computational error. Alan and Kai were the writing team, and my native Australian obtuseness, laziness, and general lack of discipline were kindly corrected. Kai writes English like Joseph Conrad with extraordinary precision but an occasional verb at the end of the sentence. Alan edits magnificently. I left in 1971 to return to Australia.

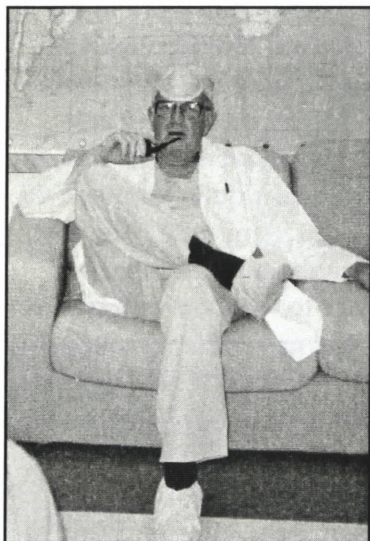
Alan again took charge of my career again in 1974 when he and Dick Theye invited me back from Australia into 15 years on staff in Rochester. Alan has mentored me in various capacities, as chief, colleague, and close friend since that time. I will always be grateful for the opportunities given and the strong support shown me at Mayo by all members of the staff but particularly Alan.

Alan has done this for many others during his years as chair, a member, and then President of the American Board of Anesthesiology (ABA), an American Society of Anesthesiologists (ASA) officer, in the Foundation for Anesthesiology Education and Research (FAER) administration, and on the various boards on which he has served. He is a brilliant judge of character and ability. He is an outstandingly loyal friend and tireless mentor, endlessly encouraging. His principles of scholarship and excellence have driven the various organizations lucky enough to absorb his energies.

From the "foreign legion", many of whom were or are chairs and/or anesthesiology group leaders at one time or another in many countries all over the world, all our thanks and best wishes for continued success.

Fond Memories of Charlie Restall

Peter Southorn, M.D.



Charlie Restall delivering his comments in the staff lounge.

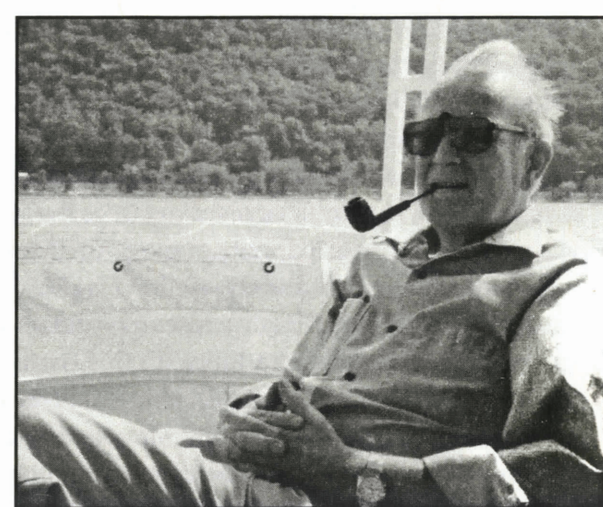
"What's good about it?" That was Charlie Restall's usual response to being told it was a nice day. A gruff, lovable curmudgeon of a man, it has been ten years since he passed away. To many of us he remains a revered teacher and treasured colleague.

Charlie played a heroic role in World War II (something he never talked about*), and wartime injuries were rumored to be the reason for his deafness and consequent tendency to speak several decibels louder than anyone else. He was one of the last residents to be taught by John Lundy with whom he appears to have had a love/hate relationship. For years, he was in charge of providing regional anesthetics for patients undergoing colon-rectal or urological surgery at the Worrall and, subsequently, the Rochester Methodist Hospital. Under his guidance and close scrutiny, one soon acquired an expertise in spinal, epidural, and caudal anesthesia (although one was never as good as Charlie-particularly with the caudals). Each block had to be tested with a large hemostat applied to a sensitive area before the surgeon was allowed to proceed. I don't know if he invented it, but he was certainly the first person to teach me how to use 10% procaine to make hyperbaric spinal solutions. When I arrived at the Clinic in the early '70s, Charlie's other invention, a microwave oven designed to warm blood before transfusion, which he had developed with Paul Leonard and others, was also in use.

One always knew where one stood with Charlie. He was a straight talker, and as one who hadn't gone to a charm school, he told it like it was. When you went to the consultant's lounge or the office, you had to breathe in clouds of pipe tobacco smoke as he delivered his pithy comments. Charlie's propensity for speaking his mind was not reserved for the staff. One cherished example of this occurred after Charlie had given his old nemeses, the

mayor of Rochester, a caudal for a hemorrhoidectomy. As he finished this, Charlie made the comment, "I hope they do a better job on your __ than you __s in the council did on my sidewalk!" Incidents like this were legion. We residents particularly were the butt of his comments, but we knew we could answer back and that, provided we did not sit in his favorite chair, our transgressions would not be remembered. In time, we also learned he had a great sense of humor and a heart of gold. His leadership role in the U.S. Coast Guard Auxiliary, his love for Wabasha and his houseboat there, his enthusiasm in ham radio, his tireless work in sustaining the Minnesota Society of Anesthesiologists for many years, and finally, the benefits our department derived from his friendship with the leaders of our clinic at that time were also appreciated.

Charlie, you were a good guy, and we miss you.

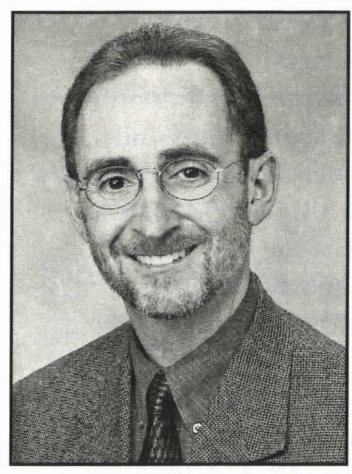


Charlie enjoying a summer day cruising the Mississippi on his houseboat.

*At his funeral, the mourners learned for the first time that his military decorations included the Silver Star, the Bronze Star, and the Purple Heart.

Beating Joe Camel

David Warner, M.D.



David Warner, M.D.

I have been fortunate to pursue a variety of research interests in my career at Mayo, ranging from my first project, which involved dipping isolated lungs in a foam made from fire-retarding gel (sounds strange, but there really was a good reason to do this), to studies of isolated cells and proteins, to human studies using three-dimensional imaging techniques studying anesthetic effects on the respiratory system (if you participated in these studies while a resident, thanks again for enduring all of those EMG wires), to a variety of analyses of outcomes after anesthesia and surgery. In this article I would like to tell you about recent work concerning cigarette smoking in surgical patients.

We have all seen the adverse effects that cigarette smoking has on our patients, ranging from the ravages caused by smoking-related diseases such as emphysema, to the increased frequency of complications such as wound infections and pneumonias. Nonetheless, we may feel that, as anesthesiologists, we can have little influence on our patients' smoking behavior, and indeed that it is so hard to quit that little can be done by anyone. However, there are three important things to know. First, tobacco interventions performed by physicians, even if brief, can approximately double the rate of quitting. Second, even short-term abstinence from tobacco can dramatically decrease the rate of postoperative complications. Finally, surgery may represent a "teachable moment" to help patients quit permanently. If we can help our surgical patients quit, they will enjoy benefits far