

Executive Summary – Concern

An animal welfare concern was reported to [ORS 192.345(30)], Senior Scientist and Division Head, Neurosciences, by a graduate student. [ORS] referred the student to the IACUC Chair, [ORS] OR [ORS], Attending Veterinarian [ORS 192.345(30)] and Director of the Animal Care and Use Program [ORS 192.345(30)] interviewed the student, a laboratory technician, a post-doctoral scientist and others with first-hand experiences during the incident of concern. Interviews were conducted with the PI and the collaborating scientist.

The graduate student had concerns regarding practices observed during a lengthy but terminal surgical procedure conducted on May 5th and 6th. The student questioned whether or not; 1) the procedures conducted required aseptic approaches, 2) local anesthesia was sufficient in the area of incision while the animal was in a deep plane of anesthesia, and 3) appropriate lubrication had been provided for the animal's eyes. Upon review of the IACUC protocol, no items of non-compliance were identified. The surgical procedures were terminal and therefore did not require strict aseptic techniques. Injection of lidocaine at the site of the incision supported multi-modal pain management by enhancing the effectiveness of systemic anesthetics but was not the primary agent for initiation or maintenance of an appropriate anesthetic plane. The anesthetic regimen was determined adequate. Contact lenses were used to protect the animal's eyes during the procedure as described and scientifically justified in the protocol.

DCM veterinarians familiar with the work were interviewed. Oversight of the animal's physiological condition and management of anesthesia occurred several times during the 30+ hour procedure. There were no concerns from the veterinary staff regarding the management of the anesthesia. Veterinarians were confident that investigators were well experienced in the techniques used. Laboratory personnel were not directly involved in the surgical procedures and served as support personnel for calculations of precise locations of the craniotomy microelectrodes and any necessary adjustment to the equipment.

The student expressed frustration with a lack of understanding of the expectations for their participation during the procedure. They also expressed a lack of confidence in the training they had received to execute the duties they believed they were assigned. The student had not read the IACUC approved protocol and did not understand they had access to the document from the time of approval through the eIACUC system. A technician in the laboratory expressed similar concerns indicating poor communication regarding planning for the study and preparation for the procedures to be conducted.

Interviews were conducted with the PI and a research collaborator who was the subject of the concern. Both faculty members expressed the view that laboratory personnel had been adequately trained for the duties they were assigned. The PI was present throughout the anesthetic period and was personally responsible for maintaining an appropriate anesthetic plane in the animal. The laboratory personnel were to record quantitative monitoring parameters but were not expected to adjust the levels of anesthetic or interpret the recordings.

Students expressed concerns that they did not have access to the IACUC-approved protocol. This was a failure in the transfer of information because all personnel can log into the eIACUC system and access any protocol on which they are listed as personnel. Notifications to laboratory personnel listed on the protocol do not automatically occur through the eIACUC system, so it falls upon the PI to inform

personnel of their access to the document. There was a lack of understanding by both PIs regarding the responsibility to communicate this access to laboratory personnel.

Steps Taken to Improve:

The IACUC office has evaluated the process for notifying all protocol personnel of their access to the approved document. The IACUC office is adding language to the protocol approval memo reinforcing this responsibility to the PI and providing a direct link to the approved protocol so it may be forwarded to laboratory personnel.

The Attending Veterinarian implemented enhanced oversight and engagement by the DCM veterinary staff during the next scheduled procedure. The procedures were completed without incident. The veterinary team is also reviewing and revising, if appropriate, guidance for maintaining optimal anesthesia during lengthy terminal procedures.

Following the conclusion of the investigation, the IACUC leaders met with the student and technician who filed the concerns and thanked them for bringing forward information. The IACUC leaders stressed the importance of engagement of all stakeholders on behalf of the welfare of the animals.

The IACUC was informed of this concern and subsequent investigation at a convened meeting on July 20, 2021. There were no negative impacts on the welfare of the animals. The ILT recommends that communications within the laboratories be improved, but concluded this incident does not require reporting to the federal regulatory agencies or to AAALAC, International.

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Reason	Page (# of occurrences)	Description
ORS 192.345(30) OHSU Medical Researcher	1 (7) 2 (1)	OHSU faculty and employee animal worker exemption.