in the 21st Century: Reaching to the Next Level, Education Out of the Classroom." Dr. Schwartz concluded by indicating that the formal training for educators in anesthesiology, while somewhat available, still has a long way to go.

Discussion at the end of the panel centered on the impact that the panelists have had on their respective institutions and the promise that specially trained individuals can bring toward pollinating their departments to be more productive in every sense of the word. Dr. Schwartz shared a germane football sports analogy, as coined by medical educator Robert Petersdorf, M.D.: "A good team needs performance by an offensive group, a defensive set and 'special teams.'" Faculty members armed with an M.B.A., J.D., M.P.H. or M.S.Ed. (or their equivalent) clearly constitute a special teams group.

# AUA President's Panel

## *Anesthesiology's Influence on Health Policy and the Nation's Health: How Do You Train the Next Generation of Health Policy Anesthesiologists?*



*W. Andrew Kofke, M.D., M.B.A.  
University of Pennsylvania  
Editor, AUA Update*

**L**ee A. Fleisher, M.D., presented examples of how anesthesiologists can position themselves to influence national health policy. Certainly one option is to run for public office and use that platform to make health policy. Another, perhaps more realistic, is to achieve recognition for health policy expertise and then to become positioned to be influential in health policy. One method to achieve this expertise and influence is through the Robert Wood Johnson (RWJ) Clinical Scholars program. There are currently four universities overseeing the training of these fellows: UCLA, University of Pennsylvania, University of Michigan and Yale. These programs provide access to health policy experts and decision-makers inside and outside government. The scholars interface with these leaders, present their research to them, and thus form lifelong relationships that help them after they graduate from the program.

**Susan Goelzer, M.D., M.S.**, a past RWJ fellow, presented her experience while giving an overview of some major issues in health policy. During her fellowship, she was involved in the genesis of several legislative bills that were passed, including the Medicare Prescription Drug, Improvement, and Modernization Act, the Closing The Health Care Gap Act, the Patient Safety and Quality Improvement Act Of 2004, the Organ Donation and Recovery Improvement Act, and the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003. This sort of experience can prepare an anesthesiologist for future positions as dean, hospital executive, AAMC advocacy person or a government office, although Dr. Goelzer chose none of these options (not yet!). She then went on to discuss the Wisconsin Partnership Program, reviewing the programs which it funds.

**Roger Johns, M.D.**, a current RWJ fellow, presented ideas on some major problems in health policy in the context of the current presidential campaign. Some examples: health insurance premiums have increased 87 percent over the past eight years, in contrast to about a 20-percent increase in inflation and workers wages over the same period; quality gaps in numerous important diseases, Medicare costs will eventually equal the entire gross national product, among other issues. He pointed out the paradox that 64 percent of Americans want the federal government to guarantee health insurance for all of its citizens, yet 80 percent are presently happy with their own care. He overviewed the different approaches between Republicans and Democrats. The Dems generally favor universal coverage whereas Republicans generally favor tax incentives for the purchase of private insurance, with each party having a variety of other contrasting approaches to manage our developing health policy crisis. He ended by pointing out that the demographics of our country are such that a serious decline in the number of workers per beneficiary will happen. The current state of affairs is not sustainable. Anesthesiologists can have a role in shaping the policies that will frame the coming inevitable changes.



# Medical Idiocracy\*

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

*The following was inspired by the presentation of ASA President Jeffrey L. Apfelbaum, M.D., and the SAB Plenary Session at this year's AUA Annual Meeting.*

What a trip! An hour ago, I entered the UPenn hyperbaric chamber, but there was a power surge and ... poof! The lights went out, the barometric pressure undulated up, down and all over, and I found myself in the chamber after the lights came on, but different folks were running the unit. I looked at the clock, and it was the year 2050! I stepped out to find the tech frantically turning knobs and spinning wheels and trying to figure out what was going on. He did not seem very able as a problem solver.



*(The hyperbaric technical society, founded in 2010 and following the lead of the nurses, successfully lobbied and got a law passed in 2020, giving the techs full autonomy to run hyperbaric chambers. The Ph.D.s all were released. In a repeat of the scenario that occurred with the 20th century steelworkers, most enrolled in nursing school as a pathway to a remunerative, satisfying, autonomous career. Notably, the Journal of Hyperbaric Medicine, receiving an insufficient number of submissions, stopped publishing in 2031.)*

Wow! I thought, it's 2050! I couldn't wait to find out how anesthesiology had progressed and was eager to check this out. So I ran over to the hospital, now called UPMC-HUP (yes...UPMC bought the UPenn Health system in 2025) to check things out. I really wanted to observe things in my old neuro rooms.

The neurosurgery advances were just magnificent. The robot worked wonders, and all the guesswork was gone. The UNIX-versant neurosurgeon put the patient in pins, programmed the computer, and was able to oversee six craniotomies at once. Very cool. But the anesthesia... the anesthesia was a different matter.

*(The many patient safety efforts of visionary M.D.A.s that started in the mid 20th century progressed through the first two decades of the 21st century. The APSF's work continued with 50 research grants annually, more than 60 patient safety standards in effect, and more than 100 instructional patient safety-oriented videos in use by 2020. Anesthetic death and morbidity was approaching zero. However, the AANA, after a persistent and brilliant lobbying campaign, got a law passed in 2015*

*that allowed them to practice independently while concomitantly increasing the number of CRNA and Ph.D.-level CRNA graduates... all according to their secret strategic plan laid out in 2001 and implemented with little resistance from the highly paid, overworked and otherwise complacent M.D.A.s of the early 21st century. The law specifically allowed Ph.D.-level CRNAs to present to patients as their anesthesiologist and their anesthesia doctor. In addition, over the next five years, in the context of a catastrophic health care funding crisis with rampant systemic rationing of resources, the AANA brilliantly and effectively argued that each SRNA was self-funded and M.D.A.s were overpaid with no added value, given the spectacular safety record of anesthesia. Moreover, they convinced the legislators that it would be in society's interest to stop funding all M.D.A. anesthesiology residencies. The federal health care act of 2020 provided for no funding for M.D.A. training while abolishing anesthesia-related lawsuits. This contributed to the spectacular growth of SRNA residencies over 2020-30. Third world health care, already dreadful, became a calamity as nurses from those countries flocked to the U.S. to take the newly vacated, well-compensated bedside nursing jobs.)*

So, my old anesthesia department, august tradition of Dripps, Eckenhoff and Vandam notwithstanding, was phased out of the medical school in 2030, and now the CRNA Ph.D.s were running the anesthesia service line. I must admit they ran an efficient operation. Everyone got propofol, vec and desflurane. All got the same airway management, and most of the patients that I saw woke up just fine. I was told there was the occasional stroke and the occasional cardiac arrest and postop MI, and sometimes there was a difficult airway-related death. In fact, the anesthesia death rate had risen since 2008 and those who did not do well in surgery had a financially mandated withdrawal of support. Things like this

were necessary in a world with more beneficiaries than workers; it seemed like these negatives were acceptable cost-benefit trade-offs in order to keep the federal health service running. Other than that, it was just like 2008, but with shorter turnover times.



I found one of these latter-day anesthesia doctors so I could have a discussion about what was going on. I was eager to hear about how the nascent issues of 2008 neuroanesthesia had grown. So I asked, "What had happened to developments in genomics to tailor anesthesia? What about the new brain protection strategies? Had the new laser IR to support brain ATP been translated? Surely that was in use by

*Continued on page 12*

# SAB Scientific Advisory Board

## 2008 Annual Meeting

Michael Crowder, M.D., Chair  
Scientific Advisory Board

Seventy-four abstracts were presented at the AUA 2008 Annual Meeting, with 16 talks and 58 posters. The majority of the abstracts, 25, were classified as clinical/educational, with basic research on neurobiology/pain a close second at 23 abstracts, physiology/pharmacology/inflammation with 15, and ischemia/cardiac/neuroprotection with 11 abstracts. The oral abstract sessions continue to be impressive in their quality and wide range of topics, which I believe is a faithful reflection of our member's scientific interests. The poster session was very well attended, and the discussions were loud and lively. I moderated the ischemia/cardiac/neuroprotection group of posters and found myself exchanging business cards with more than one presenter with the hope of future collaborations or at least an exchange of ideas or techniques. I trust that others did the same.

I am happy to report that the number of abstracts with residents as the first author was 17 this year, up significantly from 12 last year. I attribute this to increased awareness of the resident travel award. This year the resident travel awards went to **Justin Ortiz, M.D.**, Oregon Health & Science University (OHSU), and **Sachin Kheterpal, M.D.**, University of Michigan. Both abstracts received high enough scores from the SAB and each gave excellent talks. Dr. Ortiz gave one of three talks in the Friday oral session related to  $\alpha_2$  adrenoreceptors. Dr. Ortiz, working in the laboratory of Dr. Selden, also from OHSU, performed experiments showing that stress-induced hypoalgesia could be blocked by  $\alpha_2$ -adrenoreceptor antagonists, supporting the hypothesis that these receptors are required for stress-induced hypoalgesia. Dr. Kheterpal delivered an outstanding talk on preoperative and intraoperative predictors of untoward postoperative cardiovascular events. Preoperative predictors of untoward cardiac events included age > 68, existing hypertension and coronary revascularization; intraoperative predictors included case length, number of units of packed red blood cells transfused, tachycardia > 100, and systolic hypotension < 70.

The SAB plenary speaker was **Debra A. Schwinn, M.D.**, University of Washington. Dr. Schwinn's talk was titled: "Passion and Fire: Building the Foundation for Academic Departments of the Future." She made the point at the beginning of her talk that the ratio of nurse anesthetists and anes-

thesiologist assistants to anesthesiologists is increasing and that the scope of practice of nurse anesthetists is likely to increase in the future for economic reasons. She suggested that one obvious way we can distinguish ourselves from these anesthesia providers is by subspecialty training. She pointed out that this added value of fellowship training may already be appreciated by residents, as the percentage electing to enter fellowships has increased at least at some medical centers. If so, the increase in fellows offers an opportunity for academic anesthesia. Dr. Schwinn went on to give a personal account of her experiences that have led to her academic success. The persuasive message that emerged from her account was that perseverance, belief in your self and tackling of important scientific problems are essential to a successful academic career.

The NIH session this year was a bit different. In the past, I have invited either an administrator from the NIH or someone that has considerable experience with study sections or funding mechanisms at the NIH. This year, I thought I would use the NIH session as a forum to highlight the importance of the Foundation for Anesthesia Education and Research (FAER) in the careers of many NIH-funded investigators in our specialty. So, I chose two relatively recently FAER-funded investigators who have gone on to receive significant NIH funding. The two individuals were **Thomas Floyd, M.D.**, University of Pennsylvania, and **Zhiyi Zuo, M.D., Ph.D.**, University of Virginia. Both received FAER awards in 2000, and both have gone on to receive NIH RO1 awards. They each gave talks on their current research interests, with an emphasis on how FAER helped them to succeed.

Finally, I want to thank the AUA members for allowing me to serve as SAB chair for the last five years. It has been a privilege to help shape the scientific content of the meeting. **Marie Csete, M.D.**, California Institute for Regenerative Medicine, and Emory University, will now take over as chair of the SAB. We can all look forward to an interesting and high-quality scientific program under Dr. Csete's guidance.



Michael Crowder, M.D.



# Treasurer's Report: 2008

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

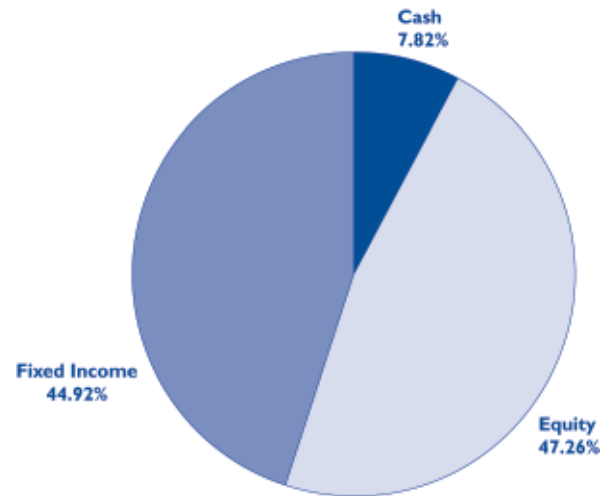
The treasurer's report is summarized in the following figures. Notable points are:

- Total assets = \$458,371
- Revenue after expense = -\$3,346 for 2007
- \$30k deficit in 2006
- Investments are still making money but less than prior years: 12 percent versus 6 percent
- Past two meetings lost a few thousand dollars each
- Corporate donations were \$11,000 in 2006 and \$27,500 in 2007
- Web site costs \$18.5k in 2006 (for the nominations software) and \$3.8k in 2007
- We cannot count on continued investment income. The situation should be observed for another year. More corporate support would be helpful.

## Investment Summary:

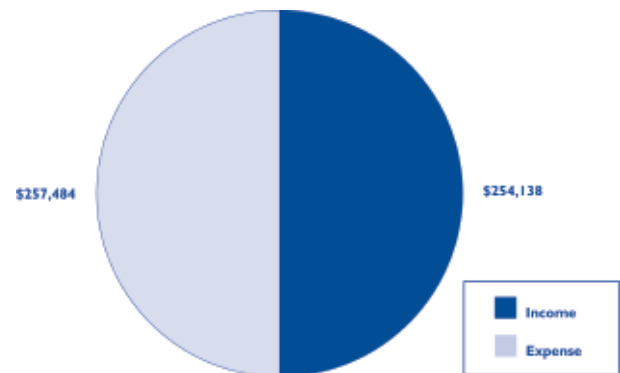
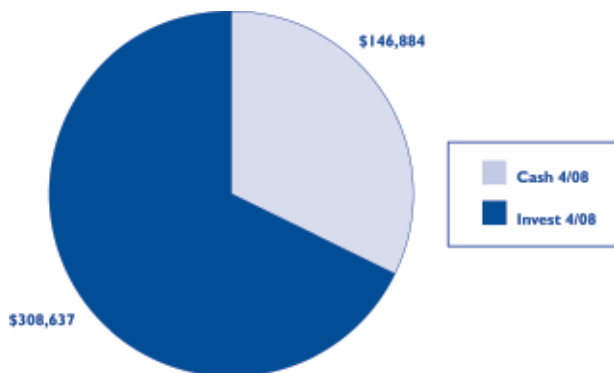
### Asset Class Analysis - Summary

As of close of business: May 2, 2008



## Balance Sheet: April 2008

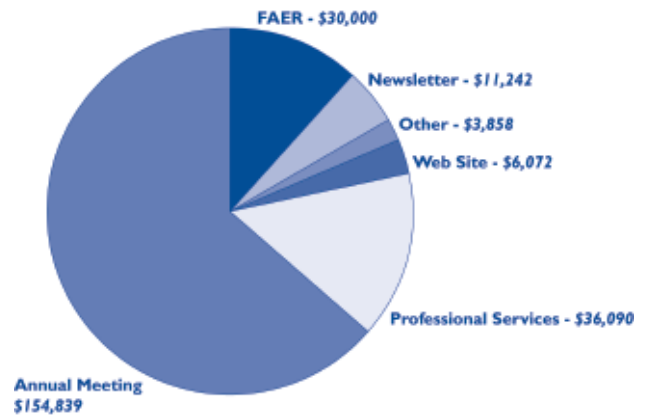
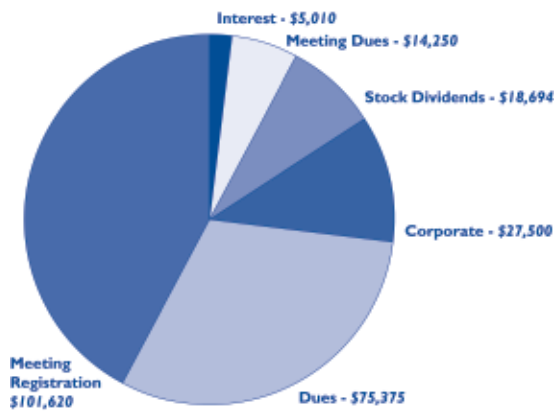
## Income/Expense: Dec 2007 (-\$3,346)



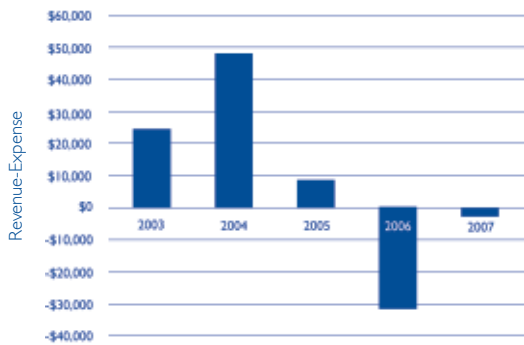


## Income 2007

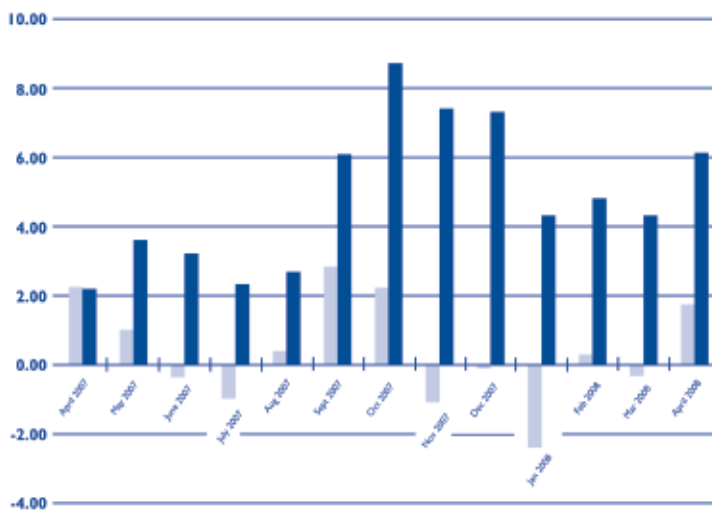
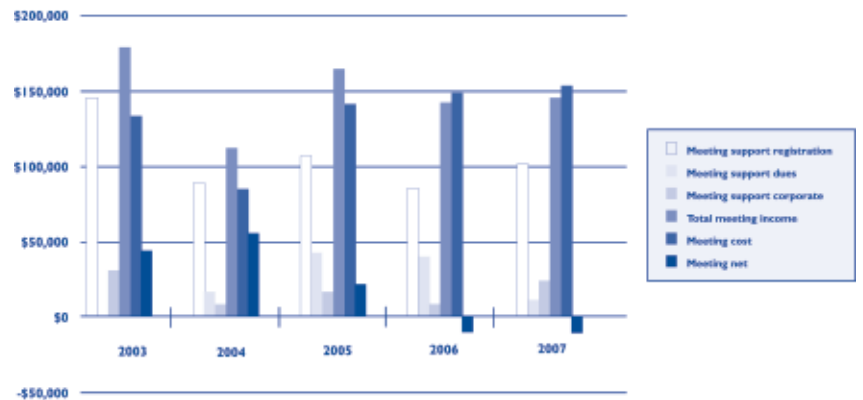
## Expenses 2007



## Net Balance Trends



## Meeting Analysis



## Rate of Return 2007-08

S&P is -8.4% during the same period

# UTMB to Host 56th AUA Annual Meeting

Donald S. Prough, M.D.  
Professor and Chair  
Rebecca Terry White Distinguished Chair  
Department of Anesthesiology  
The University of Texas Medical Branch  
Galveston, Texas

The Department of Anesthesiology at the University of Texas Medical Branch (UTMB) will host the AUA 2009 Annual Meeting at the Moody Gardens Hotel, Spa and Convention Center in Galveston, Texas, on April 3-5.

## Moody Gardens

The Moody Gardens Hotel, Spa and Convention Center will be the site of the 2009 AUA Annual Meeting. This venue not only provides an excellent hotel with outstanding conference facilities but also features wide-ranging attractions. The full-service spa facilities are excellent, and the new Moody Gardens Golf Course has recently re-opened after undergoing a \$14 million comprehensive renovation. The new golf course, planned by Jacobsen Hardy Golf Course Design, provides an outstanding seaside layout.

A complex of pyramids at Moody Gardens provides educational displays ranging from worldwide marine environments, tropical habitats and scientific exhibits. The Aquarium



Pyramid contains exhibits on several marine habitats. The Caribbean Exhibit features sharks, sea turtles and thousands of tropical fish that swim overhead as you navigate through an underwater tunnel surrounded by the exhibit's 1 million gallons of water. The South Atlantic Exhibit features several species of penguins in an enclosed, frigid Antarctic environment. The North Pacific Exhibit showcases seals and sea lions as well as a kelp forest that highlights the diverse underwater world that stretches from Northern California to the Gulf of Alaska. The South Pacific Exhibit showcases marine creatures from the Great Barrier Reef to the Coral Sea.

Birds, fish, reptiles, amphibians and mammals that inhabit tropical regions of Asia, Africa and the Americas are presented in the Rain Forest Pyramid. The Discovery Pyramid features the world of science and presents traveling exhibits from around the world. Spectacular films are shown in the IMAX 3D and 4D Special FX theaters. The Moody Gardens complex also offers the white sands of Palm Beach, a relaxing beach

development. The Colonel Paddlewheeler docks at the Moody Gardens Complex and cruises the waters of Offatt's Bayou and Galveston Bay.

Overall, the Moody Gardens complex provides an outstanding venue for conducting the AUA meeting and provides easy access to numerous activities and resources. Learn more about Moody Gardens at [www.moodygardens.com](http://www.moodygardens.com)



Donald S. Prough, M.D.

## Galveston

When the first Europeans landed, Galveston Island was home to Akokisa and Karankawa Indians. The Spanish explorer Cabeza de Vaca was shipwrecked on the island in 1528 and lived among the Karankawa Indians as a medicine man and slave. In the late 1600s, the explorer Robert Cavalier La Salle claimed the island for King Louis of France. Still later, Jose de Evia was sent in 1786 by the Spanish colonial governor and general Bernardo de Galvez to chart the island and surrounding waterways.

Evia named the island Galveston in honor of his patron. The pirate Jean Lafitte arrived on the island in 1817, making it the base of his operations. The founding of the current city of Galveston dates to 1836, under the auspices of the Republic of Texas. Two of the original homes that were owned by Galveston's founding fathers still stand — the Michel B. Menard Home (1838) and the Samuel May Williams House (1839). The Menard home is open for public tours.

Galveston thrived as a major port and financial center during the late 19th century. A large number of the buildings that comprised the original city have been preserved through the efforts of the Galveston Historical Foundation, and there are approximately 1,500 island buildings on the National Register of Historic Places. Galveston boasts three districts on the National Register of Historic Places, including the Strand National Historic Landmark District, East End Historical District and Silk Stocking District. The Strand Historical Landmark District, formerly known as the "Wall Street of the Southwest," is now home to numerous shops, antique stores, restaurants and art galleries. It has one of the largest and best-preserved concentrations of Victorian commercial architecture in the country. The East End Historical District is the original residential area of Galveston and was built during the period of 1840-1900. There are numerous shops and restaurants in the area, and some of the historic homes are open for public tours. The Texas Seaport Museum is home to the restored tall ship *Elissa*, which is maintained by a team of volunteers and sails periodically. The *Elissa* and the rest of the seaport museum are open for public tours. Galveston served as a major port

# April 3-5, 2009

of entry for European immigrants during the settling of the southwestern United States. The history of that period is chronicled in the Seaport Museum as well as the Galveston County History Museum. "The Great Storm," shown at the Pier 21 Theater, gives a glimpse of the devastating 1900 storm through a multimedia documentary.

The temperate climate of Galveston allows visitors to enjoy the beautiful outdoors year-round, and April is a great time to visit Galveston — the average low temperature is 65 degrees and the average high temperature is 74 degrees. Popular outdoor activities include fishing, kayaking, surfing, birding and



golfing as well as just strolling on the beach or seawall. Hurricane season does not start until June, so tropical storms are not a threat in the month of April.

For more information on Galveston, visit [www.galveston.com](http://www.galveston.com).

## The University of Texas Medical Branch

UTMB is the oldest medical school in Texas — founded in 1891. It is also home to the oldest schools of nursing and allied health in the state. In 2007, patients from 221 of Texas' 254 counties received care at UTMB, which included 753,000 outpatient visits and 41,000 inpatient admissions. A central mission of UTMB is to provide medical care and services to underserved populations. As such, UTMB provided care to indigent patients from 168 counties in Texas in 2007. In addition to operating six hospitals in Galveston, UTMB also operates the Women's Hospital within Brackenridge Hospital in Austin, Texas, 90 community-based clinics throughout east and southeast Texas and is a level I trauma center serving as the lead trauma care resource for a nine-county region. The Shriners Hospital for Children-Galveston is also affiliated with UTMB and sits within the UTMB hospital complex. UTMB operates a pioneering Electronic Health Network that conducts more than 66,500 telehealth consults annually. The AT&T Center for Telehealth Research and Policy is the only center in the nation devoted to demonstrating the efficacy of telehealth technology.

UTMB has trained more physicians than any other Texas medical school and annually admits a class of more than 200 medical students. The combined number of students in the

Schools of Medicine, Nursing, Allied Health Sciences and Graduate School of Biomedical Sciences is more than 2,400. There are approximately 700 medical residents and fellows in training at UTMB. The Institute for the Medical Humanities is internationally recognized and offers the only combined M.D., Ph.D. program in medical humanities currently available in the United States. The Institute for Human Infections and Immunity is a world leader in global health and emerging infectious diseases. UTMB is the only institution in the nation to receive designation as both a Regional Center of Excellence in Biodefense and Emerging Infectious Diseases and to host a National Biocontainment Laboratory. Aging and longevity research are also major strengths of the institution. UTMB is one of 10 Claude D. Pepper Older Americans Independence Centers and a center for the study of Alzheimer's and other neurodegenerative diseases.

The host program at the 2009 AUA Annual Meeting will focus on many of the strengths of UTMB, including global health, Alzheimer's disease, telemedicine and health care allocation.

Learn more about UTMB at [www.utmb.edu](http://www.utmb.edu).

## Transportation

Galveston lies 45 miles southeast of downtown Houston at the end of Interstate 45. Hobby Airport in Houston sits adjacent to I-45, 35 miles north of Galveston and is served by Southwest, American, Delta and JetBlue Airlines. George Bush Intercontinental Airport is in northeastern Houston and about 60 miles from Galveston Island.

Ground transportation options include rental cars as well as several shuttle services that provide transportation between Galveston and the Houston airports.

For more information on ground transportation see [www.galveston.com/transportation](http://www.galveston.com/transportation).





## President

Ronald G. Pearl, M.D., Ph.D.  
Stanford University

## Immediate Past President

Roberta L. Hines, M.D.  
Yale University

## Secretary

Thomas J.J. Blanck, M.D., Ph.D.  
New York University Medical Center

## Treasurer

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

## Councilors-at-Large

Jeffrey R. Balsler, M.D., Ph.D.  
Vanderbilt University

H. Thomas Lee, M.D., Ph.D.  
Columbia University

Rona G. Giffard, M.D., Ph.D.  
Stanford University

## AUA Update Editor

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

## Educational Advisory Board Chair

Robert E. Shangraw, M.D., Ph.D.  
Oregon Health & Science University

## Scientific Advisory Board Chair

Marie E. Csete, M.D., Ph.D.  
California Institute for  
Regenerative Medicine

## Council of Academic Societies Representatives

Lee A. Fleisher, M.D.  
University of Pennsylvania

Steven J. Barker, Ph.D., M.D.  
University of Arizona

Association of University  
Anesthesiologists  
520 N. Northwest Highway  
Park Ridge, IL 60068-2573  
(847) 825-5586; fax (847) 825-5658  
aia@ASAhq.org  
www.aiahq.org

# Medical Idiocracy

Continued from page 6

neuroanesthesiologists of 2050. What new drugs had been developed? How about blood substitutes? Any new monitors? Any continuous CBF and CMRO<sub>2</sub> monitors that were being discussed in 2008? New simulation technology? Had anything changed since 2008?"

The anesthesia doctor I spoke with looked askance at me and suggested that there were no significant problems — the surgeons had solved all the important problems, and all the stuff I was asking about, after review by the Best Practices Board of the AANA, had been dropped as just expensive fluff stuff. They were doing just fine without it.

So after a week or so in 2050, I headed back to the chamber and hoped the "hey dude" gang could get me back to 2008.

\* Story line adapted from the cult movie, "Idiocracy." If you've never heard of it, learn more from [www.imdb.com/title/tt0387808](http://www.imdb.com/title/tt0387808) or [en.wikipedia.org/wiki/Idiocracy](http://en.wikipedia.org/wiki/Idiocracy) or just Google it.

