



# AUA

Association of University Anesthesiologists

# Update

Fall 2007

The Future of Academic Anesthesiology: A Time for Action	5
Program for Accreditation of Education Institutes Becomes a Reality	6
Tech Tips: VPNs	8
Membership Nominations	10
Call for Abstracts	11
EAB and SAB Call for Nominations	11

## Embryonic Stem Cell Hostile Language Avoided by Georgia Legislature

Marie Csete, M.D., Ph.D.  
 Associate Professor and  
 John E. Steinhaus Professor of Anesthesiology  
 Co-Director, Emory M.D./Ph.D. Program  
 Director, Emory/Georgia Tech  
 Human Embryonic Stem Cell Core  
 Director, Liver Transplant Anesthesiology  
 Emory University Hospital  
 Atlanta, Georgia.

*The Georgia Legislature, in developing legislation in support of a state cord blood bank initially considered a bill that would have explicitly prohibited research on embryonic stem cells. Dr. Csete and others, successfully for now, persuaded the legislature to not address embryonic stem cells. Her story follows.*

When reporters call Emory University for “expert commentary” on some stem cell-related event in the news, our public relations office refers the calls to me. Given the visibility of stem cells in the news, I was not surprised to see a call-back number from our public relations office last year and assumed that I would have a brief conversation explaining some technical issue surrounding yet another stem cell story. This call, however, was different. A well-meaning state senator (the Democrat who serves Emory’s district) was trying to draft legislation to establish a cord blood bank in Georgia — a noble idea. The senator’s aide and I talked (she is a lawyer with an Emory physician father and brother), and she forwarded the legislation to me. Unfortunately the bill contained a lot of technical errors and, importantly, also would have banned any attempts at derivation of new human embryonic stem cell lines or any attempts at therapeutic cloning in the state.

After these problems were pointed out, the senator rewrote the bill to remove these bans. But somehow — in politics of the state legislature that I do not understand — the bill was eventually re-proposed, this time by another senator of the majority Republican party, who also happened to be head of

one of the key committees that would hear expert opinion about the bill before its presentation to the full legislature for a vote. The bill was much the same, but this time the language banning the derivation of new human embryonic stem cell lines and attempts at therapeutic cloning were more prominent, and any such attempts were punishable by a fine and jail time. The first hearing before the legislature’s Science and Technology Committee was scheduled without much notice. In fact, I managed to get there because the original author made a frantic call to my office urging me to get down to the state house immediately. Although the precise laws governing these hearings are obscure, the spirit of the hearings is clearly to give equal time to testimony for and against pending legislation. The original author of the bill asked me to put together a five-minute primer on stem cells and the importance of furthering this field with new technologies, and I was signed up to be a speaker at the hearing (the sign-up process also is a political landmine).

An hour was devoted to the hearing, but less than five minutes were given to those of us with concerns about the legislation. Patient advocacy groups (Parkinson’s Action Network and the Shepherd Spine Center, among others) had mobilized to speak about their concerns with the bill as well. Although the credentials of the speakers in favor of the bill were elaborated on in detail when they were introduced, when I was called to testify, it was with open distaste on the face of the committee chair. Furthermore, I was told that I could not show a picture of an embryonic stem cell or use my computer. (So much for free speech!) Nonetheless, the fact that significant concerns were raised in the last minute of the hearing



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

Continued on page 2

## Embryonic Stem Cell Hostile Language Avoided by Georgia Legislature



Dr. Csete sits before a panel in the Georgia Legislature.



was sufficient to slow a process that could have otherwise steam-rolled through the legislature.

It is hard to describe the level of hostility that greeted any attempt on my part to speak to the value of furthering work on human embryonic stem cells, particularly their importance in modeling developmental diseases and to screen for therapies that can improve embryonic viability and development. At one subsequent hearing, I expressed concern that the definitions in the bill were inaccurate, and I stressed the importance of accuracy so that scientists and legislators were all talking about the same things. For example, the bill equated an unfertilized egg with an embryo, meaning that all research on eggs could also have been banned in the state. When I pointed this out, the senator in charge of the hearing stated, “I know that you are using definitions to hide what it is you actually do in your lab. I know that you are making human clones and implanting them into pig uteruses to grow up and use for your research!” (Our Emory/Georgia Tech Human Embryonic core facility uses only the presidential lines, all under the guidelines proposed by the National Academy of Sciences, and I don’t use pigs in my stem cell research.) Several of the local newspapers had reporters at the hearing, and this comment was widely printed, prompting some very interesting calls to my office from colleagues around the state! Almost all the hearings were followed by live interviews with local television reporters, and the local media paid a lot of attention to the debate.

As these hearings went on, the Georgia Biomedical Partnership (GBP) also mobilized to speak against the bill, and their leadership devoted considerable effort to under-

standing the issues and working behind the scenes with the legislature and the governor’s office. Personally, one good outcome of this long process was meeting and working with colleagues in the local biotechnology industry to influence the legislative process. As a result of the efforts of patient advocacy groups and my efforts in the state house, and most importantly the GBP activity behind the scenes, the bill mutated into one that established a governor’s advisory council on stem cell research. (No surprise: I was not appointed to the council.) GBP also organized meetings over the summer in which we discussed ways to respond to the inevitable reappearance of the original bill. As part of these discussions, a survey covering opinions about embryonic stem cell research was written and funded by GBP. The Washington, D.C. firm (Ayres, McHenry & Associates, Inc.) that conducted the statewide survey of 600 voters was quite surprised by the results: By a margin of two to one, Georgians expressed support for embryonic stem cell research on donated embryos that would otherwise be discarded, and a majority of those surveyed supported research on therapeutic cloning. The survey was published in its entirety by the *Atlanta Journal-Constitution*.

It was quite clear that the second author of the bill was very disappointed in its demise, and as anticipated, the bill re-emerged in the next legislative session. The bill contained no punishment for deriving new embryonic stem cell lines but repeatedly called human embryonic stem cell research “unnecessary” and “destructive.” In my opinion, the bill was worded so that once the research was officially legislated as unnecessary and destructive, another bill banning the

**“Stem cell biologists around the country have been quietly fighting similar battles — battles that are only raging in the local newspapers and never seem to rise to national prominence.”**

research would be easier to pass. This year, the first committee hearing was once again controlled by the author of the bill, and his unbalanced appropriation of testimony time was again the modus operandi. An “expert” on stem cells gave a slide show (allowed to use *his* computer!) for the entire 60 minutes of the hearing. The expert was a local cardiac surgeon who had one paper (sixth author) related to stem cells in PubMed at the time, a study in which he apparently helped with surgery in animals treated with adult stem cells. He emphasized the amazing pluripotency of adult stem cells and, therefore, the irrelevancy of work on human embryonic stem cells. Like most talks by scientists and physicians who read about stem cell biology but are not experts in the field, the talk was both sophisticated and full of misconceptions, some quite wild. Since the talk filled the entire hour, no one who had qualms about the bill (including a large number of patient advocates in the room) was given time to speak.

Another hearing followed that was, perhaps no coincidence, held on “Right to Life Day” at the state House. This hearing was jammed with people there to express opposition to abortion. Again, the time given to those in favor of the stem cell bill far outweighed the time given to me and the patient advocates. A representative of GBP read a statement supporting establishment of a state cord blood bank but suggesting that the bill should not be passed with the references to embryonic stem cells. The chairman of the committee literally attacked the GBP speaker over technical issues and the fact that there was at least one member of the GBP who disagreed with the GBP position — the verbal assault was (charitably) loud and unpleasant.

In a stunning tactic, when I was called to give expert testimony, someone who I had never met before was called by the chair to sit next to me at the microphone — a handler! She was introduced in glowing terms as a friend of the committee chair and a family physician with an adjunct appointment to Mercer Medical School. She first attacked my stance as a scientist who doesn’t see or appreciate patients. Once I pointed out that I do care for very sick patients, she next attacked me for not valuing life. Of course her comments went unchecked, and no one who gave testimony in favor of the bill was ever forced to have a handler. Nonetheless I did manage to get the attention of a new member of the legislature who had not been exposed to a scientist discussing the increasingly vital importance of human embryonic stem cell research for all of biomedicine. Again, the steamroller was temporarily slowed.

Fortunately this year, a final committee (the economics committee) required to hear testimony on the stem cell bill was controlled by a chairman who actually allotted 30 minutes to those in favor of the bill and 30 minutes to those not in favor of the bill. What a difference from all the prior committee experiences! GBP gave expert testimony on the cost of establishing a cord blood bank independent of the established large banks. (In the latest iteration of the bill, the cord blood bank will be funded by voluntary donations of Georgia taxpayers, who will be solicited at the time they file their taxes.) Several patient advocates spoke eloquently about the importance of new human embryonic stem cell lines and

*Continued on page 4*

## Stem Cells Defined:

**S**tem cells are defined by their potential to both self-renew and to differentiate into more than one distinct cell type. Human embryonic stem cells are totipotent, meaning that they can be induced to differentiate into any cell type, both somatic and germline. Human embryonic stem cell lines were first isolated from blastocyst stage embryos (about 200 cells) that would normally have been discarded in IVF clinics. These embryos were no longer needed by the parents, and no legislation governs their disposition. The process of pulling out cells from the interior of the blastocyst (the inner cell mass) to establish a human embryonic stem cell line destroys the embryo with current surgical technologies. In 2001, President Bush established a registry of established stem cell lines and also banned the use of federal funds for derivation of any new lines or study of lines derived independent of this registry. Derivation of new embryonic stem cell lines is not banned by law but must be funded outside of federal dollars. (Recently President Bush again vetoed a bill supported by the director of the National Institutes of Health that would have freed up federal dollars for the study of “non-Presidential” lines.) Since then, other sources of human embryonic stem cell lines that do not require destruction of a blastocyst have been developed by scientists around the world, including pathogenetically stimulated eggs (unfertilized). But these lines have not been added to the registry, and use of federal funds to study or use these lines is currently banned.

Therapeutic cloning is more aptly called nuclear transfer. In this process, a nucleus from any somatic cell is transferred into the cytoplasm of an unfertilized egg. The egg nucleus is either removed manually, or less commonly, inactivated, then the egg with its new chromosomal information is stimulated to divide. From a cluster of cells equivalent to a blastocyst stage embryo, human embryonic stem cells can be derived as described above. Although this process circumvents the use of blastocysts from in vitro fertilization clinics, it requires an egg donor, and opponents to this

*Continued on page 4*

therapeutic cloning in the hunt for new therapies for diseases that destroy the quality of their lives. I spoke about the various research applications unique to human embryonic stem cells and emphasized their importance in screening drugs that can affect the developing human. The author of the bill commented that he couldn't understand how I would be willing to destroy something so wonderful as a cord blood bank because of "wording" in the bill. I repeatedly testified that I was in favor of the cord blood bank but that the stem cell bank would still be established with removal of the "wording" that was worrisome for scientists and biotechnology industry representatives.

After I returned to my office that evening, I received a call from yet another state senator who questioned me in detail about the contents of the bill. He asked me to rewrite the bill so that its inaccuracies were removed and to get rid of all mention of human embryonic stem cell research as "unnecessary." In addition various interest groups conducted enormous amounts of (confidential) behind-the-scenes negotiations over the next few days. Ultimately the bill that passed is not really distinguishable from my edited version. The cord blood bank is officially legislated, without significant funding, and embryonic stem cells are not mentioned (see [www.legis.state.ga.us/legis/2007\\_08/fulltext/sb148.htm](http://www.legis.state.ga.us/legis/2007_08/fulltext/sb148.htm)).

What were the learning experiences here? Over the last two years, I made several trips to Washington when stem cell bills were pending at the federal level. The obvious difference between Washington (believe it or not!) is that the dialogue is much more civilized than it is at the state legislature, where extreme statements, rants and accusations were the norm. And in Washington, I talked with Republicans almost exclusively, people who felt very strongly that President Bush was right to ban federal funding of new stem cell lines. Much to his credit, Georgia Senator Johnny Isakson really made an effort to understand the technical details of the biology, and he heard me out politely on several occasions. Even though I didn't convince him to vote for federal funding for new human embryonic stem cell lines, the dialogue was intelligent and concerned, a far cry from what happened in Georgia. Through Emory's government legislative office and the Association of American Medical Colleges, I had the opportunity to give a primer on stem cell biology to the health aides in the Senate in D.C. Lots of these men and women took copious notes, questions from both sides of the aisle were excellent, and clearly the idea was to gather real data for their respective positions — again in stark contrast to the silencing of real data and dialogue in the state. Though the tactics encountered in Georgia were distasteful, the main learning experience is that a single, persistent voice can make a difference, bolstered by partners who understand the politics and economic concerns of the government.

Stem cell biologists around the country have been quietly fighting similar battles — battles that are only raging in the local newspapers and never seem to rise to national prominence. Our experience in Georgia cannot be more different than that in California, where billions of dollars are being devoted to human embryonic stem cell research, an area that California legislators feel will maintain the state's leading position in biotechnology.

*kind of research are concerned that a potential embryo is created only to be destroyed.*

*At the most recent International Society for Stem Cell Research meeting in June, the main subject of interest was "nuclear reprogramming" of somatic cells using various molecular techniques to change the expression pattern of the cell to be equivalent to that of a human embryonic stem cell. Three recent papers provide firm evidence that the technique is feasible using mouse cells, and a surprise lecture by Shoukhrat Mitalipova, Ph.D., at Oregon Health & Science University described the first nuclear reprogramming of primate cells. To date, no human somatic cells have been reprogrammed, but the technical advances described at the meeting are an important step in the successful reprogramming of human cells.*

**A videotape of Dr. Csete's testimony at the April 9, 2007, session of the Georgia Science and Technology Committee can be seen at:**

**[media.legis.ga.gov/hav/science/science40907.wmv](http://media.legis.ga.gov/hav/science/science40907.wmv)**

***"It is hard to describe the level of hostility that greeted any attempt on my part to speak to the value of furthering work on human embryonic stem cells, particularly their importance in modeling developmental diseases and to screen for therapies that can improve embryonic viability and development."***

*Roberta L. Hines, M.D.*  
*AUA President*

The specialty of anesthesiology is experiencing a resurgence in interest from our best and brightest medical students. For those of us who have lived through the nadir of interest in our specialty in the mid-1990s, this indeed comes as a breath of fresh air. Our current resident applicants have record USMLE scores, a high percentage of them have received AOA honors, and we are once again attracting individuals with advanced training in research and board-eligibility in specialties such as medicine and pediatrics.

Clearly this is wonderful news and presents us with opportunities for embellishing and expanding the academic foundation of our specialty. The challenge that now confronts us is one of creating an environment that exposes students and residents to research and academics early in their careers. Most importantly we must embrace novel ways to demonstrate the rewards inherent in academic anesthesiology. I would like to

in this program will elect to pursue careers in anesthesiology, but I am confident we have succeeded in attracting many who, without this opportunity, would have failed to appreciate the research opportunities available in our specialty.

Having exposed medical students to the breadth and scope of career paths available in academic anesthesiology, the next challenge revolves around nurturing and developing our residents into successful physician scientists. While many of our entering CA-1 residents express an interest in pursuing an academic career, the continued attrition away from academics concerns all of us. To address this issue, several residency programs have embarked or are embarking upon programs aimed



*Roberta L. Hines, M.D.*

# The Future of Academic Anesthesiology: A Time for Action

share some innovative and exciting programs specifically aimed at attracting, retaining and nurturing the next generation of academic leaders in our specialty. My hope is that by highlighting these remarkable programs, I will energize others to think creatively in ways that will ensure a healthy and vibrant future for academic anesthesiology.

As a result of earlier presentations in the AUA newsletter, many of you may be familiar with the Foundation for Anesthesia Education and Research Medical Student Anesthesia Research Fellowship. This program is designed to attract medical students interested in anesthesiology research careers (after their first year of medical school) and partner them with host departments and mentors. This program has been extremely successful in exposing medical students to the diverse research opportunities at the basic, translational and clinical levels available within our specialty. The numbers of host programs and interested students have grown each year since the program's inception. Having served as one of the host institutions for this summer program, I can attest to its success in recruiting the best and brightest medical students. The response of the students to the scope of research experiences available in anesthesiology has been extremely positive. Clearly it is too early to know if the medical students involved

at identifying students who express an interest in remaining in academic medicine. While the precise details will vary by program, the common theme is one of early emersion into research and academics.

These programs match residents with mentors and engage them in research throughout their residency. They are designed to provide resident scholars with the requisite skill-set to be competitive in today's difficult funding arena. This is vitally important as the anesthesiology specialty continues to lag behind our colleagues in medicine, pediatrics and surgery in securing peer-viewed funding for our investigators. Examples of two such active resident scholar programs currently utilizing this approach are the Virginia Apar Scholars Program at Columbia University and the Resident Research Program at Yale (for those that have not been mentioned, please do not be offended). In these programs, potential resident applicants with a desire to embark upon an academic career identify themselves during the "traditional" residency application process. While these residents must meet all of the necessary criteria for admission to the core residency program, they undergo additional interviews and screening and receive

*Continued on page 9*

*This article was initially published in the November 2006 Bulletin of the American College of Surgeons.*

# PROGRAM FOR ACCREDITATION OF EDUCATION INSTITUTES BECOMES A REALITY

BY CARLOS A. PELLEGRINI, MD, FACS,  
SEATTLE, WA;

AJIT K. SACHDEVA, MD, FACS, FRCSC,  
DIRECTOR, DIVISION OF EDUCATION;

AND KATHLEEN A. JOHNSON, EDM,  
SENIOR MANAGER, PROGRAM FOR THE ACCREDITATION  
OF EDUCATION INSTITUTES  
AND EXPERIENTIAL LEARNING PROGRAMS

**I**t was a historic day for the American College of Surgeons on June 28, because the ACS Program for Accreditation of Education Institutes made its first set of accreditation decisions. Seven institutions were accredited as level I ACS-accredited education institutes (see box, next page). The decisions were made by the Accreditation Review Committee (see box, next page) based on the review of the completed applications and surveyors' reports. Accrediting education institutes was a significant milestone for the College.

The program was officially unveiled at the 2005 ACS Clinical Congress in San Francisco, CA. The aim of the program is to offer new and innovative educational programs to surgeons, surgical residents, medical students, members of the surgical team, and surgical patients. The program should enhance patient care and patient safety through education. The goals of the program are consistent with the College's mission.

During the fiscal year 2006-2007, the ACS Division of Education expects to receive 20 to 25 applications from either level I or level II institutes. ACS staff has been contacted by several institutions about the requirements necessary to become accredited or for applications. Many of the institutions requesting



**ACS-ACCREDITED EDUCATION INSTITUTES,  
AS OF JUNE 2006**

Centre of Excellence for Surgical Education  
and Innovation  
University of British Columbia,  
Vancouver, BC

Minimally Invasive Surgery Education Center  
University of California-Irvine, School of Medicine,  
Orange, CA

Simulation and Skills Center  
Beth Israel Deaconess Medical Center,  
Boston, MA

Basic Advanced Trauma Computer-Assisted Virtual  
Experience Medical Simulation Program  
The University of New Mexico Health Science Center,  
Albuquerque, NM

Institute for Clinical Simulation and Patient Safety  
Temple University School of Medicine,  
Philadelphia, PA

Southwestern Center for Minimally Invasive Surgery  
University of Texas Southwestern Medical Center,  
Dallas, TX

Institute for Surgical and Interventional Simulation  
University of Washington,  
Seattle, WA

**ACS PROGRAM FOR ACCREDITATION  
OF EDUCATION INSTITUTES  
ACCREDITATION REVIEW COMMITTEES**

**Review Committee I**

Chair: Carlos A. Pellegrini, MD, FACS, *Seattle, WA*  
Peter B. Angood, MD, FACS, *Oakbrook Terrace, IL*  
Robert W. Bailey, MD, FACS, *Miami, FL*  
Mark W. Bowyer, MD, FACS, Col., USAF, MC, *Burke, VA*  
Daniel B. Jones, MD, FACS, *Boston, MA*  
Helen M. MacRae, MD, FACS, FRCSC, *Toronto, ON*  
A. Karim Qayumi, MD, PhD, FRCSC, *Vancouver, BC*  
Lelan F. Sillin III, MD, MEd, FACS, *Rochester, NY*  
C. Daniel Smith, MD, FACS, *Atlanta, GA*

**Review Committee II**

Chair: Carlos A. Pellegrini, MD, FACS, *Seattle, WA*  
Richard J. Finley, MD, FACS, FRCSC, *Vancouver, BC*  
Gerald M. Fried, MD, FACS, FRCSC, *Montreal, QC*  
John G. Hunter, MD, FACS, *Portland, OR*  
Lenworth M. Jacobs, MD, MPH, FACS, *Hartford, CT*  
Adrian E. Park, MD, FACS, FRCSC, *Baltimore, MD*  
Robert V. Rege, MD, FACS, *Dallas, TX*  
Richard M. Satava, MD, FACS, *Seattle, WA*


**Staff:**

Ajit K. Sachdeva, MD, FACS, FRCSC, *Chicago, IL*  
Kathleen A. Johnson, EdM, *Chicago, IL*

accreditation information are in the process of building their own facilities, which will house surgical skills centers. In anticipation of the work required to process these new applications during the next year, ACS staff is aiming to recruit and train an additional 25 surveyors.

Based on the goals of the program and the interest among institutions, we believe the ACS Program for Accreditation of Education Institutes will shift the paradigm for how surgical education is delivered and will enhance the educational opportunities available. The institutes will offer educational programs to support acquisition and maintenance of competence and maintenance of certification. The institutes will also engage in collaborative education research and development.

For future information about the ACS Program for Accreditation of Education Institutes

or how to apply for accreditation, please contact Kathleen Johnson at [kjohnson@facs.org](mailto:kjohnson@facs.org) or 312/202-5276. 

**Dr. Pellegrini** is Henry N. Harkins Professor and chair, department of surgery, University of Washington, Seattle, and a member of the Board of Regents.



35

NOVEMBER 2006 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS

**AUA Editor's note:**

To learn more about activities and future plans for surgical simulation, see the March 2007 issue of the Bulletin of the American College of Surgeons at: [www.facs.org/fellows\\_info/bulletin/2007/satava0307.pdf](http://www.facs.org/fellows_info/bulletin/2007/satava0307.pdf).

# Tech Tips:

# Virtual Private Networks

Keith Ruskin, M.D.  
Department of Anesthesiology  
Yale University

Fifteen minutes before I was scheduled to give a lecture to the residents, I realized that my PowerPoint presentation was exactly where I had left it: On my desktop computer at home. Thanks to my Netgear VPN router and some software on my laptop, I was able to connect to my home network and upload the talk. I did all of this from the podium in the department's conference room. Unfortunately for hackers, my computer and my network were able to create a highly secure connection, meaning that my computers and information were safe.

## What Is A VPN?

A virtual private network, or VPN, allows computers to exchange confidential information over the Internet. Corporations use VPNs to link offices together or to allow employees to gain access to their internal networks from home. If you use your home computer to access your hospital's laboratory or scheduling system, you may already be using a VPN.

Although sophisticated cryptography makes them very secure, the basic theory behind a VPN is easy to understand. A VPN is simply a cryptographic tunnel that allows two protected networks to communicate over an unsecured, public network. When the VPN is created, specialized hardware and software negotiate a connection. During the negotiation process, the true identity of each end is verified using either a user I.D. and password combination (less secure) or a digital certificate (most secure). A computer requesting a connection to a network over a VPN is usually assigned a network address from the remote network. Once the connection has been created, information leaving one network is encrypted and sent to the VPN device on the other end, at which point it is decrypted and sent to its final destination. Once it is created, the VPN is "transparent." To the users on each end, it appears as if there is a single network that connects all computers.

Many people have thought of allowing outside users to access limited portions of their home network. Unfortunately, however, hackers (or computers loaded with their software) troll large sections of the Internet looking for open networks. Unless you've loaded the latest security patches on all of your computers, you can be sure that you'll be victimized by viruses, worms or other nasty software. VPNs solve this problem. Because they use strong authentication and encryption, you can open a tiny hole in your network that lets only you or your family in. It's safe to send confidential information back and forth because only you and your software have the keys to decrypt it. Suddenly, leaving that PowerPoint presentation on your home desktop is not a problem. Best of all, you no longer need a roomful of IT staffers and a budget bigger than IBM's to create your own home VPN.

## Getting Started

Setting up a VPN is a straightforward process. You'll need three things: a fixed IP address (or Dynamic DNS), a VPN router or appliance, and a VPN client.

Most cable and DSL providers use a dynamic IP, or Internet Protocol, addressing system. Each time your router is turned on, it is assigned a new IP address. Some companies even assign a new address periodically, so even though the new router you got over the holidays has been powered up since New Year's Day, your IP address may have changed six times or more. This process is usually invisible, since all of the connections that you have been making until now have been from a home computer to an outside server. Since you now want to connect to your home network from the outside world, you'll need to know its address, and there are two ways to do that: You can



Keith Ruskin, M.D.

"Setting up a VPN requires a trip to the local computer store and takes a couple of hours, but you'll be glad you did it when you realize that the lecture that you're about to give is still on your desktop computer at home."

ask your Internet service provider to assign you a "fixed" IP address. Most providers offer this service to their commercial clients and will be happy to do this for an added fee. If you can't get a fixed IP address, an alternative strategy is to use a "dynamic DNS" service. DNS, or "domain name system" resolves network names (like www.ASAhq.org) to IP addresses (e.g., 66.153.120.12). This association is usually fixed, but a dynamic DNS allows the IP address to be changed remotely. The service that I use to do this is DynDNS (www.dyndns.com). Practically speaking, you create a name for your home network and load a program onto one of your



// Unfortunately, however, hackers (or computers loaded with their software) troll large sections of the Internet looking for open networks ... VPNs solve this problem. //

home computers. That program periodically checks the IP address of the computer that it's on and updates the DNS if the address changes. Fortunately, the VPN hardware we're about to talk about has this feature built in.

The next step is to add VPN functionality to your home network. There are some programs that you can load onto a computer to do this, but when I'm exposing my network to the outside world, I prefer the added security that a hardware-based solution provides. The easiest way to get started is to upgrade your home firewall and router. The Netgear FVG318 Pro-Safe VPN Firewall costs less than \$130, and gives you a brand-new, secure firewall and wireless network access point in addition to a virtual private network. A configuration wizard helps with the initial setup. (You also can use this router to improve the security of your wireless network, but that's a story for a different article.) After the router is installed, you can configure both the dynamic DNS and VPN server from your Web browser.

You'll probably also need a VPN "client" for your laptop. If you're a Windows user, you can just buy the Netgear client for approximately \$50 when you buy the router. If you're a Mac user, the Equinux VPN Tracker client works with Netgear's products as well as many corporate VPNs. ([www.equinux.com](http://www.equinux.com)) Both products come with excellent documentation that will have your VPN up and running in an hour or two.

## Conclusions

VPNs allow you to get access to all of the equipment on your home network safely and securely. Setting up a VPN requires a trip to the local computer store and takes a couple of hours, but you'll be glad you did it when you realize that the lecture that you're about to give is still on your desktop computer at home.

## The Future of Academic Anesthesiology: A Time for Action

*Continued from page 5*

a separate ranking based on their appropriateness for entry into the research scholarship program.

Once accepted, these students commit to either a two-year clinical or a research fellowship program following residency. The expectation is that individuals will decide upon a clinical, basic or translational track at the time of admission to the residency program. Traditionally the basic or translational scholars transition to a T-32 program at the conclusion of their residency. The clinical scholars will be expected to choose a two-year clinical fellowship program, which includes a defined clinical research project.

While the number of these "resident scholars" chosen each year will vary by program, the average is one to three per year in each of the participating programs. Currently at Columbia (which started the Virginia Apar Scholars Program in 2004), there are 12 resident scholars! Imagine the impact that could be achieved by expanding this approach for developing academic anesthesia to even 10 percent of all residency training programs!

Having successfully identified and developed our young and talented physician scientists, the next challenge revolves around exploring creative solutions for balancing the clinical and academic demands of junior faculty. Our faculty is faced with increasing clinical production pressures and is often left to wonder why they chose to pursue a career. We need to utilize all available resources to give

them the time (truly a precious commodity these days) needed to engage in the research, education and scholarly activities that initially attracted them to academics. While data presented by the Society of Academic Anesthesiology Chairs (SAAC) have shown a small increase in the amount of nonclinical time awarded to faculty, the current time available is clearly inadequate to meet the requirements for faculty development. I would like to suggest that emeritus faculty represent an underutilized resource for "freeing up" faculty. Clearly how those individuals can be incorporated into departmental academic activities will be governed by local university and faculty bylaws. These talented individuals, however, represent a wonderful source for mentoring, providing assistance in grant writing and manuscript preparation as well as leading educational activities (e.g., journal clubs, research conferences). When appropriate, they also may provide clinical coverage, thereby relieving faculty of their clinical responsibilities.

This is both an exciting and challenging time for academic anesthesiology. With the amazing intellectual talent being attracted into our specialty, we need to utilize both traditional and nontraditional methods for identifying, developing and nurturing the next generation of academic anesthesiologists. I trust that these ideas and programs highlighted above will energize all of us to "think" globally and act locally.

# Membership Nominations

## **AUA Membership: Online Nomination Process Available Soon**

**Submission Deadline: January 15, 2008**

### *How Do I Nominate Someone?*

All AUA members are invited to nominate candidates for membership in the association beginning on Thursday, November 1, 2007. Qualifications for active membership are: An individual a) who occupies and has occupied a faculty position in anesthesiology in a medical school or its affiliated teaching hospital in the United States or Canada for at least 24 months, following completion of graduate university residency training in anesthesia, and b) whose work as anesthesiologist, teacher or investigator gives promise of a successful career in academic anesthesia. However, c) individual exceptions to the above residency qualifications shall be made at the discretion of the Executive Council when one of the following two conditions apply: 1) when the candidate has had a course of graduate training in anesthesia of a high standard or 2) when the candidate has shown a continued productive interest in, and contribution to, academic anesthesiology.

The Council recommends for election by the general membership those candidates who seem best qualified. In the Council's deliberations, great emphasis is placed on excellence in areas of pertinence to the goals of the Association. This year the Council is requesting that the nominator identify — from among the areas of teaching, administration and research — the one in which the candidate is most outstanding. The nominating letter should discuss accomplishments and contributions in teaching, research, administration and patient care, but should emphasize the identified area of excellence.

The Council seeks evidence of a nominee's impact on anesthesiology beyond his or her own institution and of activity of more than local interest. Such documentation should be as objective and non-anecdotal as possible. Ensuring that all the documentation is in order will facilitate consideration of the nomination. Lack of documentation of achievements and lack of supporting letters are frequent causes of failure of a nomination.

Although AUA is primarily oriented toward U.S. and Canadian anesthesiologists who have actively contributed to academic anesthesiology, occasionally it is appropriate to provide Honorary Membership to anesthesiologists residing in other countries. Honorary Membership in AUA should be lim-

ited to those few exceptional individuals who have made sustained and significant contributions to the specialty. Their contributions should have significantly and fundamentally altered the practice of anesthesiology and/or enhanced the understanding of basic science related to anesthesiology.

These individuals and their accomplishments should be known and recognized by most, if not all, members of AUA. The reason for such Honorary Membership should be clearly stated by the nominators, emphasizing how such recognition would benefit the AUA. The format for nominations is the same as for Active Members; nominators should also state the willingness of the nominee, if elected, to meet the same meeting attendance requirements as Active Members.

**Only electronic submissions via the AUA Web site will be accepted beginning Thursday, November 1, 2007.** Paper nominations will not be considered by the Council and will be returned to the nominator.

Nominators can access the online nomination process by visiting [www.auahq.org](http://www.auahq.org) and clicking on the "Membership Process" section. You will need the AUA username "auamember" and password "papper." Please have the following information available before you begin the submission process. You will not be able to save your information during this process. All information must be completed at one time in order for the submission to be completed. Please allow approximately 30 minutes to complete the following steps needed to submit your nomination.

The following information is needed in order to complete the nomination process:

1. The nominator contact information (full name, title, institution, address, phone, fax and e-mail address).
2. The nominee contact information (full name, title, institution, address, telephone, fax and e-mail address).
3. The nomination letter (this information can be copied and pasted into text boxes).
4. The seconding nominator information. (full name, title, institution, address, telephone, fax and e-mail address).
5. The seconding nominator letter (this document must be in a Word or PDF file).
6. Five references (full name, title, institution, address, telephone, fax and email address).
7. Curriculum vitae (this document must be in a Word or PDF file).
8. Peer-reviewed grant funding (this may be copied and pasted into a text box or uploaded as a Word or PDF file).

If you have questions regarding the new process, please contact the AUA office at (847) 825-5586 or via e-mail at [c.dionne@asahq.org](mailto:c.dionne@asahq.org).

# Call for Abstracts

The Scientific Advisory Board (SAB), chaired by C. Michael Crowder, M.D., Ph.D., invites you to submit an original research abstract for presentation at the AUA 55th Annual Meeting, May 15-18, 2008 at the Washington Duke Inn & Golf Club in Durham, North Carolina. **The abstract submission site will go live September 28, 2007.**

As is tradition, all submitted abstracts will be accepted. Only one abstract per member (*authored or sponsored*) will be accepted. SAB peer review will assign abstracts to oral and poster sessions. Individuals whose abstracts are selected for oral presentation will be asked to not be overly technical in their presentations and to provide adequate background and context for their work. Oral presentations are not intended for post-doctoral fellows or senior faculty. To maintain the traditional high quality of abstract submissions, it is essential that member authors and sponsors critically review their submissions. Members are encouraged to consider submission of clinically oriented abstracts, for there has been a decline in the numbers of such submissions for recent meetings.

The Association has made it easy to submit your abstracts for presentation at the AUA Annual Meeting. We encourage you to submit an abstract by visiting the Society's online submission form at:

[www.auahq.org](http://www.auahq.org)

Review the layout and format instructions, complete the submission form and upload your blinded and unblinded abstract as an MS Word document. It is that simple! **Please note:** ONLY electronic submissions will be accepted for consideration.

Abstracts selected for viewing at the AUA 55th Annual Meeting will not be published, allowing members to submit essentially the same abstract to the ASA 2008 Annual Meeting.

## Resident Travel Awards

Abstracts submitted by Residents within one year of residency/fellowship at the time of the Annual Meeting should be marked accordingly by checking the respective box on the online submission form. In order to be considered for the award you must attend the meeting. The top two scoring abstracts judged by the Scientific Advisory Board will be awarded a \$1,000 travel award.

## 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.

Committee members are expected to attend the 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 on attending AUA annual meetings and who are willing to help undertake the work of the committee are encouraged to submit their names or those of other members with a brief resume by **March 1, 2008**, to:

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

[shangraw@ohsu.edu](mailto:shangraw@ohsu.edu)

The AUA Council and the EAB chair will choose three candidates who will then be contacted to confirm their willingness to serve. The three-year term begins after the AUA Annual Meeting.

## 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 and provides input to the AUA Council on issues pertinent to the scientific mission of AUA. An SAB member has three responsibilities: 1) grade abstracts for the AUA Annual Meeting; 2) attend the Annual Spring Meeting to help with scientific sessions and to meet at the SAB luncheon for discussion of issues relevant to the SAB; and 3) contribute a 500- to 1,000-word article pertaining to science in some way 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 e-mail curriculum vitae by **March 1, 2008**, to:

C. Michael Crowder, M.D., SAB Chair

[crowderm@morpheus.wustl.edu](mailto:crowderm@morpheus.wustl.edu)

The AUA Council and the SAB chair will choose three candidates who will then be contacted to confirm their willingness to serve. The three-year term begins after the AUA Annual Meeting.

# AUA

Officers and Councilors-at-Large

## President

Roberta L. Hines, M.D.  
Yale University

## President-Elect

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

Jonathan B. Mark, M.D.  
Duke University Medical Center

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

C. Michael Crowder, M.D., Ph.D.  
Washington University

## 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  
aua@ASAhq.org  
www.auahq.org

# 55th Annual Meeting

May 15-18, 2008

## Washington Duke Inn and Golf Club



Washington Duke Inn and  
Golf Club



Nasher Museum of Art



Duke  
University  
Medical  
Center



"DRIVEN TOO FAR BY HIS ATTENDING, THE PSYCHOTIC ANESTHESIA RESIDENT SEEKS REVENGE"