

*The Rovenstine Inheritance—A Chain of Leadership**Emery A. Rovenstine Memorial Lecture on the Occasion of the Annual Meeting
of the American Society of Anesthesiologists*

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On occasions such as this, there is a sense of a lifetime compressed into a single moment. Can it be as many years since, as a young intern, I was first interviewed by Dr. Rovenstine for an appointment to the resident staff at Bellevue Hospital? Could as much have happened in the field of anesthesiology—to its clinical and scientific scope, to the men and women who have devoted their professional lives to it, and to the societal and organizational framework in which our specialty functions, nationally and internationally? The answer, of course, is yes, it has. The passage of time and the unfolding of destiny are both real and irrefutable and are brought home even more deeply at landmarks such as this.

Last January, when Dr. Louis Blancato called me to invite me to present the 21st Emery A. Rovenstine lecture, I was deeply moved. I realized, of course, the high honor being bestowed. The invitation also rekindled, almost immediately, memories of a relationship that was very special to me, which, in fact, influenced and shaped my entire professional life.

The preparation of this, the most prestigious lecture in anesthesiology in this country, is a fearsome responsibility. But I felt that somehow my long and always-stimulating association with Dr. Rovenstine would make it possible for me to cope with this trust.

Previous Rovenstine lectures were all thoughtful and discerning tributes to Dr. Rovenstine, and much, much more. Most of the distinguished lecturers in past years, you may recall, chose to take the Rovenstine legend as a springboard for voicing their concerns and satisfactions about the state and foreseeable fate of anesthesiology. The focus ranged from the quality of education in our specialty, the relevance and support of research in anes-

esthesiology, the super-specialist approach to patients at the cost of humane, personalized doctor-patient relationships, and a justifiable pride in our overall record of quality care. Last December Dr. Emanuel Papper, at the New York Postgraduate Assembly noted, additionally, Rovenstine's role in the development of anesthesiology as a great and powerful movement throughout the world.

Each of these well-developed themes, I am sure, struck a note of recognition and response in all of us. But in choosing my own thrust, I decided to follow my instincts, based on the fact that when Dr. Blancato invited me, he said frankly, "You're among the last of the original Rovenstine residents, you know." Disregarding the chill of mortality this produced in my loins, I decided that, perhaps this was a signal. This lecture should rightfully have more emphasis on the personal—a human and professional evaluation of the man as well as the anesthesiologist we honor here, withall trying to avoid the sentimental pitfalls of nostalgia. The other decision was to focus on the concept of leadership, a quality that Dr. Rovenstine personified and passed on. A quality also shared by so many of our colleagues whose talents and dedication have enriched and will continue to shape the progress of anesthesiology.

Leadership—it is a word, an idea, and an ideal, both timeless and sharply contemporary. Ralph Waldo Emerson puts it into proper place "Life only prevails, not the having lived," he wrote. "Power ceases at the instant of repose, and it resides in the moment of transition to a new state, in the darting to an aim."

Those who teach us, inspire us, who mold and direct our actions are enshrined in our memories when their lives are over. But their real contributions are measured by how they enlarge and change their fields in years to come, both by seeding and by example. Opinion and sentiment can create heroes. But the substance of their true leadership is the use they made of themselves and how they transmit it to a new state. How their fire helps others to dart to a new aim. In our frame of reference this would include first and foremost, improved care of patients and clinical excellence. Next, the constant extension of the scientific bedrock on which anesthesiology is based, through research and education. Also, the drive

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for increased stature in the medical and public world—the latter a capricious world in which a seemingly innocuous item noted in the mass media sometimes can lead to unexpected consequences.

But first, let me begin with the personal. I had known Dr. Rovenstine in his early years at Bellevue when I was a third-year medical student. He had given our class a series of brilliant lecture–demonstrations in the famous Stewart Surgical Amphitheatre at Bellevue. This experience had a great deal to do with linking my strong interest in pharmacology to anesthesiology as a *bona fide* clinical–academic specialty. I incidentally note with pleasure that so many of the scientific presentations at this annual meeting link many areas of pharmacology with clinical anesthesia practice.

At the interview, which I remember as pleasantly brief, Dr. Rovenstine finally said simply, “You can come to Bellevue.” Eighteen months later, just 3 weeks after Pearl Harbor, I started as one member of that very special group known as Rovenstine Residents. Yes, it was 40 years ago that I had the good fortune to enter what was much more than a training program, but also an arena, a showcase, a crucible—The Department of Anesthesia at Bellevue Hospital in New York.

I call it an arena because even though it nourished affinities, it was also a setting for the clash of assertive young minds, and because there was a certain amount of jousting with surgeons and other medical colleagues who had not yet awakened to this new brand of anesthesiology and this new breed of anesthesiologists. It was a showcase, as well. Academic anesthesiology based on clinical science as well as on clinical skill, was there to see every day, a model for that time and for years to come. And it was a crucible, a forging ground for many talents, male and female, of many backgrounds. They knew they were pioneers in a fledgling medical discipline seeking the best.

Among those who had already been there before I arrived were John Adriani, Virginia Apgar, Charles Burstein, Mary Lou Byrd, Stuart Cullen, Stevens Martin, Perry Volpitto, and Lewis Wright. Others were part of my time: Evelyn Apogi, Donald Burdick, Robert Dripps (not for the whole course), Austin Lamont, James Marin, Emanuel Papper, and Frank Thompson. Somewhat afterwards, many still in uniform came back to study with Rovenstine: Richard Ament, Sam Denson, George Finer, Martin Helrich, Louis Orkin, Boardman Wang, and James West. Many who had done anesthesia in the Army on the basis of a 3-month crash course returned for short courses to update themselves. This was the start of formalized continuing education in anesthesiology, which, as some of you may know, is a field of medical education of special interest to me. All of these students of Rovenstine, today, are practically a roll of honor. They were part of his great plan—the links in the chain of leadership

he forged. I'm pleased to see a number of them here today.

Those of you of my generation in anesthesiology, or thereabouts, are well aware of Rovenstine's key role in the formulation of anesthesiology as a full medical specialty, including its recognition as such by the entire medical community. Interestingly, he also felt strongly that the public, too, had to be made aware of the full and special nature of physician anesthesia. To those who have followed the ASA's recent public relations activities, it is evident that Rovenstine was ahead of his time in recognizing the need for such effort. In those years he did this at some risk to himself. The roads he took did not always pass through friendly territory. Town-gown tensions were deeply rooted in many enclaves along the way. In one such instance, after he was featured in a series of three low-key, informative profiles in the prestigious New Yorker magazine in 1947, a veritable hall of fame for current luminaries, Dr. Rovenstine was charged formally with unethical conduct—self-advertising. He was suspended from membership in the New York County Medical Society and was asked to resign his membership in the New York Academy of Medicine. Today he would probably be a star on a cable network—those intense dark eyes meeting audiences head-on and his Hoosier directness raising his ratings. Fortunately, this unhappy period of misunderstanding and contention is well in the past. We all now recognize the importance of the public image of anesthesiology and anesthesiologists.

Even without Dr. Blancato's friendly reminder, I do realize that the ranks of us earlier-vintage anesthesiologists who lived in the Rovenstine–Bellevue era are thinning. So that it is worthwhile to note a few of the salient facts of Rovenstine's colorful life and remarkable career to underscore the nature of the debt we owe to him as a principal architect of our specialty. There is not time for a full biography, but here are some of the actualities of his life and perspectives gleaned from many sources and from my own recollections.

Rovenstine was born and reared in Atwood, Indiana, a town of 200 population, located in a farming community. He was the eldest of four sons. His family owned the general store. The Rovenstine family work ethic was strong, as was their drive to self-improvement, traits he diligently retained throughout his life. His work was his life. Human relations being what they are, there were times when those around him felt his consuming interest in his work was the cause of some tragic events in his personal life. But this did not deter him.

Rovey's childhood ambition was to be a school teacher, a goal he eventually achieved. He started his high school studies in Atwood, then transferred to a larger high school in Blue Island, Illinois, where he lived with his uncle. He was a good student, but probably a better athlete, playing on his school's baseball, football, and basketball teams.

Oddly, it was his athletic ability at high school that fortuitously resulted in his much later entry into anesthesiology training at the University of Wisconsin. During his senior year, in the final quarter of a basketball game during which young Rovenstine felt that the referee had been in his way whenever he had the ball, he butted the referee in the stomach. The referee, a large man, picked up the boy and spanked him. By chance, the referee, a former athlete, was a physician on the faculty of the University of Indiana Medical School. His name was Arthur F. Guedel, none other than the distinguished anesthetist who first described the stages and planes of anesthesia.

Years later, Rovenstine, when he became a medical student at Indiana, reminded Guedel of the incident, which the older man had not forgotten either. Rovey and Guedel developed a special student-teacher relationship that continued after Rovenstine's graduation. And it was Guedel who arranged an appointment for Rovey with Dr. Ralph M. Waters at the University of Wisconsin. Thus, a low blow in a schoolboy basketball game led to perhaps the most significant single event that launched Emery A. Rovenstine on his brilliant course in anesthesiology.

But let's fill in some years. After high school, Rovenstine entered Wabash College on an athletic scholarship and was graduated in 1917, just in time to enlist in the Army Corps of Engineers for service in World War I. He was sent to France as a Second Lieutenant and assigned to a courier detachment that brought him to the front lines. It was here, he felt, that he developed his first deep interest in medicine, seeing and talking to the wounded and to medical corps personnel at ambulance pick-up stations.

His interest in medicine, he would sometimes say, somewhat tongue-in-cheek, was also hereditary. His grandfather, a Civil War veteran, traveled between his two farms in a wagon from which he sold a home-brewed liniment that he claimed, with great flair and showmanship, could cure a long list of ailments. If Rovey inherited anything from his grandfather, it was a talent for showmanship, which, while it never extended to snake oil therapy, was evidenced in other ways. Once, at a New York Academy of Medicine Graduate Fortnight, a prestigious annual event, he kept a dog anesthetized under water in a large fish tank to demonstrate the merits and safety of endotracheal anesthesia. Luckily the dog didn't drown. As for the technique, it also survived and its acceptance is long years beyond question.

Rovey, upon his discharge from the army in 1919, taught high school in Northern Michigan for four years. Then he gave up teaching for medicine. He entered the University of Indiana School of Medicine and took every course in anesthesia Guedel offered. After graduation and a year of internship in Indianapolis, he returned to La Porte, Indiana, where he set up in general practice

with anesthesia as a part-time specialty. Within a year he decided that he had to learn more about anesthesia if he were to develop a larger and better-paying anesthesia practice. It was then that Guedel arranged for his interview with Dr. Waters.

When Rovenstine started his training at Wisconsin in 1930, the Wall Street Crash had just occurred and it was the beginning of the Great Depression. Yet everything was burgeoning in this still quite new, unique anesthesia center that was to mean so much to the development of anesthesiology. Ralph Water's department was the model that pioneered the formation of separate, distinct departments of anesthesia at other medical schools. It also provided a brand new framework from which today's training programs in anesthesiology evolved. Although Waters was primarily a clinician, he was probably the first academic chief-of-service to encourage and support laboratory research that linked the basic sciences and basic scientists to the clinical art and practice of anesthesiology. His own leadership is honored annually in the Ralph M. Waters Lectureship of the Midwest Anesthesiology Conference.

For five years, Rovenstine thrived at Wisconsin, clearly a favorite disciple of Ralph Waters. He had come there to perfect his knowledge and skills as a well-rounded clinician. But somewhere in the process he had become an academic anesthetist, a career then only tentatively defined. His interests, his knowledge, and his views widened greatly. His research capabilities were aroused and developed. He spent much time in the animal laboratories with members of the Pharmacology Department studying various drugs. But it was his work with Waters on cyclopropane that earned for him an early reputation. Rovey had the rare satisfaction of knowing that cyclopropane, often referred to as the "champagne of anesthetic agents," was the most widely used, new inhalation agent during his entire lifetime in anesthesiology—in fact, the most important new agent since the introduction of ethyl ether and nitrous oxide into clinical anesthesia, almost a century before cyclopropane.

In 1935, Waters was asked to suggest someone who could set up a modern department of anesthesia in the medical school of New York University. He suggested Rovenstine, by now an assistant professor. The appointment was offered promptly and accepted quickly. And, on New Year's Eve of 1935, Rovey, at the age of 40, left the Midwest for New York to begin his new assignment. It was both a tremendous challenge and the fulfillment of a dream. To some of us he, at times, would recall his feelings about the importance of the Bellevue name and its world-wide reputation and his desire to establish a first-rate department of physician anesthesia. His drive was always evident and his dedication to this purpose seemingly limitless. They all paid off—the Rovenstine era at Bellevue became a period of great importance to

anesthesiology in this country and, in fact, the whole world.

His achievements have endured as they have because, in the wisdom of his leadership, he shared his own developments, his triumphs, his concerns, his insights with the people around him. He was, in the purest sense, an educator, for he knew from the beginning that, in William Osler's words, "No bubble is so iridescent or floats longer than that blown by the successful teacher." He taught us well, and in doing so, insured the continuity of what he had started, and helped to make education one of the foundation stones of anesthesiology.

Insight into how Rovenstine viewed the state of anesthesiology in his early years at Bellevue is provided explicitly in a talk titled, "The Development of Anesthesiology," which he gave at the Annual Meeting of the Medical Society of the State of New York, later published in the Society's journal in October 1942. Quite apart from its message, this three-and-a-half-page article is a good example of Rovenstine's elegant literary style and discerning grasp of the events that characterized anesthesiology from its then century-old beginnings. In the article he deduced that, "The specialty has a favorable position to approach its task of keeping abreast as medicine marches triumphantly on." Thus he indicated that the time was right for anesthesiology to catch up and become a *bona fide*, scientifically based clinical specialty with all the trappings of the more established disciplines in medicine. The article was also a masterful blueprint for structuring the second century of anesthesiology as it moved toward this goal.

The elements of his plan were simple and basic. His first priority was stated clearly. "The ultimate goal is the patient's need, and whatever service may best supply it with reasonable economy and convenience." How farsighted this was of Rovenstine to pinpoint the factors that later were to become the crucial issues of the health care community and the public, now called, quality, cost, and accessibility to health care.

Next, he believed, "The present need in anesthesia is widespread, appropriate organization that favors the accumulation of knowledge and, of no less importance, the dissemination of knowledge acquired." In his view, the element of education incorporated learning, research, and teaching. But he expands on this theme, adding, "Moreover, it must be realized that the obligation to teach and to seek new knowledge is no greater than the necessity of keeping intellectually fit to utilize and disseminate knowledge." Again translating into the 1980s, we see the formal continuum of medical education recognizing, as never before, the necessity of lifelong professional education. I'll say more on this subject a bit later. In the same article and in other of Rovenstine's writings, he points out that these evolving changes should be developed from within the organization of medical schools,

hospitals, and, of no lesser importance, the professional agencies of anesthesiology—meaning, the American Board of Anesthesiology, the AMA Section and state society sections on anesthesiology, and, of course, the American Society of Anesthesiologists.

Having conceptualized the masterplan for the second century of anesthesiology, Rovenstine did not retire to an ivory tower. Rather he labored tirelessly to build his Department and train his students in keeping with his plan. And he became a prime mover in all the major initiatives affecting the civic and professional sectors of our specialty. There is not time to enumerate all of his causes, but two stand out. One is the American Society of Anesthesiologists, so well represented in this room. The other is the commitment to continuing education. Because neither have been accorded their full recognition in the overall scheme of contemporary anesthesiology, they sometimes fall between the cracks on occasions such as this and deserve a passing note.

First, the ASA. Rovenstine was one of the two presidents of ASA to hold that office twice. He was a prime mover in driving the Society towards its highest aspirations. In 1946 he was instrumental in moving the Society's executive office from its rent-free, humble quarters in New York, staffed by a part-time secretary, to Chicago, then as now, the headquarters city for many of the major national medical societies. He saw to it that a well-qualified, full-time executive secretary was recruited promptly. This was a major step in the destiny of ASA. Today, this foremost specialty society stands as a tribute to the many, many members whose sense of collective responsibility and whose wisdom have provided the continuing chain of leadership that is the core strength of ASA.

All of us know that this excellence springs not only from our physician members. A good measure of the credit also must be directed to our talented and deeply appreciated Executive Secretary, John W. Andes, who this year marks his 25th year with the Society. He has worked with all of us, often more than we realized, to make ASA the great society it is. I feel privileged, on this occasion, to ask for a round of applause to show, in some small manner, our recognition of Jack Andes' leadership, exercised so well in our behalf.

And now to the second subject—continuing education, one of the three major components of the educational continuum in medicine, and as old as the practice of healing itself. It is no news that ASA offered such post-graduate education to its members long before continuing medical education, some 20 years ago, was formalized into its present prominence in the life of the practicing physician. It would serve no purpose to rehash the litany of the pros and cons, whys and wherefores, and introspective searching surrounding CME to this sophisticated audience. Suffice it to say that anesthesiologists, almost universally, believe in the importance of continuing ed-

ucation, and through the ASA, support and voluntarily participate in its extensive, well-organized program—one of the best in any national specialty society. Thus, we demonstrate that lifelong learning is no longer an option. It is a vocational and ethical necessity.

The crushing accumulation of new knowledge, the fragmentation of once-simple issues, and the remarkable advances of technology-based clinical management greatly have sharpened our awareness of this need. As a result, there is a new air of excitement in the continuing education component of professional education. This is probably the basis of my own involvement and lies behind the direction of my time and effort in the Society's educational activities. This interest and its many dimensions have been a source of much satisfaction throughout the years. And perhaps, the most satisfying has been the *ASA Refresher Courses in Anesthesiology*, the publication creatively conceived by Dr. Siker, and that I edit along with Drs. Betty Bamforth and Howard Zauder. As it celebrates its Tenth Anniversary volume this year, there is reassurance in the fact that this is the most successful annual publication in anesthesiology, thanks to the talented members of the Society who have contributed to its excellent contents.

What is the present state of continuing education? And how is it likely to change in the next 20 years? One can prophesize by reading literature and following trends. But one is finally dependent on one's own accumulated hunches and built-in crystal ball.

Continuing medical education, most people will agree, is in a state of considerable confusion and disarray. Despite the fact that there is general agreement that it is here to stay, almost every aspect of its formulation and delivery is in question. There are vacillations, well-meaning, but still indecision on identifying curriculum needs, criteria for evaluation, and on questions of content and emphasis. We face a scenario of noncoordination based mostly on differing and oscillating points of view among the various agencies of organized medicine. Shall continuing education be mandatory? And for what constituencies of medical practice? For revalidation of our license to practice? For maintaining board certification in good standing? For continued membership in major specialty societies? Or for retention of hospital staff appointment? How much education? What modes of its presentation and what scope of its content are necessary to retain professional competence? Is 50 hours per year the magic number? And how is this time to be allocated in the six categories of credit? What subjects are or are not acceptable based on their relevance to practice? And most problematic, how is individual learning to be verified? By written examination, practical examination, peer review? Or, as is currently trendy, by self-evaluation based on confidential examination, or simply by personal decision. And yet, despite all the uncertainties, it is clear that continuing education is moving effectively towards its fundamental

goals—the benefit of patient care. I'm not at all certain of the need to expend the time, energy, and money required to grapple with these arbitrary questions. I believe that the formalized structure of the "new continuing medical education" should be designed and utilized within the framework of what it essentially is, namely, a means more effective than earlier means for accelerating and facilitating the acquisition of new knowledge and techniques for sound clinical application.

Nor should continuing education be mandatory. The required documentation of a specified number of "brownie points" is no assurance of physician competence. This credit-accumulation process, inevitably, has become a new type of adult game, which, just as inevitably, demeans our profession. Given the physician's basic motivation to practice up-to-date medicine, this incentive will be best served if the educational means to do so are reasonably accessible at reasonable cost. And, most important, if the student-teacher relationship in the conduct of individual educational exercises supports rather than deflates the physician's self-esteem.

What projections for the future are in view? For one, there will be increasing emphasis on self-directed learning oriented toward clinical problem solving. Physicians, on a formal basis, will be offered guidance in the art of self-learning. Stripped of educator jargon, this approach will accelerate and facilitate the use of new knowledge in clinical practice. In such context, this approach also reduces the perceived threat of technology to the physician's traditional role and responsibility in clinical decision making, thus contributing to personalized patient relationships.

The second projection is already discernible. The major national specialty societies, like The American Society of Anesthesiologists, will provide the largest volume of continuing education to the medical profession. This is a significant relocation resulting both from marketplace factors and emerging civic forces. Why is this likely? All of medicine today is practiced within the officially designated disciplines of the various medical specialties. And each has its own dedicated organization and its own built-in postgraduate student constituency. Thus, they are understandably closer and more sensitive to the interests of their members than other, more broadly-based continuing education provider groups and institutions. These societies also automatically incorporate, within their own membership, the best-qualified and largest faculties in the nation to teach their own special discipline, and at the most reasonable cost. Because of such natural selection, each society can respond to its members' needs—and yes, often demands—in many areas. They will concentrate increasingly on continuing education. The reality of this trend is evident. We are already seeing a contraction in the number of continuing education offerings by the medical schools and other organizations. I con-

fidently predict that the ASA will continue to be a leader in providing for the ongoing educational needs of anesthesiologists.

Lastly, we face the implications of what has been called the communications revolution, or the age of electronic information, which may indeed change our professional as well as our personal lives. Nowhere in the field of education will the change be more evident than in continuing education to which the many new technologies are so applicable. There are the various linking and interactive types of cable television, already a reality. Database types of computerized information networks are very much with us. The American Medical Association has already inaugurated such a nationwide electronic network last month called AMA/NET. This system eventually can permit printouts for individual home use. Self-contained, microcomputerized technologies, which are largely portable, and can function anywhere at anytime, working from tapes, videocassettes, or videodiscs also will become part of our learning and teaching routines.

Such technologies may, in large measure, ultimately replace the live lecture. And at future dates an ASA conference may be satellite-beamed to five or more cities instead of one. Meanwhile, however, the traditional media—books, journals, newsletters, closed circuit television, and film—also will continue to be used generously as modes of delivering continuing education. Admittedly, it sometimes seems advisable to resist the new technologies for continuing education as a stifler of human contact and individualized learning. But this is as foolish as insisting that we should all have come to Las Vegas by horse and wagon. It is no high-technology freak dream that the day may come when the whole of continuing education will be linked together by computer intelligence, on line, with instantaneous, interactive exchanges of information. However, it is unlikely that computers ever will replace physicians. But they can and will assist as expert consultants. The ultimate decision requires personal, subjective considerations and still will rest with the clinician. I do not foresee anesthesia robots.

What is more likely is the use of the old and the new for comprehensive and more effective continuing education. The integration of electronics will take considerable time to invade the judgmental world of daily clinical practice and should not be seized on just because they are new. We should meet the challenge of this future gladly, as a great opportunity. Record keeping and data collation already are being revolutionized. But we should move carefully among our options to those systems that best support us in our basic mission—the highest quality anesthesia care of patients. When the chips are down, and I use the word in all its modern connotations, that's the vital question.

As I come to the close of my remarks today, I return to the man in whose name this lecture is given. What lesson, if any can be learned from the life of this unusual man? I have myself learned a lesson in the preparation of this talk, and I hope you have shared my feeling of encouragement that he has left us all a valuable legacy.

Dr. Rovenstine's extraordinary achievements were made possible, at least in part, because of the opportunities at his time and at his place. Others may have been there too, but he had the skill, the dedication, and the enthusiasm to grasp the chance he was offered and make it meaningful. Opportunity is not limited to any given time in the ceaseless development of medicine. Each period in every generation has different challenges. Many are lying there, scattered on the open ground, and passed by. Others must be self-conceived and developed with courageous and revolutionary thinking.

I have already spoken on technology as part of continuing education. Apart from that, we all know that we still do not have the ideal, or even nearly ideal, general anesthetic for regular clinical use. It is conceivable that the mind-boggling advances in neuroscience, elucidating the intimate functioning of the brain, could be directed to the perennial search for a more nearly perfect anesthetic modality. Conversations many of us have had with electronic physicists and engineers have indicated that the state of this science, if assiduously applied, could very likely antiquate current patient monitoring procedures. The development of information-science technology stands ready to increase, infinitely, our ability to document, to understand and to make critical judgments virtually on-line. Electronic anesthesia as in science fiction movies? It was explored several decades ago, unsuccessfully. Maybe this science now is sufficiently advanced to reexplore its possibilities.

There are lessons to be learned from the past and the present for the future. There are leaders in this room who will, down the pike, possibly have their name on memorial lectures, though, hopefully, not soon. And there are young men and women who may feel that their world is not as full of opportunities and open doors as it was in the early days. They are wrong. There is a quotation from the ancient Hebrew Talmud which seems opportune: "In every age there comes a time when the leadership suddenly comes forth to meet the needs of the hour. And so there is no man who does not find his time, and there is no hour that does not have its leader."

For the better part of the last hour I have pictured a leader who dominated his time in anesthesiology and who began a chain that extends into this room and into all our professional lives. He helped to make our specialty great. It is up to us, and especially to our newest, youngest members, to carry on in equally inspiring tradition.