Traditionally medicine has been conceived of as "a calling" and the noblest of professions. Its most revered figures, like Virchow and Osler, were superior scholars, clinicians, and bedside teachers. The perversion of our academic reward system from one at its best altruistic, to one focused unprofessionally on the economic bottom line undoubtedly has led some clinician-scientists astray. Many authors have worried about a burgeoning epidemic of academic misconduct that seems coincidental with these adjustments in academic "recognition" and pressures.[4] Unfortunately, anesthesiologists (Scott Reuben and Joachim Boldt, as two recent examples) have figured prominently in notorious, scientifically and clinically damaging, instances of such conduct and may serve as warning beacons of an academic culture, even in anesthesiology, whose integrity deserves scrutiny.

When pondering failures to grow our academic workforce, we need to look beyond the trainee recruitment process, and the hypothetical implication of deficits among our (in fact, talented, fresh, and mainly unselfish) recruits, although that element deserves attention. We need also to consider the possibility that witnessing a degraded culture and a tarnished sense of "professionalism" in the academy may also drive *nonacademic* career choices among otherwise *appropriately selected*, but academically discouraged, residents.

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In Reply:

We wish to thank Dr. Nemergut for his informative comments regarding the financial pressures surrounding research funding and graduate medical education. Dr. Pryde's suggestion that "the failure to produce academically-oriented anesthesiologists has less to do with the aptitude and character of selected applicants and more to do with the unsavory aspects of the current culture within US academic medicine" may be more of a tangential comment than an alternative view. Both De Olivieria's article[1] and our Editorial[2] focused on the criteria used to select residents, with emphasis on whether research training and publications were predictive of successful match. Neither the article nor the Editorial addressed whether our training programs are encouraging or discouraging residents from embarking on academic careers. Indeed, we are unaware of data indicating that there has been a negative change or failure to attract young anesthesiologists to University faculties.

Although we appreciate Dr. Pryde's view of academic anesthesiology as an "ethically challenged" and "morally questionable healthcare-for-profit motivated endeavor," we do offer an alternative view. The 21% incidence of dissatisfaction and a desire to leave the academy cited by the author is a statistic from a survey related to all of academic medicine, not primarily to academic anesthesiology. Further, the survey provides neither a comparator of dissatisfaction with community practice nor historical controls for rates of dissatisfaction with academic practice in prior years. We clearly recollect the events of the late 1990s when most academic anesthesia departments were severely understaffed due to substantial departures of faculty members toward community practice coupled with inability to attract graduating residents to faculty positions; this is decidedly not the situation today.

There are undoubtedly financial and regulatory strains on academic anesthesiology, but we believe that the burdens on academic anesthesiology are currently no different than on medicine as a whole. Medicine is changing dramatically, in part because of public awareness and demands for greater accountability with increasing concerns for safety and better outcomes. There is a greatly increased awareness of variability in medical performance and the incredible cost of medical care is impinging on other public mandates, including education and research. The public is demanding that resident and attending physicians perform at higher standards because they are paying for their training through Medicare dollars. The training of physicians is becoming more regulated and rigorous, and future clinicians will be more tested, more reliable, and perhaps more capable. There are unintended consequences of these new demands, including reduced time and resource for faculty and resident scholarship, which may have negative impact on academic culture.

Dr. Pryde's comments do not speak to the issues regarding the training of future researchers in anesthesia, which remains vital to our specialty and requires an understanding of the demands of research funding, mentoring, and access to research support. Anesthesiology must change to provide greater value to the health of the public, and academic anesthesiology will need to remain a leader in this transformation. Advances in anesthesiology are considered among the biggest improvements in patient care and safety in the past century, and our role in patient safety has been lauded by many. Attracting academically talented residents into anesthesiology and helping them to develop into successful

investigators is paramount to our continued success in leading improvement in medicine. Remorse about the "lost Camelot" of academic medicine of a century ago should not prevent us from pursuing these goals.

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