

# 2006 CSA Annual Meeting

## Address of President-Elect Mark A. Singleton, M.D., to the CSA House of Delegates 2006

I am humbled and honored to be standing before you this afternoon. I have watched quite a few of my mentors and people I have greatly admired in this same spot, and I can hardly believe I'm here too. Yet this is how it happens. One starts out from a point of curiosity and perhaps naïve idealism, and before you know it, you're volunteering for all sorts of things. Our spirited and dynamic organization attracts those who believe in the power of doing good and who understand that one of the most fulfilling experiences in life is to be a participant in the collective creation of something valuable. That's why you are all here—because you are proud of your profession, its privileges and responsibilities and because being an anesthesiologist is so much more than just the best, most fun job anyone could ever have.

I have been around the CSA since shortly after I finished my residency and fellowship at UCSF more than 20 years ago. I had the good fortune (or maybe it was karma) to become influenced by two local anesthesiologists when I started private practice in San Jose, Drs. Steve Jackson and Larry Sullivan. They exuded an activism that naturally attracted me, and over the years they became my rabbi and priest. I have sought advice and absolution from both and tried to emulate their spirits of dedication, devotion to the practice of medicine, and advocacy for patient care. Like many other past presidents of this Society, they had, in abundance, that essential element of character that we all share here today—**passion**.

This year the CSA will need your passion, and your willingness to take on a number of issues that will challenge all of us. Some of these issues are ongoing efforts that the CSA will continue to pursue, and others will arise over the course of the year. Some we can anticipate and others will come out of the blue. The great strength of the CSA rests equally in the talents of the volunteers among its membership, and in the skill, knowledge, and efficiency of the CSA staff. Barbara Baldwin, Michael Whitelock, Andrea de la Peña, Linda Risdon, Lesley Franco, Terrie Rowe, and Faye Parks have become a powerhouse, and epitomize a smooth-running, high-productivity, lean and (not at all) mean nonprofit corporation staff. An immeasurable amount of credit for the successes of the CSA also goes to our highly esteemed governmental advocates, the Barnabys, and astute legal counsel, Mr. David Willett and Mr. Phillip Goldberg. As president, I will be tremendously fortunate to have these individuals to guide and empower this Society in its endeavors.

I have mentioned challenges and issues, and passion and dedication. This is the fuel that fires the engines of our organization. These engines are, of course, our two divisions and several standing committees. Each of these has specific duties and, in the coming year, will have some special challenges. Aside from generating the two superb CME programs we present in Hawaii each year, the Educational Programs Division will be asked to frame a new vision for this, our Annual Meeting. The work of the Task Force on the Annual Meeting will provide the basis for this, and one possibility is that this meeting may become focused exclusively on practice management education, in conjunction with its legal mandate to conduct the official business of the Society through this House of Delegates. New opportunities for educational programs will be evaluated. Moreover, our State Legislature—in its often puzzling wisdom—continues to set mandates for CME, the latest of which attempts to assure that “cultural sensitivity” becomes part of CME offerings.

Our Legislative and Practice Affairs Division tackles some of the most complex problems facing individual members and the specialty as a whole. Governmental regulation, the arrogance and greed of the health insurance industry, and the shifting perspective from which society views the medical profession—these all undermine physician autonomy and the free exercise of medical judgment. The LPAD agenda will continue to focus on economic advocacy for our members in the arenas of workers' compensation, obstetrical analgesia for Medi-Cal patients, insurance coverage of anesthesia services for GI endoscopy, and our right to hold the patient responsible for payment when our services are provided “out of network.” Recently, the Department of Managed Health Care, a state agency charged with protecting consumers and the public (therefore physicians) from the unethical practices and excesses of the HMO industry, opined that by providing care to a patient, we give our “implied consent” to whatever terms of payment their health plan wishes to impose after the fact. This DMHC statement blatantly disregards two recent court decisions (*Bell v. Blue Cross of California* and *Prospect v. Northridge*) that have upheld the principles of physician autonomy in contracting, and the right to fair compensation for professional services. These are the dragons we have set out to slay. We will persevere, and we will not allow the compromise of our professional integrity by those who wish to diminish us.

We have enjoyed successful results from the hard work of the LPAD on many issues, but most are also far from resolved. I must emphasize that these successes are predicated upon our close relationships with the CMA, the ASA and, yes, even the AMA. I cannot overstate the importance of your membership in these organizations. Although not always apparent, your additional membership in these allied organizations gives us a power that is far greater than the investment of your annual dues payments. Without your

support—which comes as a direct consequence of CSA members belonging to these organizations—our unquestioned credibility and recognized effectiveness in Sacramento and Washington would be doubtful.

Several of CSA's Standing Committees will have significant tasks to accomplish this year. One of the first challenges will come to the Committee on Public and Professional Communications from Hollywood in the form of the anticipated movie *Awake*. The hype in advance of this blockbuster, which centers on a patient's awareness during his heart transplant surgery, promises to rekindle the inferno of media opportunism that erupted last summer over the JCAHO's sensationalistic sentinel event press release. We have an opportunity here to present the accurate picture of this extremely rare complication, to advance patient understanding about the varieties of anesthetic experiences possible through modern anesthetic pharmaceuticals and techniques, and to make a distinction between expected awareness and that which is unintended.

I have asked the Physician Health and Well-Being Committee to consider the impact of everyday stresses that we all bring with us into the operating room and how our emotional responses may affect the safety of our patients. The emotional repercussions of arguments with our teenagers, conflicts with colleagues, and disagreements with spouses can impair us and distract our attention. How do we recognize and diffuse this? Are there tools and techniques that would help us improve our mental fitness at these times?

The Membership Committee has been working for several years on reevaluating the geographic boundaries of the 14 districts that define our membership and are the basis for representation at our Board of Directors. I have asked this committee, which consists of the district directors, to continue this work in order to simplify the boundaries, and also to develop the commonalities within individual districts.

So, there you are; just a short preview of some of the year ahead! I cannot adequately express the enthusiasm and optimism with which I anticipate this coming year. I am deeply grateful, in a very personal way, to my fellow officers and to all of you, for sharing your passion and applying your talent and intelligence to make the CSA a preeminent medical specialty society. We may, at times, feel that every aspect of our medical practice is under assault and that we are powerless to control the continually evolving environment in which we practice. While we must accept the overwhelming forces of our changing society and economic markets, we must never cease advocating for our patients as our highest purpose, and in so doing, bring continued dignity and integrity to the profession of anesthesiology. I believe it was Woody Allen who

said, "The world is run by people who just show up." Thanks to all of you who think showing up is important.

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### 2006 Distinguished Service Award—Caryl J. Guth, M.D.

*Presented by Peter L. McDermott, M.D., Ph.D.,  
ASA Past President, CSA Past President*

When I was asked a year ago to present the DSA to Caryl Guth, I immediately agreed. It is, after all, a great honor and one I could hardly refuse. As I reflected on the honor of being the presenter, it brought my mind, humbly, to reflect upon *myself*, a source of constant enjoyment. My musings were interrupted by my wife who told me that the real honor was not mine, but was for Dr. Guth. I've had trouble grasping this concept. And so it is with some regret and enormous reluctance that I shift gears and turn my attention away from myself to the presentation of the greatest honor this Society can confer—the Distinguished Service Award—not to me, but to Caryl.

Caryl was born in Peoria, Illinois, not too far from Waukegan where I was ... I'm sorry, there I go again.

She was raised in North Carolina and earned bachelor and medical degrees from Wake Forest University. She had her internship on the plains of Kansas in a city of the same name (Kansas, I learned, is to the left of Missouri, under Nebraska, and disturbingly close to Oklahoma—I had to look it up). In 1963, she landed one of the most coveted anesthesia residencies in the U.S., at the University of Pennsylvania, when it was at its greatest strength—Bob Dripps, Jim Eckenhoff, Henry Price among others. After distinguished fellowships here and abroad—and time served educating residents and medical students—she came to California in 1967 to begin what was to become a long and distinguished career in the private practice of medicine in anesthesiology. The next year she married John Falsted, the love of her life, who sadly passed in 2001. At moments of great honor such as this, we know Caryl, and many of us with her, wish John could be here—he'd be beaming.

In private practice, Caryl did what excellent people do—she cared deeply for her patients and her specialty. And so it followed that she became involved in maintaining standards of medical care and improving the quality of patient care—this means, as you all know, becoming involved in medical staff affairs and professional organizations. Caryl knew that collective action is necessary, that organizations have their own power, and that if doctors are to make

patient care better, they had better work together. She served as chair of her Department, member of the medical staff executive committee, member of the hospital board of directors, and as chief of staff—this in addition to multiple committee assignments. This is the stuff you don't learn in medical school.

Caryl also found work in her county medical society and in the CMA; but most important for us, she found her way into the CSA and contributed as much as anyone I've known to its growth and quality. I'm sorry, I just thought about me again: I came to California to become a partner of M. Kathleen Belton—a phenomenal and formidable woman. She was the first woman to become CSA president—Caryl, also phenomenal, was the second, taking that office in 1982. She brought her experience as assistant treasurer and editor of the *CSA Bulletin* to the office of president, and she put the CSA operation on a modern footing, establishing external auditing and financial management changes, and computerizing the office. She sometimes encountered fierce opposition from the gang that believed that “if it ain't broke, don't fix it” and the “but we've always done it this way” types. The good is the enemy of the better.

In addition, Caryl fought with CMA for the recognition of autonomous anesthesia departments as a policy in medical staff governance. She vigorously defended anesthesiology as the practice of medicine and opposed the expansion of scope of practice by CRNAs by state legislation. Some battles seem never to be resolved, but persistence is a historical imperative.

It was Caryl who identified physician impairment as a problem and established the first committee to confront the issue—only later did ASA follow her lead. She was at the forefront of those highlighting the dangers of drug and alcohol abuse, long work hours and the attendant fatigue, and the necessity of effective peer review and physician education as remedies. In CSA and ASA Caryl pushed for new ways of telling our story as anesthesiologists to the public by creating spokesperson training and patient education initiatives.

Finally, Caryl mentored many of us. I was one of her projects. Caryl encouraged and supported my earliest steps of involvement in ASA. I have no doubt that without her efforts, I would not have succeeded. Many others were mentored by her—Steve Jackson, Tom Cromwell, Kent Garman, Patsy Dailey and many more were imbued with her sense of mission and commitment. Caryl takes things seriously. This is nowhere more apparent than in her dissection of the reports and correspondence in the House of Delegates Handbooks of CSA and ASA. All of us at one time or another have paused in apprehension as Caryl has pointed out to us the consequences of using the wrong preposition or the cunning assault upon Western civilization that an

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errant comma can wreak. We have all learned to be better at reading the lines and between the lines as a result of Caryl's example.

Underlying Caryl's contributions to strengthening CSA and ASA is her dedication to excellence in physician performance, patient care, gender equity, recognition of diversity in the practice of medicine, and issues of public health—most especially the dangers of tobacco use. All this flows from her decency and humanity, the bedrock of values that give direction, purpose, and energy to her enduring pursuit of excellence.



*Dr. Caryl Guth and Dr. Peter McDermott at the 2006 CSA Annual Meeting  
in Rancho Mirage*

Caryl has most recently become involved in the Wake Forest Medical Alumni Association, rising to become its president.

The CSA has had no more worthy recipient of its highest award, the Distinguished Service Award, than Dr. Caryl Guth. If you seek a role model, an inspiration, look no further. The selection of Dr. Guth to receive this award does more than acknowledge the accomplishments of an extraordinary physician; it enhances the award and the CSA itself by this public tribute to my friend, our mentor and distinguished colleague—Dr. Guth.

## Acceptance Speech by Caryl J. Guth, M.D.

Peter, thank you for your kind and thoughtful words. It is a humbling experience to hear one's past exhumed by the "History Professor" of CSA and ASA. I could not have dreamed or contemplated that I would ever return to accept CSA's highest accolade—the Distinguished Service Award. I'm greatly honored to be here and to attend another CSA Annual Meeting where I can renew some wonderful acquaintances.

Before I give my remarks, I must acknowledge and thank numerous behind-the-scene folks who contributed to whatever success that I might have accomplished. However, at the risk of unintentionally omitting some of the living, I shall just mention a few deceased key people who affected my early involvement. These were: *Bulletin* Editor, Bob Foulke, who conned me into taking over his editorship, thus initially involving me in CSA activities; Kay Belton who broke the CSA presidential glass ceiling for women; past president and my key mentor, Gerry Nudell, who demonstrated his faith in me when I was assistant treasurer to ask if I would accept the nomination as president-elect, and whose wise counsel I frequently sought. Thanks also go to Past President Henry Green and still vivacious Bill Barnaby for their legislative mentoring and expertise in our successful battle with the Morehead Nurse Anesthetists' "expanded scope of practice" bill. Most of you are thinking, "Wow, that was a long time ago!" Yes, a quarter of a century ago! (And some of you were still seeking dates for the prom!)

Finally, and most heartfully, permit me to introduce my awesome family. Thanks for your love and support.

We live in a society today that is characterized as being the most litigious in history. By all logic, our specialty should top the list of medical groups in the realm of over-priced malpractice insurance. Yet, even though we hold the patients' hearts in our hands every single day, according to recent reports, our malpractice costs still rank near the bottom of the medical specialties. This envied ranking did not come quickly or easily. During the past three decades, anesthesiologists have worked long and hard to gather claims data, conduct research and institute issues such as peer review, safety guidelines, teaching simulators, equipment standards, and legislation that govern our practice. I feel honored and fulfilled to have been a part of—and to have benefited from—these advances, many pioneered or influenced by the CSA.

Unanswered questions remain regarding anesthesia and the general healing process. We still do not know the precise mechanism of action of the anesthesia that we control. Nor do we understand the full path to recovery that marks the

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disparity among patients. The great early 20<sup>th</sup> century physician and teacher, William Osler, said, “It is more important to know the patient who has the disease, than the disease the patient has.”

The thoughts of legendary physician and 1952 Nobel Peace Prize winner, Dr. Albert Schweitzer, paralleled those of Osler's. When asked how he could accept the systems of the local African medicine men, Schweitzer replied, (and I paraphrase) “Everyone has a doctor within. If the medicine man's chanting can activate this healer, so be it. Neither does western medicine have all the answers.”

In my new life I, too, am searching for some of these answers. Unanswered questions have haunted me during this past decade and led to my latest crusade—to effect change in the curriculum at my medical school by promoting the integration of holistic and more preventive concepts into medical research and practice and, in particular, the study of energy medicine. We are in a period of dramatic change in the health care system and need to focus on prevention for the new frontier of medical science.

Energy medicine could play a huge role leading to a better understanding of the interaction of physics and chemistry upon cellular functions, healing and prevention. Historically, conventional western medicine remains as the sole medical system that has virtually ignored the impact of energetics. Is it time for ancient healing wisdom and the utilization of energetics to be integrated with modern research and technology? If so, perhaps we could even find a missing link to the mechanism of action of anesthesia.

In closing, I'd like to quote Maya Angelou, the sage professor at my alma mater, Wake Forest University in North Carolina. This southern lady speaks words of wisdom, having found excitement in her 7<sup>th</sup> decade of life. I have chosen five one-line quotes of hers that resonate with me and I'd like to share them with you. Dr. Angelou said,

- *“I've learned that no matter what happens, or how bad it seems today, life does go on, and it will be better tomorrow.”*
- *“I've learned that you shouldn't go through life with a catcher's mitt on both hands; you need to be able to throw some things.”*
- *“I've learned that every day you should reach out and touch someone. People love a warm hug, or just a friendly pat on the back.”*
- *“I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”*

And finally Dr. Angelou said,

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- *“I’ve learned that making a ‘living’ is not the same thing as ‘making a life’ and that life, sometimes, gives you a second chance.”*

I too feel like I’ve been given a second chance at the dawn of my 7<sup>th</sup> decade. I’m delighted and honored that I made you feel good enough to remember this humble southerner because I will never forget how you made me feel today.

Thank you.

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## 2006 Forrest E. Leffingwell, M.D., Memorial Lecture

### Excerpts from “Musings on Anesthesiology from the Arena”

*By Clyde W. Jones, M.D.*

President Canada, Officers of the California Society of Anesthesiologists, Honored Guests, Ladies and Gentlemen:

On the 19<sup>th</sup> of September last, I received a call from your President, Dr. Eddie Canada, inviting me to be this year’s Leffingwell speaker. Interestingly, this was the 42<sup>nd</sup> anniversary of the day I started my residency in anesthesiology. I immediately sought to understand this singular honor and deemed it an attempt by a grateful former resident to pay tribute to his aging chief.

I was born on the tiny Caribbean island of Barbados. From this island have come only two anesthesiologists of world renown. The first was Henry Edmund Gaskin Boyle, the inventor of the Boyle Machine at St. Bartholomew’s Hospital, London. Next was Sir Wesley Bourne, Chairman of Anesthesiology at McGill University, Canada, and president of the International Anesthesia Research Society in 1925. He was the only non-U.S. physician ever honored by being elected president of the American Society of Anesthesiologists in 1942. So, finding myself failing the “world renown” category, I then considered the “unknown soldier” maneuver. However, it occurred to me that I am a sailor, and I am still alive. Then I decided that, as recipient of the honor, it was not for me to quibble about my worthiness, for that would only cast aspersions on the impeccable judgment and perspicacity of your president. Moreover my wife, three sons, and adopted twin grandsons would consider me ungrateful to refuse such an invitation. Thus, I graciously accepted.

I do not know how I first decided to become an anesthesiologist. Anesthesiology was not a strong department in my medical school. Moreover, I did not rotate on anesthesiology during my internship at Los Angeles County General Hospital, as it was an extremely busy program with 150 interns and

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would have taken two years to cover all the rotations. Our marching orders were “see one, do one, teach one.” I remember a very humorous anesthesiologist called Fenton Sink, who kept us entertained when I came to the operating room during my surgery and OB-Gyn rotations. It was alleged that Fenton once, during a difficult induction in a parturient, realizing that the baby was in trouble, said to the obstetrician, “Get the baby out!” When the surgeon hesitated, Fenton reached over the ether screen, grabbed a scalpel and made a bold incision from the symphysis pubis to the umbilicus and reiterated, “Get that baby out!” I was never able to verify if this actually happened or was one of the many urban legends that abounded at the County. However, it served as a source of amusement for many intern classes.

Perhaps the seed was sown one day when I was in the lounge and saw the incoming anesthesia residents being fitted with earpieces by Kathi Burdick, the daughter of Doris Burdick—who with her husband Ralph, I later discovered, were perennial participants at regional and national anesthesia meetings. Being a lover of gadgets, I had her make me one, although at the time I had no interest in pursuing anesthesia. When I mentioned this device in an article I later wrote for the *CSA Bulletin*, Dr. Robert E. Ploss, a previous editor of the *Bulletin*, told me the story of the invention of the monaural stethoscope.



*CSA President Edgar Canada, M.D., (left) is presented with an honorific quilt made by Mrs. Clyde Jones (right) at the 2006 Annual Meeting. Dr. Canada's wife and Dr. Clyde Jones are in the middle.*

While at L.A. County, Dr. Ploss had a patient for a hip pinning suffer a cardiac arrest intraoperatively. The patient was successfully resuscitated with open chest cardiac massage, but Dr. Ploss felt that had he been listening to the chest, he would have been warned. He settled on a monaural stethoscope so he could still listen to the surgeon. He then asked Ralph Burdick, a dental technologist, to make ear molds for him for the first monaural stethoscopes. Dr. Ploss' twin brother, William R. Ploss, D.D.S., M.D., a gadgeteer, then made a fluid switch valve to switch to the blood pressure manometer when the cuff was inflated. This became the Ploss Constant Monitor System, the first continuous monitor in anesthesiology. Before that, anesthesiologists said that they kept a finger on the pulse, which we know could not be continuous due to the myriad functions we perform.

Some modern anesthesiologists have implied that the precordial stethoscope has been superceded by modern monitors. This is an opinion with which I vehemently disagree. I will never administer an anesthetic without it. (See Dr. Reicher's Tip from the Top on page 57.) We precordial and esophageal stethoscopists do not listen only to ensure that the heart and lungs are present and accounted for, but we find particular value in evaluating the quality of the heart sounds, especially the second sound. When I read the accounts of catastrophes incident to anesthesiologists leaving the cockpit, and the hand wringing over silenced alarms, I say, "Where was the precordial stethoscope?" Many years ago, I participated in some human studies with enflurane with the late Rod Calverley, Ty Smith, Ted Eger, II, and Prys-Roberts. One of our monitors was the phonocardiogram, which invariably warned us of impending blood pressure fall, even before the intra-arterial line.

When I was serving in Okinawa as a battalion surgeon with the Marines, I told one of my colleagues of my intention to pursue residency training, probably in family practice. Aware of my fondness for technical things, he suggested that I consider anesthesiology. I started to read about it, consulted with the anesthesiologist at the Army Hospital, applied for and was accepted for Residency Training at the Naval Hospital, San Diego, and so my career began. San Diego was the Navy's largest training program and had a great deal to recommend it. Like all military programs, the constant infusion of reservists brought a great variety of teaching styles and techniques to the training scheme. Some of the reservists you would know who rotated through San Diego were Drs. John Hattox, Tom Hornbein, Russell Jackson, Ron Miller, the late Eric Wahrenbrock, and Thomas Cromwell.

By far the residency's secret weapon was Dr. John A. Dekrey, a conduction anesthesiologist of wide repute, who preached, practiced and taught with uncommon zeal. A character of unquestioned notoriety, he received many invitations from other training programs. The many exploits of this unusual

man were cunningly chronicled in an article I wrote for the *CSA Bulletin*. Dr. Dekrey was recipient of the Distinguished Service Award of the American Society of Regional Anesthesia (San Diego, 1996.) He has been often imitated but never duplicated, and has been widely known either in person or by reputation to the anesthesia community.

At the time I started my residency, there were few black physicians practicing anesthesiology, for one reason or another. I believe that I received excellent training as what I deem a “Cockpit Anesthesiologist.” That has been my passion and my joy throughout my career. My greatest satisfaction has been providing surgical and obstetrical anesthesia with a special love for pediatrics.

When I was stationed at Camp Pendleton in February 1968, I was ordered to Vietnam during the Tet Offensive with a Marine Regimental Landing Team. There was increased activity by the North Vietnamese at that time. I was issued my combat gear—including my weapon, a .45-caliber pistol—and given 48 hours to get under way. As you know, medical personnel, by Geneva Convention, are noncombatants, but, unlike the chaplains, we are allowed to be armed for our protection and that of our patients.

I am an unquestioned expert with the laryngoscope or the spinal needle or as a phlebotomist, but this skill does not extend to my weapon. I was concerned as to how I would fare if I had to provide such protection. Then I remembered “Canteen Cup Barnett.” Sergeant Barnett was a Marine tanker who was standing beside his tank during the Korean War when he was set upon by an enemy soldier. He reached into a cubicle in his tank where he kept a sidearm for such an occasion. This day, however, his fingers merely folded around the handle of an aluminum canteen cup. Utilizing the element of surprise and an improvisation that is legendary in the Marine Corps, he sprang upon this hapless foe and beat him to death with the canteen cup, being ever after known as “Canteen Cup Barnett.” I met this remarkable Marine several years ago, at which time I thought I might find a novel way to use my weapon other than firing an errant missile at a moving assailant.

My tour in Vietnam was invaluable to my medical training as far as the handling of mass casualties; the brisk sorting and preparation for surgery of traumatized patients; and anesthetizing, stabilizing and transfer to rearward facilities. On the other hand, I saw firsthand how wasteful is war in terms of human and material resources, mainly of our youth.

At that time, Ron Miller was stationed at a Naval Station Hospital not far away from our Field Hospital. He was sent out from the Naval Hospital, San Diego. It was here that he began a lot of his outstanding studies in blood transfusions, fluid management and muscle relaxants in trauma. I spoke with Ron one day when I visited his facility, with two friends, by jeep. Ordinarily we bush

doctors were watched when we visited upgrade facilities because it was known that we were likely to appropriate items of equipment. This day, however, the reason for my visit was an invitation to a spaghetti dinner, cooked by one of my friends from San Diego, who considered himself the best spaghetti man in the combat zone, or perhaps all of Vietnam. I was not disappointed. There was some risk, since we had to return to our unit in the evening. But a John Piconi spaghetti meal was “a meal to die for.”

By far the most eventful occurrence in Vietnam was my meeting with Ben Shwachman. He was a combat-seasoned veteran, facile with conduction anesthesia, the possessor of a wry wit that occasionally borders on the macabre. He was known throughout the combat zone as “El Shwacho” in those days. He was a most valued member of my department. Subsequently, he became a lawyer and served as the speaker of the House of Delegates and president of the California Society of Anesthesiologists. He is known to be a parliamentary catalyst in the House of Delegates of the American Society of Anesthesiologists by simply intoning into a microphone “Shwachman, California.” I have deftly detailed some of the exploits of this funny man in an article I previously wrote for the *Bulletin*. I am pleased to say that Ben is one of my best friends over the years.

When I left Vietnam, I was stationed in Guam. There I saw the casualties from another perspective. Such problems as infection, succinylcholine problems, depression, and the like were manifest. My family and I were victims of a severe automobile accident when we were struck by an inebriated sailor and knocked into a ravine. Were it not for a bamboo thicket, we would have plummeted into the sea over a coral precipice. I had to be placed on a 10-day bed rest for sternal injuries and contused kidneys. My wife had severe and extensive facial injuries from flying glass and my plump 5-month-old son had to have an exploratory laparotomy. My staff member, a conservative chap who anesthetized my son, reported to me that he did an awake intubation. In answer to my query he said, “The lad was a worthy adversary.”

The only plastic surgeon on the island, a civilian, closed his office and came in to do the initial and follow-up surgeries on my wife's face and refused to charge me, even though I told him that the Navy would pay. My wife remembers a stern admonition by her anesthesiologist when another member of my staff suggested that he use a Miller Two instead of a MacIntosh Three laryngoscope blade. I found some gratification in this report. I am ever happy to hear someone defend the superiority of the curved blade for larger children and adults, even under duress. I know there are some young whippersnappers in the audience who might take issue on this point. If there are, I refer you to my friend, Stephen Jackson, Editor of our *Bulletin* and a renowned clinician, who will

repudiate, with extreme vigor, any feeble arguments you may present to the contrary.

In 1971, I returned to San Diego and became departmental chairman in 1973. I trained many outstanding residents now practicing throughout the country. Those of you who train residents know that they become like your sons and daughters. I could not be more proud of Eddie Canada if he were my natural son. He did it all! He was head of the Anesthesiology Department at Children's Medical Center/San Diego, chief of staff of that institution, president of the San Diego Medical Society, speaker of the House, and now president of the California Society of Anesthesiologists. All this, and he is an acclaimed clinician, by all reports. Another graduate of our program, James Hicks, received great accolades for his exceptional participation in the Katrina rescue. Another graduate, known to you, who trained under the chairmanship of my friend, Bob Buechel, is Mike Rosenthal, a renowned Stanford researcher, teacher and lecturer, with an unmatched gift of the gab, vouchsafed to few.

I received excellent support from Stanford and all the Universities of California. They participated liberally in our lecture program. Residents from UCSD rotated for regional anesthesia training and sometimes for obstetric anesthesia training. It was on one of his visits that my friend, Bill Hamilton, invited me to be an associate examiner for the Board. When I hesitated, I remember his response as if it were yesterday: "Clyde, if an old fart like me can do it, so can you." This afforded me an opportunity to meet, know and associate with many of the luminaries of our specialty. Even though I was more scared than the candidate when I was paired with some of the more austere senior examiners, in the beginning, I enjoyed a dozen years of the most challenging and enjoyable work I have ever done.

It was during my tour in San Diego that I became interested in hypnosis. We were beginning spinal surgery for scoliosis. In those days repair was accomplished by Harrington and Dwyer Instrumentation. Unlike today, these were formidable procedures. Besides preoperative traction and/or casting, they were followed by immobilization on a Stryker frame and a body cast with recumbency for six months or more. One of my colleagues thought that hypnotic supplementation would make this significant perioperative experience smoother. The "wake-up test" of spinal function, after rod replacement, was to be conducted intraoperatively because of the chance of physical impingement on the cord or its blood supply. Because these were mainly younger patients, they were generally excellent hypnotic subjects. This was an exceptionally successful program. At the Navy and later at Kaiser, San Diego, I performed over 200 of these cases. Although I later was replaced by evoked potential testing, I have been told that some centers returned to the "wake-up

test.” I also taught for the San Diego Society of Clinical Hypnosis, wrote on the subject, and was invited to speak in many places in the U.S. and once in Canada.

As 1978 approached I had to make a big decision. There was much arm-twisting by those who wanted me to stay in the Navy and become an Admiral. Such things as “You will be the first African-American Medical Flag Officer in the Regular Navy.” Some of my backers were admirals who knew what they were talking about. It was most tempting, but my desire to remain a cockpit anesthesiologist won out, so I left the Navy in 1979 and joined the staff at Kaiser Permanente, San Diego. I became Chief of Anesthesiology at Kaiser from 1981 to 1987.

While at Kaiser I had the opportunity to practice as a hypnotist on a limited basis. I received many consults from the Obstetrical Department when their favorite drug for the treatment of hyperemesis gravidarum, Bendectin, was withdrawn by the FDA. I had great success with these patients—although one of them, during a treatment session, propelled a bolus of vomitus into an area that I very recently had occupied, striking a glancing blow to the left border of my laboratory coat as I adroitly darted to starboard. Not a failure, but a tricky case.

The head and neck surgeons sent me an interesting patient with intractable tinnitus aurum for hypnosis. I told them that I was loathe to mask a physical affliction. When they assured me that all diagnostic tests were exhausted, I accepted the patient. Deciding not to attempt to totally eliminate the symptom and have it replaced by a more troublesome one, I decided to help her reduce the noise to a tolerable level. She was an excellent hypnotic subject. Under hypnosis we created a knob behind the offending ear, in the region of the mastoid process, and I taught her to turn the knob clockwise to increase the volume, and counterclockwise to decrease it. I had her turn it to a level where the noise was perfectly tolerable and then turn it one more turn. I used to see her at longer and longer intervals for knob recalibration until she stopped coming back. Somewhere in San Diego, perhaps there is a lady twirling her retroauricular knob to ensure auditory comfort. In 1976, my friend, the late Rod Calverley, invited me to go on a UCSD-sponsored Plastic Surgery Field Program to Mexico to treat patients, predominantly children with cleft lips, cleft palates and other deformities. I became hooked. Later I joined Operation Smile, based in Virginia. Between these two programs I made 84 missions in 30 years, the last in February of this year, including two craniofacial teams to Manila, Philippines. As you know, craniofacial surgery is quite complex and therefore it is quite commendable to accomplish such in a field program. This is a tribute to Dr. Bill Magee, the originator of Operation Smile, who believes

that ordinary people can accomplish extraordinary deeds. I exhort you to become interested in such programs. There are many, including the Overseas Anesthesia Teaching Program, started by the late Nicholas Greene and sponsored by the ASA. World medicine generally, and anesthesia in particular, sorely need your help, and you will derive inestimable joy in the process.

My training in hypnosis was invaluable in my work in these field programs. Communication in hypnosis is largely nonverbal. Because I did not speak the language of most of my overseas patients, I drew heavily on nonverbal techniques. As most of them are children, they are significantly nonverbal beings. I always told them, "You are about to ride with Clyde." It did not matter that they did not understand my metaphor, for it was always accompanied by my serene countenance and my reassuring demeanor.

I must say a few words about our Component Society. It has been my privilege and pleasure to have been associated with the CSA since 1963. This Society has always been serious. It has waged many battles, often against segments of our own membership, to promote professional integrity among our members, peer review, continuing education and constant improvement in our image in the hospital. This was at a time when many other component societies were in various fledgling stages. We have produced many outstanding leaders who have taken their rightful places nationally and internationally. Without a doubt we have led the way, consistently.

People of my vintage are expected to comment on the future of anesthesiology. I can do so briefly. I know that the environment in which we practice has become increasingly complex with manifold vicissitudes. However, there is no doubt in my mind that the bright young men and women entering our specialty will utilize the extensive knowledge and burgeoning technology available to them and transport the field of anesthesiology to heights that could only have been imagined by the likes of me when we started so many years ago.

Today, as I speak from the Departure Lounge, ever hoping that departure is not imminent, I can state several assurances. I have been most fortunate to have selected an area of specialization that I was able to practice with a passion. I have been supported by a host of colleagues, trainees, international surgical teams and perioperative personnel, patients, church members, and the like. I have been blessed with an understanding and supportive wife and three sons who did not begrudge me the time I spent away from them in the pursuit of my vocation. And today, you honor me most significantly by allowing me to speak in the memory of a great anesthesiologist of local, national and international import, Forrest E. Leffingwell, M.D.

I thank you with all my heart and will never forget this singular honor. Have a magnificent day!