



# AUA

Association of University Anesthesiologists

# Update

Winter 2002

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## A Giant Falls: E.M Papper, M.D. 1915-2002

Robert M. Epstein, M.D.  
University of Virginia  
Charlottesville, Virginia

**E**manuel M. “Manny” Papper, M.D., Ph.D., former Chair of Anesthesiology at Columbia University, New York, New York, Dean and Vice-President at the School of Medicine at the University of Miami, Past President of ASA (1968) and the single surviving founder of AUA (founded in Philadelphia in 1953), died suddenly of a stroke on December 3, 2002, at age 87. He was my teacher, my inspiration for remaining in academic anesthesiology and a dear friend.

Progress and prestige in our specialty are built on the shoulders of our predecessors such as Dr. Papper, Robert D. Dripps, Jr., M.D., Henry K. Beecher, M.D., and many others, including (but certainly not limited to) Stuart Cullen, M.D., James E. Eckenhoff, M.D., Austin Lamont, M.D., LeRoy Vandam, M.D., Ralph M. Waters, M.D., and Emery A. Rovenstine, M.D. At a time like this, it is good for us to remember and preserve some sense of history for residents, junior faculty and others who may not have had the opportunity to reflect on our heritage.



*E.M. Papper, M.D., Ph.D.,  
as ASA President in 1968*

Manny was one of the true greats in our specialty. He served in World War II in the European Theater as a theater consultant in his late 20s and was Chief of Anesthesia at Walter Reed Army Hospital in Washington, D.C., at 30. At Columbia, he was recruited to be chief of service at 34 and was chair of only the fourth department of anesthesiology in the world at age 37. His department grew to a position of shared eminence with the University of Pennsylvania, and it became the father to numerous chairs and chiefs, including Richard J. Kitz, M.D., at Harvard Medical School and Massachusetts General Hospital, Ronald L. Katz, M.D., at the University of California-Los Angeles, Shih-hsun Ngai, M.D. (1920-1999) at Columbia, Duncan Holaday, M.D., at the University of Chicago, myself at the University of Virginia and a few dozen more.

Author of around 400 papers, holder of honorary doctorates from Columbia, Turin (Italy) and Uppsala (Sweden), he also earned a Ph.D. in English literature, which he obtained after stepping down from his Dean/Vice-President position at the University of Miami at age 65.

***“Many of us had looked forward to Dr. Papper’s reflections at the 50th anniversary of the founding of AUA to be celebrated at the Annual Meeting next May. We shall profoundly miss his presence there and everywhere.”***

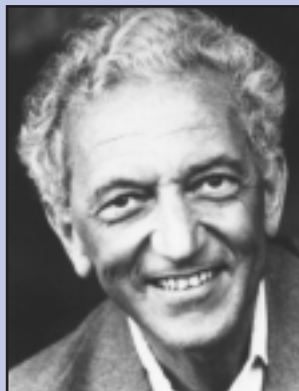
He was an active member of the summer seminars in philosophy at the Aspen Institutes, reflecting lifelong interest in that discipline. Indeed, only the Depression of the 1930s, which created an absence of opportunity for academic employment in philosophy, gave us the privilege of having him in the ranks of medicine.

Dr. Papper and Dr. Dripps, anesthesiology chair at Pennsylvania, collaborated to make anesthesia research a priority at the National Institutes of Health (NIH) at a time when our specialty was lagging in research funding and scientific focus. Both were founding members of AUA, and

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# An Interview With Peter Safar, M.D.

W. Andrew Kofke, M.D.  
Philadelphia, Pennsylvania



**T**his is the first of a series of articles that will appear periodically in the AUA Update focusing on an academic anesthesiologist's career. It is in a written interview format. The following is an interview of Peter Safar, M.D., which occurred on November 4, 2002. A more detailed overview can be found online at < [www.post-gazette.com/lifestyle/20020331safar0331fnp2.asp](http://www.post-gazette.com/lifestyle/20020331safar0331fnp2.asp) > for the November 20, 2002 Pittsburgh Post-Gazette.

**Dr. Kofke:**

*Many of our colleagues do not know that you fled Nazi Austria/Germany to the United States. Would you like to share this experience with our members?*

**Dr. Safar:**

I was born in 1924 in Vienna, Austria, during post-World War I poverty and starvation. Hitler annexed Austria in the spring of 1938. In all belligerent countries during World War II (1939-45), the survival of each teenager and young adult has its own (and often very complex) story. After spring 1938, with brief juvenile enthusiasm for Nazi sports, songs, fitness and patriotism, I saw the evil hidden behind the surface and joined, ideologically, the anti-Nazi circle of my Viennese physician parents. My father's parents ("Aryan," i.e., non-Jewish) had come from Bohemia to Vienna. Safar is a Czech name. My mother's mother was Viennese Aryan, but her father was of Austro-Jewish ancestry. The Nazi authorities considered me one-fourth Jewish. In 1939, my parents considered, but missed, the opportunity to immigrate to America. In 1942, I was allowed by the authorities to finish high school ("matura") in Vienna. We 18-year-old boys were forced into labor camps for six months; I went to a punitive one. Then we were conscripted into the German Army. After two months of basic training as an artillery telegraph soldier, I was asked, but refused, to enter officers' school. I was sent

for a few days of furlough to Vienna, already outfitted to be sent as cannon fodder (as private, lowest rank) into the battle of Stalingrad. I decided to do what I could to avoid being forced to kill and be killed, risking the Gestapo rather than the front. I "disappeared" by becoming the Gestapo student "discharged from the Army" and survived, all thanks to my life-savers — Austrian physician officers who had been conscripted into the German Army, but conducted resistance. As a "Mischling" (non-Aryan), I was supposed to not be admitted to the university, but the admitting official (who was with Austria's passive resistance) ignored the rule. The only combat I experienced was as a civilian medical student, between the Red Army and Nazi SS troops, during the battle of Vienna in the spring of 1945.



W. Andrew Kofke, M.D.

I received my medical degree in 1948 and training in pathology research and surgery at the University of Vienna in 1948-49 and Yale University in 1949-50. The disappointed European became an ex-Viennese Yankee. I became an American citizen in the 1950s.

**Dr. Kofke:**

*What first interested you to pursue a career in anesthesiology?*

**Dr. Safar:**

Surgical anesthesia at Yale, then administered by nurse anesthetists who were guided by anesthesiologist Lou Hampton, M.D., was superior to anesthesia in Europe. I decided that surgery can only advance with better life support and that I can learn life support best as an anesthesiologist. In 1950, my Viennese girlfriend, Eva, and I married, and she joined me in the United States.

**Dr. Kofke:**

*Many of our anesthesia colleagues can identify the person in their lives, be it a parent, a teacher or someone else, who ignited the fire within that made us want to be anesthesiologists. Quite a few probably identify you as that individual. Who in your life ignited that fire within you to have accomplished all that you have done over the years?*

**Dr. Safar:**

Several persons ignited in me the fire to make use of my life as a physician. They included my parents and their circle (my father was professor of ophthalmology at the University of Vienna before and after Hitler; my mother was

a pediatrician), some of my professors in Vienna and at Yale, but most of all Robert Dripps, M.D., and his faculty of 1950-52 at the University of Pennsylvania.

**Dr. Kofke:**

*You probably have seen many changes over the years, some good and some bad. What would you consider the one or two biggest changes that have occurred which have affected you the most since you began practicing anesthesiology?*

**Dr. Safar:**

The biggest change that affected and excited me when I was an initiating chief anesthesiologist in Peru and at Baltimore's (Johns Hopkins) Bayview (City) Hospital and the University of Pittsburgh was the opportunity to be part of the "adolescence" of our specialty. These were the years of expansion of our specialty in the 1960s and 1970s. American clinical anesthesiologists, however, during the phase of maturity in the 1980s and 1990s, withdrew into the operating room (O.R.).

The initial leadership by some of us American anesthesiologists for the creation of modern resuscitation, emergency medical services (EMS) and intensive critical care medicine (CCM) was followed by withdrawal of the majority of anesthesiologists into the O.R. — where the money is — and of university anesthesiologists into laboratories. There were enormous discrepancies in goals and incomes between anesthesiologists in private practice (American Society of Anesthesiologists [ASA]) and clinician-scientists — discrepancies that only recently have been mitigated. Simultaneously with these disappointing events in the United States, leadership of acute medicine by anesthesiologists had expanded abroad. Also, European anesthesiologists, who initially learned from America, are now more able to remain clinician-scientists than our colleagues in America. American anesthesiologists may be able to reverse this trend more likely as we will (and should) get a national health care system.

**Dr. Kofke:**

*During a panel at the 2001 ASA Annual Meeting, you presented information on new possibilities for saving patients following sudden heart arrest that does not respond to current resuscitation techniques and severe blood loss. Can you update us on this study?*

**Dr. Safar:**

In the early 1980s, my associates and I reinitiated research into postarrest resuscitative hypothermia. Starting in 1987, we were the first to discover and document (in dogs) the efficacy of mild resuscitative hypothermia after normothermic cardiac arrest. That led to positive clinical trials by our alumni.<sup>1</sup> In the late 1980s, we were the first to document in rat studies the extension of the golden hour of hemorrhagic shock tolerance with mild hypothermia and other novel strategies.<sup>2</sup> We also are seeking ways to preserve vital organs' viability in "unresuscitable" cardiac arrests (e.g., exsanguination cardiac arrest of combat casualties), using "profound hypothermic suspended animation (by aortic cold flush) for

transport, repair and delayed resuscitation." My associate, Samuel Tisherman, M.D., is planning clinical trials of emergency hypothermia for trauma cases.<sup>3</sup>

**Dr. Kofke:**

*As an anesthesiology resident at Pennsylvania, you were witness to some of the early discussions that led to the formation of AUA. Could you reflect on these observations?*

**Dr. Safar:**

When I was a resident in Dr. Dripps' department in 1950-52, we were told that private-practice anesthesiologists, represented by ASA, disapproved of salaried status of academic anesthesiologists. To counteract this confrontation with a united front, my friend and comenter Austin Lamont, M.D.,



*Dr. Safar, pictured here circa 1960, played a major role in anesthesiology's maturation process in the 1960s and 1970s.*

then coprofessor and advisor in Dr. Dripps' department, was the spiritual initiator of AUA. In 1952, I was present when Drs. Dripps, Lamont, Vandam and others hosted Drs. Papper, Beecher and one or two other professors from other departments to decide on forming AUA. In 1953, apparently when the first AUA meeting occurred, I was with Eva in Peru, initiating there that country's first academic anesthesia department in the Cancer Hospital of Lima. Upon our return to the United States,

I started at Johns Hopkins University in 1954 (not at Pennsylvania because the Pennsylvania state board would not let me take licensure exams). I was junior faculty member with

Leonard R. Proctor, M.D., at Johns Hopkins when we drove to the AUA meeting in January 1955 at Duke University. This was a fine event hosted by C. Ronald Stephen, M.D. Afterward, when I was department chair at Pittsburgh (1961-78), I hosted the AUA meeting in 1973. In the 1970s and '80s, during closed, limited AUA membership, lab researchers were favored and some who valiantly fought for academic anesthesiology as teachers were rejected. I did not like that. I am now told that this has changed in the 1990s, and the AUA opened up its membership. The second reason why I rarely attended AUA meetings was limited time. I was overcommitted with the co-initiation of the Society of Critical Care Medicine (SCCM) and the World Association for Disaster and Emergency Medicine (WADEM) and their journals.

**Dr. Kofke:**

*What do you see as the biggest challenges facing academic anesthesiology and critical care medicine today?*

*Continued on page 4*

# An Interview With Peter Safar, M.D.

Continued from page 3

## Dr. Safar:

After 40 years of personal clinical work in O.R.s and ICUs, I ceased being a clinician in 1989 at age 65. I have since then been merely a researcher who is not an informed responder to your question. Here are a few thoughts, however:

Since you included CCM in your questions, the Anesthesiology Board should do more than give lip service to my recommendations since the 1950s: every complete anesthesiologist is by definition a reanimatologist, intensivist and pain control specialist. That should be reflected in training and certification. In major institutions, of course, there will always be the need for subspecializing.

Academic departments should foster the development of clinician-scholars (teachers) and clinician-scientists (researchers) who move unanswered questions toward breakthroughs with the help of Ph.D.s. Having a solo Ph.D. with a National Institutes of Health RO-1 grant tucked away in a laboratory for the department's prestige is less likely to result in progress. Cross-fertilization between lab and clinic is essential. Researching anesthesiologists should think more about the importance of the topics they pursue. Breakthroughs are reflected in results that have scientific, clinical and perhaps even socioeconomic importance. Attendance at research conferences by medical students and residents should be part of academic departments' programs. The clinical years of anesthesiology residents should allow interested young colleagues to be involved in part-time research.

Chairpersons should foster protection of academic time. This is easier when, as in Pittsburgh, the department uses inside and outside O.R.s and physician-guided teams, including nurse anesthetists and technicians. The current escala-

**“It probably is unavoidable that some clinician-scholars will have to prepare themselves to become CEOs.”**

tion of paperwork for the sake of billing should be reversed.

Administrators must be guided by physicians. All this will be easier when we have a national health care system. This should have three features: 1) Provide basic health care coverage for all citizens/residents, learning from and improving on the best examples abroad. The “basics” should be defined by wise, nonparochial physicians; 2) There should be a pop-off valve of private supplemental insurances for those patients who want frills or refuse to wait; 3) All of health care must be made more cost-effective, with less waste and fewer futile, expensive measures. Some rationing is unavoidable. Such a national health care system will not only be fair to patients but also provide greater equality among specialists. It will increase the recognition of our specialty and reduce the difference in incomes between academic and nonacademic colleagues and groups. The current greed might then be replaced by more enthusiasm for service and creativity.

## Dr. Kofke:

*A recent Pittsburgh Post-Gazette article mentioned “Peter’s Laws for the Navigation of Life,” subtitled “The Creed of the Sociopathic Obsessive Compulsive.” Perhaps you could share these with the membership.*

## Dr. Safar:

These so-called Peter’s Laws came from an unidentifiable source, first presented in Pittsburgh by Ake Grenvik, M.D., on my 70th birthday. The full set of “laws” is attached and was published as Table 2 in my ASA memoirs.<sup>4</sup> It reflects how my peers perceived my instinctive methods of “persuading” administrators and colleagues to “permit” the changes I considered necessary.

## Dr. Kofke:

*What do you see in the future for academic anesthesiology and critical care medicine?*

## Dr. Safar:

Some of what I would like to see, I commented on above. What will happen in the future I cannot predict. You and our other younger colleagues now in power have the informed wisdom to predict what will happen, as influenced by health care organizations and finances (e.g., national health care system, regionalized centralization of special expensive care) and by scientific discoveries and technological developments.

## Dr. Kofke:

*Is there anything you would like to add to this interview?*

## Dr. Safar:

Do I have something to add? Briefly, here are just a few thoughts off-the-cuff: Anesthesiologists should be diligent, downplay turf and foster collegial collaboration with other medical specialists, nurses, other health care workers in care, teaching and research and administrators (who also need scrutinizing of their cost-effectiveness). It probably is unavoidable that some clinician-scholars will have to prepare themselves to become CEOs. Anesthesiology should adapt requirements for the selection of department chairpersons and program directors to the current or future changes in national and local health care delivery and financing.

When treating patients, every academic anesthesiologist should always have one or more trainees with him or her. Some free time for research as well as for family is important. I have always considered anesthesiology a surgical discipline; this means that developing mutual respect between us and surgeons is important with equal recognition of contributions made by both. The safety of anesthetizing practices has dramatically increased, but simple plumbing errors still kill occasional patients. Over-reliance on sophisticated monitoring devices in the O.R., emergency department and ICU should not make people forget how to use their human senses for quite reliable monitoring of vital parameters, sometimes causing less delay in needed remedial action than with reliance on gadgets. (I recognize airway obstruction before the SaO<sub>2</sub> decreases.) I am dismayed by smart, young students or doctors admiring monitors with their backs turned toward the patient.



Dr. Safar, left, with wife, Eva, Wood Library-Museum (WLM) Librarian Patrick Sim and then ASA Assistant Executive Director William S. Marinko at the WLM in 1993.

Research topics for the near future considered appropriate for anesthesiologists to pursue are unlimited. Pick topics of importance and work on answers (results) to be important. Important challenging topics may range from mechanisms of anesthetic actions, via searching for analgesic-anesthetic strategies that do not produce coma-induced asphyxia without life support, to the development of helpful robots and the development of rapidly acting and safe, nonlethal weapons (tranquilizers).

In CCM, resuscitate from the top of the head, around from the side of the bed. Touch the patient, and do not call it "rounds" when you merely pontificate in the X-ray room. CCM should be a continuum from scene via transport with life support through emergency department, O.R. and ICU. CCM ("reanimatology," according to V.A. Negovsky, M.D.) is not limited to the ICU. To see that this continuum happens with the highest quality, I have promoted the anesthesiologist as the driving force, coordinator and leader. That's how it all began. How will it continue?

Challenges include being imaginative and futuristic, but also retaining what proved useful in the past.

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1. The Hypothermia After Cardiac Arrest Study Group. Mild therapeutic hypothermia to improve the neurologic outcome after cardiac arrest. *N Engl J Med.* 2002; 346(8):549-556
2. Tisherman SA, Rodriguez A, Safar P. *Surg Clin North Am.* 1999; 79:1269-1289.
3. Safar P, Tisherman SA. *Curr Opin Anaesthesiol.* 2002; 15:203-210.
4. Fink BR, McGoldrick KE, eds. *Careers in Anesthesiology: Autobiographical Memoirs, Volume V: From Vienna to Pittsburgh for Anesthesiology and Acute Medicine*, by Peter J. Safar. Park Ridge, IL: Wood Library-Museum of Anesthesiology. 2000:343.

## Letters to the Editor

### Laureate Left Out

Thanks for your article on the Wood Library-Museum (WLM) in the Fall 2002 *AUA Update*.

It omits, however, an important program that the WLM handles — the awarding of the Laureate of the History of Anesthesia, an international award that began in 1996 and is given every four years. The next one, of course, will be given in 2004.

Thanks again, though, for your letter.

Nicholas M. Greene, M.D.  
North Haven, Connecticut

### Dr. Greene and the WLM

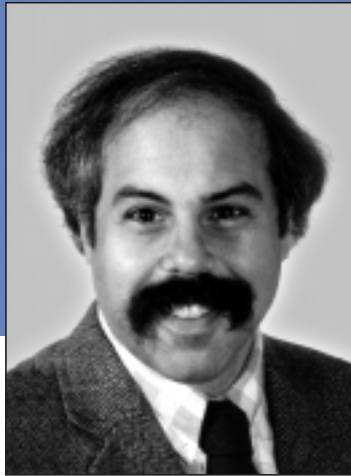
We are very happy to learn that your recent article on the Wood Library-Museum (WLM), which you published in the Fall 2002 *AUA Update*, has reached many *AUA* members and other readers. One of its emeritus members, Nicholas M. Greene, M.D., read and appreciated it, too.

As you know, Dr. Greene is Emeritus Professor of Anesthesiology of the Yale University School of Medicine, now retired. He has served on the Board of Trustees of the WLM and chaired several WLM committees. One of his lasting legacies was the institution of the international Laureate of the History of Anesthesia program in 1996. The election of this world laureate historian of anesthesia is held every four years when a panel of international historians of medicine identifies and names this individual through the aegis of the WLM. This program has since named three such laureates and will do so again in 2004.

Dr. Greene is very proud of this program, which serves as a vehicle in advancing international awareness of the heritage of anesthesia. I am mindful of the focus of your article on the role of the WLM as a repository of organizational archives in anesthesiology. This role, too, is consistent with its mission in preserving the rich legacy and heritage of anesthesiology. We are very pleased that your wonderful article has drawn Dr. Greene's attention, and we appreciate its impact on the *AUA* readership.

Patrick Sim, WLM Librarian  
Park Ridge, Illinois

# Subspecialty Report:



Peter J. Davis, M.D.

Peter J. Davis, M.D., President  
Society for Pediatric Anesthesia

## Society for Pediatric Anesthesia



**SPA feels that "...because most pediatric anesthetics are provided by general anesthesiologists, life-long learning in pediatric anesthesia should be a part of everyone's anesthesia practice.**

The Society for Pediatric Anesthesiology (SPA) is composed of more than 4,000 members. Its primary missions are to support education, research and advocacy in the anesthetic care of children. It is open to any physician who has an interest in pediatric anesthesiology, with a range in its membership from individuals who practice pediatric anesthesia full-time to those who almost never care for a child but want to improve their knowledge. SPA is a subspecialty society with a seat in the American Society of Anesthesiologists (ASA) House of Delegates and a partner of the Anesthesiology Section of the American Academy of Pediatrics (AAP).

The most visible activities of the Society are its two educational meetings per year. There is a one-day meeting on the Friday prior to the ASA Annual Meeting, which is focused on scientific advances in medicine that relate to pediatric anesthesia. The second meeting is a three-day conference held in the winter or early spring that is a joint meeting with the Anesthesiology Section of AAP. This meeting focuses more on clinically relevant pediatric anesthesia topics and issues for both pediatric and general anesthesiologists. Although most speakers come from the Society's membership, nonpediatric anesthesiologists, pediatricians, surgeons and scholars from many areas regularly contribute to the meetings.

Because the Society is not restrictive in its membership, it views the pediatric anesthesia education of general anesthesiologists as an integral component of its educational mission. Overall, attendance at both meetings has remained steady or climbed slightly over the last five years.

In 1997, pediatric anesthesiology fellowships became recognized by the Accreditation Council for Graduate Medical Education as training programs, joining pain medicine and critical care. As of July 1, 2002, there were 41 approved programs and 77 enrolled fellows. Currently there is no American Board of Anesthesiology certification for special qualification in pediatric anesthesiology; consequently, there is no clear mechanism about what "defines" a pediatric anesthesiologist. The Society feels that because most pediatric anesthetics are provided by general anesthesiologists, life-long learning in pediatric anesthesia should be a part of everyone's anesthesia practice. As SPA continues to attract members and maintain its mission, it will continue to produce educational material consistent with the goals and objectives of life-long learning in pediatric anesthesia.

# The RRC Site Surveyor: Questions Always Asked About Resident Work Hours



Randall C. Cork M.D., Ph.D.  
Louisiana State University  
Shreveport, Louisiana

A few years ago, I attended an Accreditation Council for Graduate Medical Education (ACGME) conference and found out that they were using more Ph.D. non-specialist reviewers due to a lack of anesthesiologist volunteers. I volunteered right away, and I urge you to do likewise. I am firmly convinced that an anesthesiologist-specialist site surveyor has a better understanding of what a clinical department is doing than a Ph.D. Also, reviewing other programs gives you insight into what to do with your program to keep

it out of trouble. In the course of the last three years, I have reviewed several programs, and I have “inside information” to share.

For site surveys, ACGME has taken an approach very similar to what the American Board of Anesthesiology has done with oral examinations. The questions are now much more scripted than they were 10 years ago. Thus, the basic questions are always the same although the surveyor is allowed some latitude to digress. There are too many scripted questions to go over in a newsletter article this size, so I have selected a few from the topic of Resident Work Hours, currently an area of keen interest. Keep in mind that the Ph.D. surveyor will ask these questions verbatim and record exactly

what you say, which may not be what you mean. The anesthesiologist surveyor will have a deeper understanding of what your responses mean.

The scripted questions are:

1. *Is the resident workload reasonable?*
2. *How often do residents take in-house call?*
3. *Are residents allowed one day in seven away from the hospital?*
4. *Are they required to administer anesthesia the day after being in-house on call?*

Of course, the answers are:

1. Yes.
2. *No more often than once every third night.*
3. Yes.
4. No.

However, keep in mind that these questions are asked of everyone the surveyor talks to, including faculty, residents, hospital administrators, the chief of surgery and the chief of obstetrics. It is important that everyone agrees. Be careful of the situation involving a resident carrying a beeper for rare events such as transplants. Make sure that the surveyor understands that the resident gets one day in seven off the beeper. Again, an anesthesiologist surveyor will have a better understanding of practical situations brought about by the challenge of delivery of clinical care than a Ph.D. surveyor.

That is it for the scripted questions on resident workload. Do not forget that there could be more “unscripted” questions. The best thing to do to review this issue is to take a look at the current discussion on the ACGME Web site at < [www.acgme.org](http://www.acgme.org) > .

## Future Operating Room?

The seasoned anesthesiologist may see some similarities between his or her operating room and this figure from the Environmental Protection Agency Web site at < [www.epa.gov/recyclecity/factory.htm](http://www.epa.gov/recyclecity/factory.htm) >, which offers tutorials about recycling and waste reduction.

Widget Manufacturing Co. is a model business for waste reduction. Plant managers, Tyrone Jones and Rosy Littlefeather, give bonuses to Widget workers who come up with new ways to reduce, reuse or recycle. By reducing waste, the company helps the environment and saves money, too.

You might be wondering what a widget is. It's hard to describe, but it's really important — kinda like a doodad. Now that you know, grab a hard hat and come inside to find out more ...



## Plan Now to Attend the AUA 50th Anniversary Meeting!

May 2-4, 2003  
Pfister Hotel  
Milwaukee, Wisconsin



AUA and the Medical College of Wisconsin invite you to attend this momentous occasion, which will include:

For more information, contact:  
AUA  
520 N. Northwest Highway  
Park Ridge, IL 60068-2573  
847.825.5586 telephone  
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- Advanced programming
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- Extraordinary video showcasing anesthesiology's greatest minds
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- Oral and poster presentations

For Hotel information, see:  
[www.pfister-hotel.com](http://www.pfister-hotel.com)

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## A Giant Falls: E.M. Papper, M.D.: 1915-2002

*Continued from page 1*

both of their departments contributed greatly to creating a scientific base for anesthesia research. Dr. Papper served as the "Principal Consultant" to the National Institute of General Medical Sciences at the National Institutes of Health (NIH) during a year-long sabbatical that led to the development of anesthesiology as an independent discipline recognized for NIH funding. These efforts included establishment of training grants for fellowships that allowed young anesthesiologists opportunities to learn science (and to support the faculties that taught them).

Dr. Papper was a member of President Lyndon B. Johnson's Commission on Heart Disease, Cancer and Stroke, which committed the nation to a continuing research effort that significantly reduced the mortality rates from these largest killers of Americans.

At Columbia, he established a pattern of "farming out" finishing residents (such as Dr. Kitz, Dr. Katz, Allen I. Hyman, M.D., and myself) to the basic sciences for further training. A similar pattern used at the University of Virginia led to the primary development of research scientists such as Roger Johns, M.D., and Marcel Durieux, M.D., among others, and to the continued scientific advancement (through early collaborations) of David E. Longnecker, M.D., University of Pennsylvania, Edward D. Miller, M.D.,

Johns Hopkins, Thomas J. Gal, M.D., University of Virginia, and Carl Lynch, M.D., University of Virginia.

He could "work a room" better than any other person I've ever known!

I was on a panel last year with Manny, remarkably then aged 86, at the New York State Society of Anesthesiologists Postgraduate Assembly and had the pleasure of hearing his lucid remarks at the recent celebration of the 50th anniversary of Columbia's department of anesthesiology. All of us had looked forward to Dr. Papper's reflections at the 50th anniversary of the founding of AUA to be celebrated at the Annual Meeting next May. We shall profoundly miss his presence there and everywhere.

*Sic transit gloria mundi.*

**Editor's Note:** Dr. Papper wrote a summary of his planned comments at the 50th anniversary meeting for the AUA Update. Those comments will appear in the Spring 2003 issue. Also, any readers wishing to embellish Dr. Epstein's personal experiences with and observations of Dr. Papper with those of their own should feel free to send a note to the editor for publication in the Spring 2003 AUA Update at <[andrew.kofke@uphs.upenn.edu](mailto:andrew.kofke@uphs.upenn.edu)>.

— W. Andrew Kofke, M.D.