381124_FINAL:Layout 1 11/17/08 12:53 PM Page 1

The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY Newsletter

Fall 2008 *Volume 9, Issue 2*

MGH SURGICAL SOCIETY

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PROFESSIONAL AND PERSONAL NEWS

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MEETING SUMMARY
MGH SURGICAL SOCIETY REUNION
JUNE 27-29, 2008

The old Charles Street Jail was, at least when I was a resident, an unlikely choice for the fourth meeting of the Massachusetts General Hospital Surgical Society, but it was, in the form of the Liberty Hotel, an inspired and elegant site for our group in 2008. For those of you who unfortunately did not attend, a few words about the changes of our next door neighbor: the jail was completed in 1851, and although it was said to be a "milestone of design" at that time, it was a dark and forbidding place, full of gothic overtones in its later years. The jail closed in 1991, and after a $150 million restoration, it has become a beautiful hotel with 298 rooms in a new tower and 18 rooms built in the original jail. Over one hundred of our colleagues gathered in the Liberty Ballroom on Friday evening to swap stories, relive past and present glories, and update each other on children, grandchildren, wives (and husbands), and future plans. While the program noted that this reception would be from 6:00 pm to 8:00 pm, most of the tables were still occupied at 9:00 pm as the servers cleared the room of food and drink.

We then assembled early the next morning at the MGH in the O'Keefe Auditorium where Dr. Andy Warshaw announced that our president, Dr. Robb Rutledge, would not be in attendance, and he also regretfully announced that Dr. Charles McCabe was critically ill after a series of medical problems, and that we were in the process of trying to raise money (more about this later) for the Charles J. McCabe Jr., MD, Endowed Lectureship in Surgical Education to honor Charlie for his contributions to our medical students and residents, to the institution, and to Harvard Medical School. Andy went on to discuss the status of the Department of Surgery in recent years, and it is probably no surprise that the MGH continues to thrive, even in the difficult environment that we all face as surgeons. Notable comments were that the MGH had 53 million dollars in research funding (primarily NIH) in 2007 (the Brigham had 24 million); and the surgical residency program continues to be one of the most-sought-after in the country with new interns

(Reunion continued on page 11)

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 2

Pediatric Surgery at the Massachusetts General Hospital
Looking Back Half a Century, and Further
W. Hardy Hendren '58

Pediatric surgery in America lagged many years behind Europe in attracting surgeons to the specialty of infants and children. Dr. Herbert Coe of Seattle was the first full time pediatric surgeon in America. (His son, Dr. Robert Coe, interestingly, was Chief Resident on the East Surgical Service at MGH in 1956.) In 1917 a catastrophic explosion of a munitions ship in Halifax Harbour killed and injured large numbers of people. Several Boston surgeons rallied to that disaster. Dr. William E. Ladd was one of them. Many of the injured were children. Ladd subsequently gave up his adult surgical practice to concentrate on children. He became the first full time pediatric surgeon at Children's Hospital, Boston. Dr. Ladd is considered today to be the father of pediatric surgery in this hemisphere. A line of descent can be traced to Ladd by 85% of pediatric surgeons and 68% of training directors in America. Milestones in pediatric surgery include: 1948, Surgical Section in American Academy of Pediatrics; 1965, Journal of Pediatric Surgery; 1970, American Pediatric Surgical Association; and 1975, Added Qualifications for Pediatric Surgery (after General Surgery Boards).

Ernest Amory Codman of the MGH staff was another of the Boston surgeons caring for the injured in Halifax. Codman introduced the "End result" idea at MGH, but was not embraced by other MGH surgeons because of his zeal in exposing their errors. Only today, almost a century later, has Codman been fully accorded the honors due to him. The Codman Center for Clinical Effectiveness in Surgery was established recently at the MGH.

Ladd's successor in 1947 as Chief at Children's was Dr. Robert E. Gross. Gross had come onto the world stage of child surgery when, as Chief Resident under Ladd, he performed the first successful ligation of a patent ductus in 1938 for an eight-year old girl, Lorraine Sweeny. She is alive and well today, now age 78. Gross had done that epoch-making operation when Ladd was on vacation, thinking Ladd would not have approved of that adventure. Relations between Ladd and Gross were chilly forever after, although they coauthored many papers and a book, Abdominal Surgery of Infancy and Childhood in 1941.

Our HMS Class of 1952 had two one hour lectures on pediatric surgery by Gross in the third year. That sparked my own interest to take a one-month elective at Children's. From that exposure came the resolve to take full training in adult surgery at the Massachusetts General Hospital plus three years at Children's. Our senior year was the first year of the matching plan for internships. I was lucky to be among the eight chosen for MGH. That positioned me to follow the goal of training in both adult and child surgery with the then, much sought after, Chief Residency in both hospitals.

Dr. Edward D. Churchill, MGH Chief of Surgery, and Gross worked out a combined program for me: two and a half years at MGH, followed by two years as a Senior Resident at Children's, and then back to MGH for the fifth year, plus the East Chief resident year in 1958. I then worked in the animal laboratory at Children's for six months and did the Chief Residency there in 1959-60. Before I returned to Children's for the Chief Resident year Dr. Churchill advised me, "Get your training, but do not plan to stay there". That advice was prescient. "E.D.C", as many affectionately spoke of him, was a keen judge of hospital politics and the various players involved. Therefore, in July 1960, I returned to the MGH with his warm welcome and the mandate, "Let's see what you can build here." My office was initially a former patient exam room of Dr. Joe Meigs who had just retired. My salary support was $150 per month plus what I might earn.

MGH in those days had The Children's Medical Service on the 4th, 5th, and 6th floors of the Vincent-Burnham Building, which sadly succumbed to the wrecker's ball last year along with the venerable clinics building where many of us were brought up. My first request was that the name of The Children's Medical Service be changed to The Children's Service, to acknowledge that surgery of children was to be more than just an occasional case as it had been for many years. The Burnham had 90 beds and a nursery with 10 "incubator" bassinets for sick babies. They were all covered with a sheet most of the time for lack of patients. It was an uncommon event when an infant was referred for surgery, even with a relatively common condition, such as pyloric stenosis. The overall census of The Children's Medical Service was far below capacity. That was soon to change.

Pediatric Surgery was not a recognized specialty in most of North America in 1960. Training programs existed in only seven cities: Boston, New York, Philadelphia, Pittsburgh, Buffalo, Toronto, and Montreal. Today 43 programs exist for approved training, most of them in Children's Hospitals.

The MGH opened in 1821; pediatric cases were a significant part of the patient population. Children's Hospital in Boston was founded in 1869 and there was an outcry of objection in the newspapers. Dr. Benjamin Shaw, then resident physician at MGH, wrote, "Our existing institutions, public and private, provide adequately for the hospital treatment of children." He noted that 190 of 1,264 admissions (14%) to MGH in 1868 were children. Books by John C. Warren in 1839, "Surgical Observations on Tumors" and J. Mason Warren in 1867, "Surgical Observations with Cases and Operations", both included pediatric cases. The most common admitting diagnosis for hospitalized children in the late 1800's was bone and joint tuberculosis of bovine origin, prior to pasteurization of milk.

Pediatric surgery before 1960 at MGH had been rather loosely organized. The cultural concept that general surgeons could do it all was well entrenched. In the main that was true! At that same time there was no separate chest service. Actually, when Dr. Churchill was in Europe in W.W. II, Dr. Richard Sweet, an exceptional general surgeon, organized a separate thoracic division. Dr. Churchill reversed that trend when he returned after the war. The "assignment" for pediatric surgical cases on the ward service was under the aegis of Dr. Robert Linton, before his ascent to the top of the vascular ladder. He was a superb surgeon who taught us never to leave the OR table until the job was well done. I once saw him do a splenorenal shunt for the third time, before being satisfied it would work. It did! Dr. Howard Ulfelder was the next to have the pediatric surgical assignment. He also was a superb general surgeon, then assisting Joe Meigs, and early in a distinguished career in female cancer surgery. I remember seeing a little girl, Linda W., whom Howard had saved as

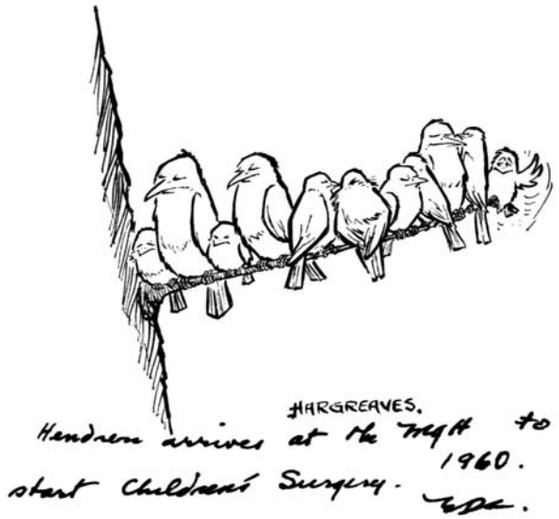
(Hendren continued on next page)

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 3

(Hendren continued from page 2)

a neonate with esophageal atresia, when primary repair of that malformation had been reported only recently (Dr. Cameron Haight, Michigan, in 1945). Dr. William Quimby then followed Ulfelder as the general surgeon most involved with pediatric cases. There was a small service at Boston City Hospital, which Bill oversaw, and he had a private practice at the Milton Hospital, the nearby town where he resided. Much later in his career Bill was very active in the Shriners Burn Hospital.

When Dr. Churchill offered me the job of formally building a division in pediatric surgery, we talked about how to go about that. First we had to attract a patient base and a cadre of referring doctors. Next would be to recruit other surgeons. Thirdly we would add an experimental laboratory and fellows to work in it. He warned me to expect a certain amount of resistance from existing surgical staff, although no surgeons were doing any substantial number of pediatric cases in those days. Dr. Churchill gave to me the cartoon seen in Fig. 1 (below) which he found in a magazine (the Saturday Evening Post?). The little bird struggling for a foothold at the end of the limb was an apt analogy for a young man coming into the midst of many older, established surgeons.



In 1960 it was a great honor to have Dr. William Ladd and Dr. Thomas Lanman, both then retired, come to surgical grand rounds in the Bigelow Amphitheater to discuss our first case of a premie with esophageal atresia. At the end, Dr. Churchill rose, turned to face the audience, and related that he had not originally believed in the merit of specializing in pediatric surgery, but his mind was changed. He described his own unsuccessful attempts to repair esophageal atresia in the 1930's.

In 1967 I was walking through the White Building OR at night when I saw Dr. Ladd about to be anesthetized for drainage of a hip fracture abscess. It was an honor to hold his large, right hand as he went to sleep. He died later that year.

I had a big slide collection made during eight years of residency, with lectures on many subjects: intestinal obstruction in neonates; pediatric tumors; pediatric thoracic problems; pediatric urologic problems, etc. Every invitation to talk throughout New England was accepted with pleasure. Patients began to come to MGH as a result. Dr. Gross had emphasized the importance of an immediate call to the referring doctor and a follow-up letter containing an operative note. That paid big dividends. It often evoked comment on how refreshing it was to hear promptly from "The Ivory Tower"! Mothers usually call their baby's doctor to report in after surgery. If the doctor has already been informed, his position with the family is boosted. If not, the referring doctor is quite rightfully annoyed. For the young surgeon availability, affability, and ability are said to be key in launching a career, probably in that order of importance. That was true also in launching a new division.

Most of the busy surgeons had private scrub nurses in those days, knowing how much more efficient that is. Although at MGH we had many fine OR nurses, it was unfair to expect a nurse with no prior pediatric experience to know how to fix a small infant. It was a Godsend to me in March 1962 to recruit Ms. Dorothy Enos, a superb scrub nurse at Children's to come to work at the MGH. She agreed to a 1-year trial. Dorothy scrubbed on virtually all of my cases for the next 40 ½ years. She also saw all of my office patients, completed statistics for papers, and had bound op notes and reprints. She retired to a new home in Florida. Generations of residents, other nurses, and visitors learned from this very skilled, intuitive, dedicated, and nursing-role-model lady. Her voice was always quiet and unperturbed, despite occasional OR emergencies. When we started a big case which might last many hours, she was always there until it ended. Many sick children survived because she was with them on the operating team!

I was lucky to get great secretarial help from a group of dedicated ladies all committed long term to building a new service: Marilyn Bryant, Paula Zafferes, Linda Lapham, Sally Cornell, and others later at Children's. Paula completed 40 years and Linda 35!

At first, pediatric surgery was included on one of "The Baker Teams". I think it was the Bartlett Team. As volume grew we had an assigned resident, first Dr. Jack Porvaznic and next Dr. Steve Hedberg, each for four months. Service cases (non-private) were not plentiful, and so the resident, usually 3rd or 4th year, often did "private" cases but with my assistance. In a small way this was a precursor of what we have today with insurance coverage and private status of most patients. The pediatric surgical OR was Room 9 in the Baker Building. It had been a delivery room when MGH still admitted maternity cases. I was happy to have it! The anesthesiologist's backside abutted the doorway which was separated from the hall by a curtain. Street clothes were the norm in the hallway. Pigeons would land on a railing of a fire escape just outside the window, which faced the White Building. Once when the window was opened on a hot day some pigeon-down drifted across the Mayo stand. We got the screen repaired. The scrub sink was in the room. If turned on too full, water splashed over to the OR table! We did everything in that room, including a neonatal Blalock Shunt for Tetralogy of Fallot. No one else was keen to work in Room 9. When Steve Hedberg began his colonoscopy practice, he did his work in a similar, but smaller, room down the hall. I remember it well because I was in that room as his patient on Thursday Dec. 12, 1974 when he viewed my transverse colon

(Hendren continued on page 6)

381124_FINAL:Layout 1 11/17/08 12:54 PM Page 4

MGH Surgical Resident Life, 2008
Emily Christison-Lagay, Class of 2010

I have loved surgery from my near vertiginous very first moments in the operating room. As a medical student, I spent hours watching the eyes of senior residents and attending surgeons with steady and unwavering gaze upon the operating field; I wanted their eyes to be my eyes, their resolve to be my resolve. Early on, I came to believe that the surgeon stands as the final recourse, often as the only chance for treatment when medical therapy has nothing left to offer; but, in order to treat, he makes an absolute demand for patient sacrifice and personal sublimation. In any other arena this relationship would be a heinous transgression of societal and personal mores—an unacceptable demand for a willing suspension of consciousness during which tegument is broken and those very structures which impart vitality are cut and cauterized. Out of this tension, this morally and spiritually unthinkable requisition, the relationship between surgeon and patient is soldered and forged. There is an irreproducible power and magic to the relationship between surgeon and patient, but it is a magic which demands that the surgeon, in those hours spent in the operating room, abandon his sense of self, the trials and tribulations of his daily life, and exist only for the patient.

But what happens when some other force outside the profession begins to structure this experience? Victor van Berkel, who just completed the program to embark on a thoracic surgery fellowship in St Louis, likened it to limiting the hours that a professional musician could practice. At the same time that our hours are being limited, the residency requirements are becoming more stringent. We are now required to have proficiency in basic and advanced laparoscopy, endoscopy, critical care, and operative and non-operative trauma. All the while, resident autonomy seems to be increasingly limited by concerns over ever-expanding litigation, medicolegal requirements for attending presence, and a proliferation of paperwork.

I think many feel that we are at a crossroads in surgical education. Although area requirements have broadened, paradoxically, there is a sense that the days of the general surgeon are gone...replaced by a trend toward ever narrowing subspecialization. It is virtually unfathomable to imagine a younger generation of surgeons like Dr. Moncure, who once held privileges in General, Thoracic, and Vascular Surgery. When Plastic Surgery moved from 5 years of general surgery and 2 years of fellowship to a 3 and 3 track, it set the stage for other subspecialties. Both Cardiac and Vascular surgery have approved abbreviated tracks, and although neither is currently favored, I suspect within a short matter of years Cardiac and Vascular-bound residents will not complete a full 5-year residency in general surgery.

This fractionation of resident life, while perhaps facilitating obedience to bureaucratic dictums passed down by national committees is, nonetheless, the subject of considerable consternation by those who trained in less regulated days. And, while it is difficult to identify a single aspect of surgical training which has suffered most, it is true that the MGH, which historically has had an attrition rate well below the national average, has, in recent years begun to lose residents to other disciplines of medicine or other fields of interest. The time-honored East-West "ward" service changed its name to the Churchill service and lost its superchief and, in the process, some of its dominion. Morale suffered. The esprit d'corps that seemed to have long characterized the residency stumbled. Senior residents mourned for days of increased autonomy and lamented the passing of the days of giants. These changes, on the one hand discouraging, have nonetheless provided us with the opportunity to reexamine the residency and its philosophical foundations. Rather than becoming a mere facsimile of other programs across the country, I think that the MGH continues to be an exceptional place to train.The difference finds its roots in two principal sources: the tradition of MGH and the physicians who choose to practice and train here.

Perhaps it all begins with the enduring tradition of the panel interview. While Dr. Hendren no longer rolls a paraffined heart with Ebstein's malformation to a cowering interview candidate seated at the far end of the table to inquire about the condition's early symptomatology and physiology, the panel interview selects candidates who are able to retain poise under pressure and who "know" something. And of the tens of candidates who "pass" this test, only a select few are ranked. These are an extraordinary collection of young men and women whom I feel privileged to call my peers. Not surprisingly they came to surgery with varied and sundry backgrounds: two musicians who have performed at Carnegie hall, a mormon missionary, a Russian émigré whose first trade was as an electrician in Latvia, a professional ballet dancer, a former Naval defense engineer, and, in this year's class, one of the Improper Bostonian's most Eligible Bachelors, which must be evidence of some sort of well-roundedness.

These achievements continue throughout residency. Fostered by a departmental policy which encourages and facilitates a leave for research, eighty percent of residents continue to choose to take at least one, but much more often 2 or more years to pursue studies in basic and translational science as well as in the burgeoning fields of clinical outcomes and public health. Shaun Kunisake who has just begun a pediatric surgical fellowship at the University of Michigan was a two-time winner of the Rosenkrantz award given by the surgical section of the American Academy of Pediatrics for his work in tissue engineered trachea. Peter Fagenholz took his research into the high Himalayas where he used a portable ultrasound machine to measure optic disc diameter to help diagnose early presentations of high altitude cerebral edema. Claudius Conrad was recently featured in the New York Times for his work studying the effect of classical music on the recuperation of critically ill SICU patients. Scott Regenbogen's ongoing work with Atul Gawande has helped create and define a Surgical Apgar score.

However, the business of a surgical residency is not to create great researchers but to create technically competent, thoughtful, informed clinicians. It is to graduate each year the eight doctors that one would choose to be at the side of a patient in extremis. Any deviation from this is a failure in the charge of the residency. The easiest place to begin to look at these data is to study the numbers. When I say easy, I mean

(Christison-Lagay continued on page 10)

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 5

Message from the President
Jo Buyske "93
Teaching Surgery

"We teach surgery, not operations."

That was a recurring theme during residency. It wasn't until after leaving the MGH that I finally understood exactly what that meant. In August of 1993, six weeks after finishing my general surgery residency, I was the surgeon on call at the Lahey Clinic. Confronted with a surgical problem I had never seen before, I panicked in the privacy of my office, then began the long slow walk to the operating room to deal with the problem anyway. A combination of the learned skills of logic, forced calm, technique, caution, attention to detail, and the understanding that the buck stopped with me got both me and that patient through an operation that neither of us had previously encountered. It wasn't pretty, but it was done. I was very grateful that day for the careful training I had had at the hands of the visits and the other residents at the MGH in the late 1980's and early 1990's. I had been taught surgery.

That is what the best of surgical training can deliver: a person who is willing AND able to tackle any problem that must be tackled, whether they really want to or not. I was lucky to train at a place where that behavior was modeled for me every day. That promise is not fulfilled everywhere, a fact that has been recognized by national surgical leadership for quite some time. The Blue Ribbon Committee, made up of representatives from the American Board of Surgery (ABS), the American College of Surgery (ACS), the American Surgical Society (ASA), and the Residency Review Committee for Surgery (RRC-S), formally addressed the issue and published their recommendations in Annals of Surgery in 2005. The message was taken up by the American Board of Surgery which formed SCORE, the Surgical Council on Resident Education. SCORE is an advisory group to the ABS, and consists of representatives from the ACS, ASA, APDS (Association of Program Directors in Surgery), ASE (Association for Surgical Education), RRC, and the ABS. Our charge has been to take the luck out of training, so that we can know that residents across the country are taught surgery.

That task has proven spectacularly complicated. Upon reviewing resident operative logs it became apparent that residents were having vastly different experiences at programs even in the same city. It turns out that very few operations are done often enough and in enough locations that we can count on the residents just learning them through exposure. In fact, only one operation is done reliably more than 50 times during residency. A poll of program directors across the country resulted in a list of 122 operations that residents should be able to do independently by the end of residency. Of those, nearly 100 are done, on average, less than 5 times during residency. Nearly 50 of these same operations are done, on average LESS THAN ONCE. We are not exposing all residents to the most essential operations that we do. Not only are we not reliably teaching surgery, apparently we are not even teaching operations with any kind of consistency.

As a first step, the resident curriculum was developed. A list of operations and diseases that residents should encounter or master during residency was developed. Next, a multimedia-teaching tool that includes text, video, references, and multiple-choice questions. More steps and checkpoints are being introduced. Residents finishing in 2010 will need to have passed Advanced Cardiovascular Life Support, Advanced Trauma Life Support, and Fundamentals of Laparoscopic Surgery, a laparoscopy knowledge and skills course, prior to applying to sit for their board exams. We are working to develop ways of measuring skill and judgment in the operating room with OPRS (OR Performance Rating Systems), ways of measuring information gathering, communication skills and professionalism with office based evaluations like mini-CEX (mini clinical evaluation exercise), computerized simulated patients, checklists of procedures, diseases, encounters. It's a veritable alphabet soup, all designed to get at what came so organically in the bygone era of unrestricted work hours and immersion in a rich environment like the MGH.

"We teach surgery" means "The buck stops here." That is the essential message of excellent surgical training, and one that was clearly delivered to all of us who trained at the Mass General. Now, we struggle with how to be sure that that message continues to be delivered. Within the constraints of limited work hours, the self-imposed restrictions on breadth of practice due to specialization, and the relatively recent emphasis on life balance, that challenge looms large. We are working with the tools teaching and measuring tools available to us, but even all of them added together do not make the full measure of a surgeon. None of us know how to do that. All we can do is continue to model the behavior as best we can.♦

The Surgical Society Newsletter

The editor for the initial newsletter was Bill Abbott. For the last six years the task has fallen to Jack Burke and Robb Rutledge. With the spring edition they too retired and the job is now in the hands of Bill Daggett and Les Ottinger. The Burke-Rutledge team kept the newsletter interesting, informative and colorful, and made it an important component of the Society. We hope to meet their standards. Of course this will require the continuing assistance of our readers. So, submissions are most welcome, the only requirement is a tie with MGH surgery and, of course, brevity.

Bill Daggett - wdaggett@partners.org
Les Ottinger – lwojso@comcast.net

In addition, with this edition of the Newsletter you will note less color as a cost-saving effort.

In Memoriam

Frederic Finseth
Charles McCabe
Nathan Munro
Roger Newstedt

381124_FINAL:Layout 1 11/17/08 12:55 PM Page 6

(Hendren continued from page 3)

carcinoma! (Dr. George Nardi removed it the next day, (Friday 13th). We later got a second small OR, Room 10 next door. It was a banner day when the Gray Building opened and we had ORs 30 and 31 assigned for pediatric surgery, plus induction rooms.

There were a few incidents with other surgeons at first. One was a baby with a double cleft lip where I sought help from an older surgeon whose experience was much greater than mine. It was an uncomfortable experience. Clearly, my revered teacher when I had been a resident, now resented my doing a case in his domain. I never accepted another lip or palate, although many pediatric surgeons did them elsewhere. On May 23, 1962, a 12-year-old boy entered the emergency ward with his right arm neatly severed and well preserved. Although pediatric surgery was then an existing service, with its own resident, the West Service Chief Resident whisked the boy to the White OR and with help of the vascular visit, Dr. Robert Shaw, and a very capable orthopedic consultant, neatly rejoined the arm. To compound the felony, the child was then put on the South Wing of White 6 as a regular ward service adult case. The impropriety of that was soon apparent, after the media blitz, and the lad was transferred to the Burnham Building. Neither our resident, Steve Hedberg, or I was ever called about the youngster. Dr. Churchill advised me to say nothing about it. (I did not; sour grapes are never palatable.) E.D.C. said, "A single case of anything is not worth starting a turf war". He quietly saw to it that such mischief was not to occur again.

We had close communications with our pediatrician colleagues. Dr. Nathan Talbot had just succeeded Dr. Alan Butler as the Chief. Dr. John Crawford was the second-in-command. They were both very astute clinicians and were already well known in metabolic and endocrine circles. The entire pediatric staff were strong players and it was fun to work with them.

We set up a rotation in which each pediatric intern rotated for six weeks through surgery. A few groused about the longer hours, the every other night on duty which was extant for surgery, but in the main, at least in retrospect, they appreciated the exposure to surgical diagnosis, learning what goes on in the OR, etc. Some of the pediatricians, years later, admitted to me that it had been a valuable experience to be a pro tem surgeon for those weeks. I must single out an outstanding one in particular, Dr. Kathryn Anderson. She was on a rotation to MGH from Children's and landed on our service! She later switched from pediatrics to surgery. She then went to Georgetown for general surgery and to Dr. Judson Randolph, an MGH surgery alumnus, for pediatric surgery training at Children's National Medical Center. In 1992 she was appointed as Surgeon-in-Chief at Los Angeles Children's Hospital. Kathryn was elected to be the first woman President of the American Pediatric Surgical Association for 1999-2000. After serving nine years as Secretary of the American College of Surgeons and a year as First Vice President, she became the only woman ever elected to serve as President of the American College of Surgeons (2005-6). Her career has been stellar in all respects.

Soon after the Children's Service was redesignated, we organized a committee of all of the surgeons with special interest and training to represent their specialty for patient care, rounds presentation, and post graduate courses in medicine and surgery. Dr. Paul Chapman led the neurosurgical effort. He had spent a year in Toronto in pediatric neurosurgery. With his obvious skills, Paul soon developed an active pediatric neurosurgical practice. Dr. Drennan Lowell spearheaded the orthopedic side and was succeeded by Dr. Michael Ehrlich after Drennan's sad passing. Dr. Wyland Leadbetter, Chief of Urology, had an active pediatric practice. With Dr. Victor Politano he had described the Leadbetter-Politano method of ureteral reimplantation for vesicoureteral reflux, a common and serious cause for recurrent urinary infection. That was a key which opened the door of reconstructive urology.

Wyland's nephew, Dr. Guy Leadbetter, was similarly very interested in children and attracted patients to the service. Guy eventually became Department Head at the University of Vermont. Because I too had become interested in that area at Children's, really by default because there was in 1960 no urologist at Children's, Wyland and I worked together and in harmony to develop a following. His residents were welcome to scrub on all pediatric cases, to everybody's benefit. Our service became a regular rotation for the urology house staff as the combined case load increased. We ultimately had a pediatric urologic fellow, a recent MGH urology graduate. Three graduated and were immediately hired to head a service – Dr. Terry Hensle at Columbia, Dr. Michael Mitchell at Indianapolis, and Dr. Kenneth Crooks at Columbus. It was a tragedy when Wyland died from a colon carcinoma in 1974, when he was President of the American Urological Association. He was in my opinion the real father of the field of pediatric urology.

Plastic surgery was performed by Dr. Bradford Cannon, a gifted and enthusiastic surgeon and teacher, Dr. John Constable, Dr. John Remensnyder, Dr. Michael Lewis, and Dr. Matt Donelan.

Dr. Hermes Grillo, long-time head of thoracic surgery at MGH, showed the world how to accomplish tracheobronchial reconstructive surgery. This was then utilized extensively in children as well.

Pediatric anesthesiology was an important activity which was desperately needed as the case load burgeoned. Under Dr. Harry Beecher, who had been appointed by Dr. Churchill to lead that service, there were several anesthesiologists who were excellent with babies, but if one of them was not on hand a disaster could happen, and sometimes did! Dr. David Seigne was the first to step forward to fill that need. He was a war hero from Britain, badly wounded in a face off with a Tiger Tank. I never met a more able, gentle, self-assured, or imperturbable anesthesiologist than David. Medicine lost a gem when he later in life died from myeloma. Dr. Eric Furmann followed. He too was exceptionally good and demonstrated those skills best when he led the anesthesia team with the first successful separation of complex Siamese Twins in Boston in 1969. When Dr. Richard Kitz succeeded Beecher as Professor and Chairman of Anesthesiology in 1969, he promised me he would organize the pediatric team to perfection. He did just that. He brought Dr. John Ryan from Columbia. Quiet, competent, unflappable, knowledgeable, and every related compliment would apply to John. (I asked John to put me to sleep for my colectomy in 1974.) John's team

(Hendren continued on page 7)

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 7

(Hendren continued from page 6)

soon included Dr. Nicholas Goudsousian, Dr. Letty Liu, Dr. Myra Jasinskas, Dr. Charles Cote, and others. Cardiac arrests under anesthesia became a rare event. In former days in one month there had been twelve arrests, but CPR retrieved most of them.

Pediatric radiology is a special field. The problems are different and the diagnostic skills must be added to those acquired in adult radiology. Early on at night on multiple occasions we surgeons would have to do a diagnostic barium enema because there was no radiologist with neonatal experience. Barium enema was essential to rule out Hirschprungs disease, which is responsible for 30% of newborn intestinal obstruction cases. Angiography was similarly vexing. A single venous bolus with a luckily obtained view of the aorta moments later served to demonstrate a critical degree of aortic coarctation causing congestive failure in a six-week old male infant one night in 1963. He is now age 45 years, sees Dr. Roman DeSanctis regularly, and ran the Boston Marathon last year! A two-month old male infant with critical aortic stenosis presented in extremis in 1967 at night. After emergency catheterization to confirm the diagnosis, the fused leaflets were opened during a brief pump run with assistance of Dr. Gerald Austen. The baby did well, but some of these nocturnal experiences were harrowing!

Dr. Alan Weber took over pediatric radiology but was eventually recruited by the Eye and Ear to head that department. Dr. Richard Pfister then became involved, especially with the urologic cases. Then Dr. David Kushner, who was later recruited to Washington D.C. to be head at Children's National Medical Center, and Dr. Spencer Borden who went to Children's in Philadelphia. A succession of able radiologists, including Dr. Diego Jaramillo, has followed through the years.

Burn expertise at MGH soared in 1942 when the Coconut Grove Nightclub fire occurred just down the street from the hospital. (A special issue of Annals soon described all facets of care of those patients.) Dr. Oliver Cope rejected the time [dis]honored tannic acid surface treatment and substituted covering the burns with sterile petrolatum gauze bandages, with markedly lower burn mortality. Early partial burn excision followed. Dr. Douglas Jackson, from the Birmingham Accident Hospital in England, worked with Dr. Cope at MGH for two years with dermatome debridement of burn wounds to accelerate removal of devitalized tissue. However, the first immediate primary excision of a major burn which I saw in a child was by Dr. Rob Rutledge in Feb. 1957. Bruce H. was 13. His gasoline soaked dungarees ignited causing deep burns of both legs, amounting to 18-20% of his body surface area. The right leg was excised that same day and the left three days later, grafting immediately with autografts from the patient. Blood loss was 2000 c.c. and 1000 c.c. respectively. At the dressing removal eleven days after the first leg was done there was virtually complete take of all grafts. (Dr. Rutledge was, incidentally, the first surgeon to perform a superior mesenteric artery embolectomy. The vascular visit placed his name first on the article although he was not in the hospital at the time! Publish or perish!) Impressed by Dr. Rutlege's burn excision result in which it was my privilege to assist him, in 1959-60 at Children's I excised five additional severe burn cases (20%-75%). Dr. Francis D. Moore served as advisor. Ten more cases were added on return to the MGH. This 16 patient experience was reported in 1968 with Dr. John Constable and Dr. Bruce Zawacki. The Shriner's began support of five burned pediatric patients at MGH in April 1964. A 30-bed Shriner's Burn Hospital was opened at MGH in Nov. 1968. Burn excision was extended and perfected under the direction of Dr. John Burke, whose laboratory investigation with Ioannis Yannis, Professor of Chemistry at Massachusetts Institute of Technology, created artificial skin. This increased the magnitude of the scope of possible burn excision. For this seminal advance in burn care Dr. Burke was awarded the Distinguished Service Award of the American Surgical Association in recognition of his monumental contributions to care of burn patients the world over.

Pediatric cardiac surgery at MGH was infrequent before 1960. Dr. Denton Cooley in Houston and Mr. David Waterston in London were then showing the feasibility of doing this surgery in small babies. After a month with Cooley in 1961 and three months in London with Waterston in 1962, we had a modest number of such patients. Addition of Dr. Alan Goldblatt in cardiology further increased the intake of these patients. My own involvement in this effort eventually waned because the numbers did not merit continuing the activity, with the superbly run service under Dr. Aldo Castaneda at Children's. Additionally, Dr. Mortimer Buckley wished to do those cases himself as the appointed Chief of Cardiac Surgery. Similarly Children's recognized that major burn care in children is best referred to the MGH-Shriner's Burn Unit.

In 1968 Pediatric Surgery was given a 400 sq. foot space for laboratory work in the research building next to the Bulfinch. Early fellows included Dr. Victor N. Nanagas and Dr. Farrokh Saidi, who was in need of a respite from Iran where times were tumultuous! Dr. Bruce Henderson, recently trained in Cincinnati, came to work clinically with us for two years in 1968. Later he went on to become the first trained pediatric surgeon at the Driscoll Children's Hospital in Corpus Christi, Texas. A thoughtful surgeon and fine gentleman, he completed recently a distinguished career in that city.

Dr. Samuel Kim in 1970 came to us after his training at Boston Children's and the Alder Hey Children's Hospital in Liverpool, England. In the 34 years that followed he became a true pillar of surgery at the MGH. His infectious good humor is sorely missed by all in the four years since his retirement. He is a superb surgeon, with equally fine judgment. He was loved by all which possibly accounts for his being asked to run the MGH operating rooms during the last part of his tenure. He was a truly independent thinker, who was at the same time a fine team player and was admired by all of the medical and surgical staff.

Dr. Patricia Donahoe came to us from the Laboratory of Dr. Judah Folkman in 1970. Judah gave her his highest possible support for her work in his laboratory and clinically. He was right! In a year she got the lab humming with good projects and spent half a year caring for patients as well. Pat then went to Alder Hey for a year of pediatric surgery with Mr. Peter Rickham and four months of pediatric urology with Mr. Herbert Johnston. Dr. Kim and I were both very pleased when Patricia accepted our invitation to join our little pediatric surgery division in 1973.

(Hendren continued on page 8)

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 8

(Hendren continued from page 7)

The first laboratory support was a $15,000 one year award from the H.P. Hood Foundation, plus our clinical earnings from the division. That funded an initial study relating to the Mullerian Inhibiting Substance which directs gender differentiation in the fetus. That first paper was rejected by the Journal of Surgical Research. A call to the editor, Dr. David Skinner, an MGH alumnus and Professor at University of Chicago, disclosed that the reviewers had simply misunderstood this unique research and its potential importance. The paper was accepted. A long line of talented research fellows from Keio University in Tokyo then augmented the increasing productivity of the lab under Patricia's tutelage. The first, Dr. Y. Ito, won the first prize award for a presentation of his work in a competition with seven American presenters at the American Academy of Pediatrics. Dr. H. Morikawa, another of the very able fellows from Keio, was President of the Japanese Pediatric Surgical Association in 2007. Fourteen successive fellows from Keio University worked under Dr. Donahoe. All of them assumed prestigious academic positions in Japan.

It was a great step upward when we moved the division office and laboratories in 1975 from the Burnham Basement to the 5'th floor of the Gray Building. Our division paid the $100,000 cost which was prescribed by the certificate of need restrictions which hampered development in those days. Competitive NIH Grants were by then the main support for the laboratory, all due to Dr. Donahoe's hard work, originality, and smooth interaction with other services participating in various aspects of these investigations in developmental biology. Patricia meanwhile declined multiple offers to go elsewhere to run a pediatric surgical service in order to pursue her goals of discovery in the milieu of the MGH. In Fig. 2 (below) is seen the division as it was in 1980, 20 years after Dr. Churchill's, "Let's see what you can build here".

L to R - Top row: Dr John Curnutte, Dr Peter Hudson, Dr Hiromichi Ikawa, Dr Akira Hayashi, Dr Julianne Bacsik, Hedy Lamar, Marcia Sullivan, Susan Powell 2nd row: Bob Morse, R.N., Dr Rich Schmidt, Dr Howard Ginsburg, Alan Ladd, Dr Steven Guy, Gerald Budzik, Tom Manganaro, Linda Lapham, Karen DelVecchio Front row: Dr John Crawford, Dorothy Enos, R.N., Evelyn DelGizzi, Dr Sam Kim, Dr Hardy Hendren, Dr Patricia Donahoe, Paul Zafferes, Dr David Swan, Sally Cornell, Marcia Wright

Meanwhile various political rumblings had occurred across town. Dr. Judah Folkman had replaced Dr. Gross as Surgeon-in-Chief; Dr. Gross had become Cardiovascular Surgeon-in-Chief. Gross retired in 1973 and was succeeded by Dr. Castaneda. Later Dr. Folkman decided in 1981 to relinquish running the department to allow him to concentrate on the ever-burgeoning laboratory. After a two-year search, I was offered the job. With very ambivalent feelings I went to Children's to be able to direct a program which could offer a full residency in pediatric surgery. Heretofore we could stimulate interest and get residents started but had to send them elsewhere to get "approved" training which depended on sufficient volume of index cases.

In 1983, Dr. Gerald Austen, Surgeon-in-Chief at MGH, appointed Pat Donahoe as Chief of Pediatric Surgery. Additional staff members were added, seen in Fig.3 (below). Her own accomplishments have continued, garnering appropriate rewards for them. They include: Marshall K. Bartlett tenured Professor of Surgery at Harvard Medical School; Member of the National Academy of Sciences; Conrad Koch Award, Endocrine Society; President, Boston Surgical Society; President, American Pediatric Surgical Association; Flance-Karl Award of the American Surgical Association; naming of the Dr. Patricia Donahoe Professorship in Surgery at Harvard Medical School; and the American Academy of Arts and Sciences. Pat stepped down as Chief in 2003 but continues her seminal research in the magnificent new laboratory setting of the Simches Building next to "The Shrine". There have been more than 90 research fellows in her lab; 34 have entered pediatric surgery. Some were MGH residents; many were not.

Back row: Drs. Raphael Pieretti, Peter Masiakos, David Lawlor, Alan Goldstein Front row: Drs. Daniel Doody, Patricia Donahoe, Chief Emeritus, Joseph Vacanti, Chief, Daniel Ryan, and Jay Schnitzer

Dr. Joseph Vacanti returned to the MGH, where he had trained, from Children's in 1999. He now holds the prestigious John Homans Chair in Surgery, the venerable chair once occupied by Dr. Churchill. Jay is now Surgeon-in-Chief of the newly named MassGeneral Hospital for Children. His brilliant career has included starting an entire new field of research, Tissue Engineering. Dr. Robert Gross once quoted Leonado DaVinci as saying, "A good teacher will be outshined by a brilliant pupil." Surely I can feel that way about Drs. Vacanti and Donahoe.

We have all just lost a dear friend and brilliant colleague, Dr. Judah Folkman. I met Judah when he was a medical student working in the laboratory of Dr. Gross in 1953-57. He then started as an intern at MGH in 1957

(Hendren continued on page 9)

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 9

(Hendren continued from page 8)

and became Chief Resident in 1964-65. He was on pediatric surgery for four months. I can remember some of the cases he did with me as if it were yesterday. It was no surprise to see his rise to stardom. He was appointed Surgeon-in-Chief of Children's at age 34 in 1967. He founded the field of angiogenesis research and was nominated multiple times for the Nobel Prize in Medicine and Physiology. His singular appreciation of the

role that angiogenesis plays in development of multiple diseases has left a permanent mark on medicine and science. None of us who knew Judah well will ever accept his sudden death this year with equanimity. We all regret the Nobel Prize is never awarded posthumously.

In summing up, it has been such a fantastic experience to be associated with the Massachusetts General Hospital, Children's Hospital Boston, and Harvard Medical School since 1950. Such an environment in which to learn! Dr. Churchill's vision was clear. Much has originated at MGH – ureteral reimplantation, megaureter repair, repair of intersex anomalies, reconstruction of previously diverted urinary tracts, repair of cloacal malformations, feasibility of immediate reconstruction of infants with severe obstructive uropathy, urethral valves as a broad spectrum, major burn excision, segmental lung resection for bronchiectasis and other lesions, immediate resection for instrumental perforation of the esophagus, the mechanism of pneumoperitoneum in pulmo-

nary air leak, microangiographic study of ureteral blood supply, renal changes with acute vascular occlusion, the separation of conjoined twins, the repair of laryngotracheal clefts and fistulae, colon interposition for esophageal replacement, vaginal reconstruction, bladder replacement with various G.I. tissues, electromagnetic esophageal bougienage, the biology of organ differentiation in the human fetus and the role of Mullerian Inhibiting Substance, creation of the female urethra, repair in cloacal exstrophy, continent urinary diversion, tissue engineering, artificial skin, a remarkable decrease in burn mortality, tracheal resection and repair, the essential use of humidification of anesthetic gasses during surgery, and still other contributions space precludes describing. For example, recently from the laboratory have come the genetic causes for congenital diaphragmatic hernia.

But the most lasting legacy of our fledgling division at MGH is the group of 47 MGH surgical residents who were inspired to enter a relatively new surgical specialty! The vast majority have pursued academic careers. (See Fig. 4 below)

Additionally, ten outstanding surgeons came to the MGH pediatric surgery division after taking their pediatric surgery training elsewhere. (See Fig. 5 below)

We can rest assured that there is much more to come from all of these primary and secondary MGH alumni now laboring in the vineyard of child surgery. I think E.D.C. would judge his investment to have succeeded.

We in pediatric surgery at MGH wish to thank all of the General Surgical Chiefs whose generous support has made the division and its advances possible: Dr. Edward Churchill; Dr. Paul Russell; Dr. Gerald Austen; and Dr. Andrew Warshaw.

Figure 4: MGH Residents Entering Pediatric Surgery (47)

***Wm. Richardson**	**John Wesley**	**Matt Donelan**
***Hardy Hendren**	***Jay Vacanti**	**Michael Lewis**
***Judah Folkman**	***Robert Shamberger**	**Sharon Muenchow**
***Lucian Leape**	**Craig Lillehei**	**Harold Ditmore**
***Dale Johnson**	***Michael LaQuaglia**	***Edward Barksdale**
***Judson Randolph**	***Scott Adzick**	**Suzanne Ildsted**
***Peter Mansfield**	***Dennis Lund**	**John Aiken**
***Willis Williams**	**Daniel Ryan**	***Jens Rosenkrantz**
***Tim Canty**	***Francisco Cigarroa**	**Raphael Levy**
Richard Harmel	**Alan Goldstein**	***Terry Hensle**
***Michael Harrison**	**John Mulliken**	***Michael Mitchell**
Boyd Winslow	**John Burrington**	***Ken Crooks**
Tracy Grikscheit	**Jessica Kandel**	**Katie Deans**
Peter Minneci	**Akemi Kawaguchi**	**Shaun Kunisaki**
Ruben Rodriguez	**Emily Christison-Lagay**	**Elizabeth Sailhamer**
Roshni Dasgupta	**Ellen Reynolds**	***Dept. Chiefs**

Figure 5

From Other Programs (10)

***Bruce Henderson**
Sam Kim
***Patricia Donahoe**
***Howard Ginsberg**
Dan Doody
Jay Schnitzer
Robert Foglia
David Lawlor
Peter Masiakos
***Raphael Pieretti**

***Dept. Chiefs**

Pediatric Surgery in America may trace its ancestral roots to William Ladd, but no giant in this field stands taller than Hardy Hendren. Herein he recounts the story of the evolution of pediatric surgery at the MGH from his own unique personal experience and viewpoint. While he traces the lineage from Ladd (through him) to the amazing number of present-day pediatric surgeons who have trained and worked here, Hardy omitted one very important note: so many MGH residents who chose other fields of endeavor (including me) learned meticulous, precise, beautiful surgical technique from him.

Hardy Hendren is an Honorary Surgeon at MGH and the Robert Gross Distinguished Professor at Harvard Medical School. A chair in surgery was recently established at Harvard in his name.

Andy Warshaw

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 10

(Christison-Lagay continued from page 4)

that as a relative term, since after 50 emails trying to prepare this talk, I learned that no one at the MGH has any idea where historical numbers of case volume, distribution, and length of stay are kept…or, in fact, if they have been kept at all. I was eventually referred to Dr. Austen's private archive, conceded defeat, and was grudgingly forced to the conclusion that perhaps the only benefit to the increasing barrage of paperwork and regulations that surround residency and hospital life in general is that it has created a paper trail which facilitates this sort of presentation. So, I have numbers beginning with the graduating class of 2001, a year before the start of my residency, a class which never saw the looming spectre of the RRC. An early and oft-cited criticism of the eighty-hour work week has been that with residents leaving postcall, operative case volume would suffer. Rather than that being the case, the opposite seems to be true (although again these numbers are dependent on resident self-reporting the trends of which may have changed over the past 8 years). The graduating class of '01-'02 finished with an average of 934 major cases, the following year 887. This year's graduating class averaged 1062 major cases, with two members logging over 1200 cases, 300-400 as chiefs. The MGH is in the top 20% of programs nationwide in case volume of head and neck, endocrine, pediatric surgery, foregut including esophagus, hand, complex biliary tract and, of course, pancreatic surgery. And over this same period of time, no doubt facilitated by recent additions to the surgical oncology, trauma, and minimally invasive staff, average volume of liver cases per graduating resident has increased by 122%, pancreatic cases by 45%, trauma by 20%, basic laparoscopy by 58% and complex laparoscopy by 71%. Over the past 10 years, general surgical volume has increased 25% from just over 7000 cases in the late 1990's to over 9000 annual cases today. Trauma volume has increased 20% since the arrival of Dr. Velmahos and his team of Drs Alam and DeMoya. And although the elective volume of the so-called Ward or Churchill service has tapered off slightly, it is still responsible for just short of 2000 cases yearly. Greater than ninety percent of our residents go on to fellowship with cardiac and non-cardiac thoracic leading the numbers, followed by pediatric surgery, transplant, vascular, and surgical oncology. In fact, there has not been an MGH resident who did not get a fellowship spot in the field of his/her choosing during the years of my training.

These numbers astonished me because it is my sense that most senior residents feel less secure in their operative skill than they did 5 or 6 years ago, a difference I have attributed to some vague, not particularly well-defined changes in resident autonomy. When I was a junior resident, the senior residents occupied the role of minor deities. I do not feel like a minor deity, and, quite frankly, I'd really like to know how it feels to be adored. But tracing the origins of this change proves to be pretty elusive. It is unlikely in a brief span of 5 years that attendings have significantly altered their intraoperative teaching paradigms. The one real change within the residency is that senior level residents no longer operate with one another and they no longer operate with a chief resident. My recollection of my internship is that I did a lot of observing of my senior and the chief from the foot of the table and that my first introduction to operating was watching cases—which I believe to be a vitally important step in surgical education. We have lost the educational experience of senior residents teaching and learning from senior residents and of junior residents learning from these interactions. One week into her residency, I took an intern who had not operated in 8 months through a formal right colectomy in a patient who had intussuscepted her terminal ileum and cecum into her transverse colon from the leadpoint of a large cecal cancer. We broke a few 3-0 silk ties in the process and it took close to 2 hours. At times it felt awkward in a way that it would not have felt if I stood across the table from another 5th year or a junior attending. The interns love it. For the last several years, the Churchill service has come out as the most popular of any intern rotation. We love it, too, because for the first time in our residency we are operating independently. Initial worries that the loss of the superchief would spell the end of resident control of a service have been allayed. And I think that our trauma experience has been vastly improved. But I do think that with this change an important part of the MGH experience has been lost; I do think that the removal of a junior attending from the daily experience of the Churchill OR and the infrequency of senior residents sharing an operating table has had an effect on the education of junior and residents.

Does it make a difference in the final product? In the end, I am inclined to think no. Several weeks ago, in the final days of their residency, Pierre deDelva and Ruben Rodriguez asked Dr. Fernandez to staff a Churchill Whipple in a patient with a replaced right hepatic artery. Dr. Fernandez never scrubbed. The patient went home without drains on POD6. In fact, the last 2 months have seen 3 Whipples, one right hepatectomy, 5 lap or lap-assisted sigmoids, an en bloc liver and gallbladder resection for cancer, 4 thoracotomies for trauma, 4 arterial bypass procedures for penetrating trauma, a common bile duct exploration, 2 subtotal gastrectomies, and 2 pancreatic debridements. Each of these cases had a senior resident as the primary surgeon. I think there are very few places in the country that could claim a similar record.

Clearly, the experience of the Churchill service is only a fraction of resident life, but I think for many who chose to train at the MGH it was lynchpin of the residency and came to epitomize the essence of surgical training. And to this day, although it has transmogrified, it remains, for the residents, the flagship service of the residency—at least as much as a service comprising a fair number of drunken degenerates, diabetic foot ulcers, and necrotizing soft tissue infections can be considered a flagship. In terms of overall operative volume and case complexity, the Baker service reigns supreme. During the course of my residency, there has only been growth, with new appointments to surgical oncology, endocrine, colorectal and minimally invasive teams. And we are one of the few programs in the country that retains a strong, permanent, if somewhat contentious presence in the Emergency Room, attempting to identify those patients with surgical needs across a wide domain of specialties: cardiac, thoracic, transplant, vascular, and general surgery. The ED senior wages a daily battle against the slings and arrows of emergency room residents and medical residents stationed for a shift or two. They troll the computerized triage Registry looking for patients with recent

(Christison-Lagay continued on page 11)

381124_FINAL:Layout 1 11/17/08 12:55 PM Page 11

(Christison-Lagay continued from page 10)
operations; they remain the final word on trauma patients and often negotiate with great diplomacy the increasingly political battleground of ED dominion. (I excuse myself from this diplomacy as the only surgical resident in recent history to be escorted out of the ED by security for assaulting an attending.)

This spring along with another resident, I took a post-call trip to NYC to see an off-Broadway show. In the vestibule of the small theater where the play was being performed was a brass plate engraved with
a quote from George Bernard Shaw:

This is the true joy in life, the being used for a purpose recognized by yourself as a mighty one; the being a force of nature instead of a feverish, selfish little clod of ailments and grievances complaining that the world will not devote itself to making you happy.

I am of the opinion that my life belongs to the whole community, and as long as I live it is my privilege to do for it whatever I can.

I want to be thoroughly used up when I die, for the harder I work the more I live. I rejoice in life for its own sake. Life is no "brief candle" for me. It is a sort of splendid torch which I have got hold of for the moment, and I want to make it burn as brightly as possible before handing it on to future generations.

I think this is the call to service which grips most of us. I think this is the charge before us. We have at the Mass General the resources of one of the finest hospitals in the world. And no matter what changes lie ahead for future residents, no matter what work hour restrictions or parsing up of disciplines, we are obligated to listen to this call and obey this charge and to continue to train and mold the best surgeons in the world.

(Editor's note: Dr. Emily Christison-Lagay graduated with distinction from the University of Virginia, and thereafter was appointed Visiting Research Scholar at University of Oxford, UK. Following receipt of her MD degree from Harvard Medical School, she was selected as an Intern in Surgery at MGH in 2003. In addition to her clinical training, Emily has accomplished important basic, translational and clinical research working in, among others, the laboratory of Dr. Judah Folkman and in the Vascular Anomalies Center with Dr. Steven Fishman at Boston Children's Hospital. Throughout her educational and clinical studies Emily has received numerous honors and awards. She is currently a chief resident in the general surgical residency program at the MGH and will take up formal training in pediatric surgery at the Hospital for Sick Children in Toronto In July of 2009. The above article is based on her presentation at the recent Alumni Reunion.) ♦

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(Reunion continued from cover page)
this year from Harvard (3), UCSF, Brown, Penn, Virginia, and Medical School of South Carolina. The graduating class of MGH chief residents mirrors a trend taking place at many of our leading academic institutions—seven of the eight are going on to fellowships around the country while the eighth is going to Kenya to work with Doctors without Borders.

The two-day program will be included with this letter, but all of the presentations were excellent. Two of these Saturday presentations deserve a few brief words: one was particularly moving and stimulated patriotic fervor and one was troubling and augurs difficulties for our profession down the road. Cam Wright spoke on his recent service in Iraq where he currently has a son serving in the military. In order to accomplish his goal of being sent to Iraq, he had to "jump through a number of hoops" just to qualify for this opportunity, and then after arriving at his post, he was confined there until his period of service had ended. He detailed the drudgery of living in a setting surrounded by dessert; the horrific wounds suffered by our troops and the efforts that he and other members of his medical group made to stabilize and then transport our soldiers; and the joy that he experienced when he could infrequently see his son during their mutual service. While Cam's talk was uplifting and inspirational, Joe Fischer followed with a talk on "The Imminent Death of General Surgery" (see JAMA, Nov. 14, 2008, vol. 298). As Dr. Fischer pointed out, we live in difficult times, and many surgeons are facing what he called an "unfavorable work environment." He did not propose many solutions to this conundrum, but rather alerted us to the magnitude of the issue. I would refer you to his article in JAMA for further enlightenment on this topic.

At the conclusion of the morning's lectures, we had some free time for a tour of the hospital, a quick run around the Charles River, or even a nap. At 5:30 pm the first of two buses came to the Liberty Hotel to take us all to the Commonwealth Museum Grounds where we enjoyed a clambake, more stories about our younger days, and more comments about how beautiful/brilliant/precocious our children/grand-children were.

On Sunday morning, our new president, Jo Buyske, conducted our Business Meeting, and we discussed a donation from our society to the Charles McCabe Lectureship, and we collectively agreed to give $20,000 to this most worthy cause. Since the time of this meeting (less than one week later), we have notified both Charlie and Rose McCabe and their daughter, Krista, that over $100,000 has been raised in Charlie's honor. The new president-elect was announced as Dennis Lund, and the new secretary-treasurer was announced as Tom Dodson. The talks that morning were optimistic for the survival of our discipline and full of promise for the better care of our patients with new insights and new technology. Four of our "giants" who have passed from our lives were eulogized by current staff members: John Remensnyder (former plastic surgery chief) by Andy Warshaw; Judah Folkman (former chief of surgery at Children's Hospital) by Pat Donahoe; Hermes Grillo (former chief of thoracic surgery) by John Wain; and Mort Buckley (former chief of cardiac surgery) by Cary Akins. Following these moving and memorable comments, a farewell luncheon was held on the Bulfinch Patio; goodbyes were said; and plans were made to meet again in 2011.

It seems fitting to close this letter with the comments made by one of our beloved teachers, Dr. Ashby Moncure, as he closed his presidential address to the New England Surgical Society in October of 2000: "As Edward D. Churchill so eloquently stated, we stand on the shoulders of our predecessors . . . the common character trait among them that led to success was their unwillingness to accept any defeat as final and a burning steadfastness of purpose in pursuing what were to become major contributions to their selected field of interest. I salute their courage and tenacious quest for truth on uncharted seas, which enabled them to make their contributions and bring their patients to safe harbor."

Tom Dodson '73

381124_FINAL:Layout 1 11/17/08 12:56 PM Page 12

Message from the Chair Andy Warshaw

The Department of Surgery is pleased to announce the following appointments:

Amy Colwell, MD joined the Division of Plastic and Reconstructive Surgery on July 1, 2008 as Assistant in Surgery and HMS Instructor in Surgery. Dr. Colwell received her medical degree from University of Minnesota, and completed the Harvard Combined Plastic Surgery residency. Her clinical interests include post-bariatric surgery body contouring and breast reconstruction. She will work closely with the MGH Weight Center and Cancer Center in these programs and will pursue outcomes studies in these areas.

Denise Gee, MD accepted a permanent position in the Division of General/GI Surgery on July 1, 2008 as Assistant in Surgery and HMS Instructor in Surgery. Dr. Gee received her medical degree from Boston University School of Medicine, and completed her residency at Boston Medical Center. Dr. Gee was the 2006-2007 Advanced Laparoscopic Surgery Fellow at MGH and has held a temporary position in the Division of General/GI Surgery pending her husband's completing his training at the Massachusetts Eye and Ear Infirmary. Her clinical focus will be advanced laparoscopic surgery including foregut (anti-reflux, myotomy, paraesophageal, hernia), solid organ, colon, bariatric surgery and hernias. Dr. Gee, who is fluent in Mandarin, will also help to develop the Division's community-based programs at the North Shore Ambulatory Care Center and Medical Office Building currently under joint development by MGH and NSMC, and/or MGH West. Her Research interests include natural orifice translumenal endoscopic surgery (NOTES) and minimally invasive techniques/technology.

Howard Kesselman MD, has joined the Division of Cardiac Surgery in July 2008 as Instructor in Surgery and an attending intensivist in the Cardiac Surgical Intensive Care Unit. Dr. Kesselman is the second attending in the CSICU alongside Dr. William Hoffman to help expand our ICU coverage. Dr. Kesselman graduated from Yale University School of Medicine, completed his residency, fellowship in Infectious Disease and fellowship in Pulmonary and Critical Care Medicine at MGH. He comes back to us from New England Baptist Hospital in Boston where he was an Assistant in Medicine.

David King, MD is a Major in the Army Medical Department on Active Duty deployment to Iraq from July 2008 through November, 2008. Upon his return, he will be joining the Division of Trauma, Emergency Surgery and Surgical Critical Care as Assistant in Surgery and HMS Instructor in Surgery. Dr. King received his medical degree in 2000 from the University of Miami. His residency training included a surgical clinical fellowship at BIDMC through 2002, a research fellowship in Surgical Critical Care and residency at the Ryder Trauma Center, Jackson Memorial Hospital, Miami. Dr. King's primary focus at MGH will be as a trauma and acute care surgery attending and as an intensivist in the SICU.

Chienwei Eric Liao, MD, PhD joined the Division of Plastic and Reconstructive Surgery on July 1, 2008 as Assistant in Surgery and HMS Instructor in Surgery. Dr. Liao received his medical degree from Harvard Medical School and completed the Harvard Combined Plastic Surgery residency. His clinical interests include craniofacial reconstruction, cleft lip and palate repair, and microsurgery and his research will focus on craniofacial developmental genetics, composite tissue transplantation, and adipocyte stem cells.

Virendra Patel MD joined the Division of Vascular and Endovascular Surgery on July 1, 2008 as Assistant in Surgery and HMS Instructor in Surgery. Dr. Patel received his medical degree from Tufts University School of Medicine, completed his general surgery residency training at Beth Israel Deaconess Medical Center and his Vascular Surgery Fellowship at MGH. In addition to his responsibilities as a vascular surgeon at MGH, Dr. Patel will also help to develop community practice activities to the North of Boston potentially to include the North Shore Medical Center and at the new North Shore Ambulatory Care Center and Medical Office Building.

Patricia Sylla, MD joined the Division of General/GI Surgery on July 1, 2008 as Assistant in Surgery and HMS Instructor in Surgery. Dr. Sylla received her medical degree from Cornell University Medical College, completed her residency at Columbia Presbyterian Hospital and a Colorectal Surgery fellowship at Mount Sinai Hospital, New York. She was most recently the Advanced Laparoscopic Surgery Fellow at MGH. Her clinical interests include colon and rectal diseases, laparoscopic/minimally invasive management of colon and rectal cancers, diverticular disease, and inflammatory bowel disease. Her research will continue to focus on natural orifice translumenal endoscopic surgery (NOTES). Dr. Sylla, who is fluent in French, will also help to develop the Division's community-based programs.

Jennifer Wargo, MD joined the Division of Surgical Oncology on August 1, 2008 as Assistant in Surgery and HMS Instructor in Surgery. Dr. Wargo received her medical degree from the Medical College of Pennsylvania – Hahnemann School of Medicine and completed her residency at MGH. She was the Chief Resident of the MGH Churchill Surgical Service in 2005-2006. Dr. Wargo was a research fellow in Surgical Oncology at UCLA in 2003, and most recently completed a Fellowship in Surgical Oncology at the National Cancer Institute. In addition to clinical practice within the Division of Surgical Oncology, Dr. Wargo will be establishing a research program in immunotherapy for cancer. She will be exploring the use of genetically manipulated T lymphocytes to metastatic melanoma.

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 13

MGH SURGICAL SOCIETY
REUNION PHOTOS

JUNE 27-29, 2008

381124_FINAL:Layout 1 11/11/08 12:52 PM Page 14

The Massachusetts General Hospital
Surgical Society
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