The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY Newsletter

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MGH Department of Surgery Annual Reception
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6:00-8:00 p.m.

WANTED
PROFESSIONAL AND PERSONAL NEWS
Please send to Editorial Office address above

A MESSAGE FROM THE PRESIDENT

Between October 2002 and June 2003, the Residency Review Committee surveyed 73 of the 252 General Surgery programs (29 %). By their tabulation, operative insufficiencies were the most frequent deficiency, and was cited 36 times (that is in 49% of the programs). By description, this category includes "insufficiencies in single and multiple categories, balance of cases among residents, and breadth of experience".

In striving to raise the quality of surgical training, the RRC has understandably focused on the actual operative experience of residents and the cases that they report they have done. Standards have been developed, and it is against these standards that programs are judged. This does raise the somewhat unsettling thought that the number of "cases done" is only in a general way related to the development of skill and judgment in operating.

Perhaps all surgeons begin their training with a central, if unexpressed, question, "will I really ever be able to do operations"? Gradually through the resident years this question is answered, but there is, inevitably, a persistent desire to demonstrate progress. I believe, however, that it is very unfortunate that in recent decades, "doing cases" has sometimes become an over-emphasized aim of many residents. The importance of counting cases has also been reinforced by the RRC and ABS in their requirements for accreditation of programs and certification of graduates.

For many of us, it is surely clear that the attempt to become a superior surgeon was not actually advanced by the demonstration of our proficiency as our training progressed. Rather, it was more often fostered by what we learned from assisting and participating in operations done by a few highly skilled individual surgeons. It was this knowledge that we treasured and carried on into our own practices. There is, of course, no way to measure or even document this aspect of the education of surgeons. Still, it should be an important consideration for those who run departments and recruit and promote department members. Maybe residents should even be counting and reporting cases done with master surgeons. That, like cases done, might make a useful statistic. *Les Ottinger* ♦

A VIEW FROM THE CORNER OFFICE

The surgical resident's world is far different from that most of us experienced. The explosion of knowledge and technology in all surgical fields makes broad expertise almost unattainable. The 80-hour work week restrictions may have improved the quality of residents' lives and possibly provide the opportunity for more reading and study, but the constraints also limit the on-the-job learning and perhaps compromise the professional commitment that is embedded in extended continuity of care. The changes continue and will likely become even more dramatic in the next few years when and if the structural revisions of training being contemplated by the Boards, RRCs, and national surgical leadership organizations are implemented. The end-point of training will then be a narrower focus or subspecialty of surgery for all residents, rather than the pretense of general competence that has been the paradigm.

Our ward service has been a jewel in the crown of MGH surgical training for more than half a century. It has provided the crucible in which young surgeons can gain the confidence and experience to function with growing independence within the safety net of the institution. While the two parallel and complementary ward services were melded into one service ten-years ago, the volume of cases has remained relatively constant at about 1600 per year under a single "super-chief". Pediatric, plastic and cardiac surgery cases migrated to privatized subspecialty services decades ago, but vascular and non-cardiac thoracic patients have been retained on the ward service, albeit with increased supervision by the relevant faculty. The latter is of particular significance when viewed in the light of increased public, congressional, and press scrutiny of our outcomes and our responsibility and accountability to our patients. The MGH bylaws in fact require that all patients be admitted under an attending physician (surgeon) and that all operations be booked in the name of an attending surgeon. The "chief resident", who has a faculty appointment, can serve legitimately in that role, but clearly cannot be in all places, including multiple operating rooms, at once. And what if at some time there would be no chief resident?

Most MGH surgical residents already continue on to subspecialty fellowships after completing the standard 5-year training paradigm. Although they value the increasingly unique experience of our traditional *(Warshaw continued on page 9)*

ROBERT R. LINTON, MASTER SURGEON By Bruce S. Cutler

Robert Linton's career at the MGH spanned 4 decades. He had a profound effect on the development of reconstructive vascular surgery and the evolution of vascular surgery as a distinct surgical specialty. Although he earned a national reputation for the surgical treatment of venous disease and the use of the saphenous vein autograft, locally he was legendary for his many surgical idiosyncrasies. You may wish to try your luck at the Linton Quiz. The average score for a former MGH house officer is 5. If you get all 8 you are a true "Lintophile"! The answers are at the end of the article.

The Linton Quiz

1. **What was the house staff's nickname for Linton?**
2. **What ligature material did Linton use?**
3. **Who was the resident that developed phlebitis during the famous 24 hour case?**
4. **How did Linton cut skin sutures?**
5. **How many stars on Linton's gold cap?**
6. **What instrument did Linton modify to make the famous Linton aortic clamp?**
7. **How did Linton personalize his instruments?**
8. **What was the name of Linton's sailboat?**

Linton was born in Scotland in 1900 the son of a general practitioner. The elder Linton left Scotland in 1903 with Robert and his older brother, settling in Washington State. The two brothers graduated from the University of Washington and both entered the same class at Harvard Medical School in the fall of 1921. Both Bob and Jim showed an aptitude for physiology and were invited by Walter B. Cannon, professor of physiology at the time, to work in his laboratory. A strong mutual relationship developed between Dr. Cannon and the two brothers.

As a result of a stimulating third-year rotation on internal medicine with Dr. Arlie Bock at the MGH, Bob applied for a medical internship at Johns Hopkins Hospital. However, during his final year at Harvard, he served a surgical clerkship at the Deaconess Hospital, and returned to work in Cannon's physiology laboratory. He later wrote, " My career in surgery actually had its beginning when I was a fourth year medical student. I elected to spend most of that year as a tutorial student working with Walter B. Cannon. At that time, he was especially interested in the physiology of the denervated cat heart. The thoracic portion of the procedure was done through an open chest so that endotracheal anesthesia was necessary. When I became a surgical intern at the Massachusetts General Hospital in 1927, I was dismayed with how poorly the patients' airways were maintained during operations. Remembering my days in the physiology laboratory doing thoracic operations without any trouble, I asked the anesthesiologist, "Why don't you use an endotracheal tube on these patients who have such marked stridor?" The answer I received was, "Don't you know young man, the trachea will not stand a tube within it!"

Soon after starting his medical internship at Johns Hopkins, Bob applied to the MGH for a surgical residency. While in Baltimore, he met Emma Buermann in January 1926, who was working as a laboratory technician. By August, Bob and Emma were engaged. He completed his internship and moved to Boston to begin surgical residency. At about this time he developed total alopecia. He asked Emma to move to Boston. He met her at the train station, his bare scalp covered with a cap. As she approached, he asked, "Will you still marry me?" and removed his cap. Without hesitation, she embraced him.

In 1928 Dr. E.P. Richardson appointed Linton chief resident of the West Surgical service to follow his medical school classmate, Reginald Smithwick. Dr. Richardson's goal was to develop a full-time teaching service at the MGH comparable to that at the Peter Bent Brigham and John Hopkins Hospitals. Linton later reflected on his chief residency: "It was of utmost value to assist the Chief of the Surgical Service, Dr. E. P. Richardson, from whom I learned a great deal of surgical technique and how to be a surgeon under stress." In fact, a strong relationship developed between the two, and Richardson asked Linton to join him in practice upon the completion of his residency. But it was not to be. In August 1930, just 3 months before the end of his residency, Dr. Richardson suffered a severe stroke. Linton went on to complete his residency, but no longer was his future at the MGH assured. Edward Churchill was appointed Richardson's successor as Chief of the West Surgical Service. Churchill recognized that the young Linton was headed primarily for a clinical career, which did not fit in well with his plans for a full-time research oriented teaching service. However, he could hardly exclude the recent graduate and protégé of his predecessor altogether and he offered Linton a position on the surgical staff, with a special assignment to pediatric surgery (a nonexistent specialty at the time) and office space in the basement of the Bullfinch Building. Churchill was probably surprised that Linton accepted the offer.

Arthur Allen was at the peak of his surgical career at the time Linton was starting. Linton admired Allen's surgical dexterity and his almost fanatical devotion to his patients. In 1928 Allen was appointed Chief of the Peripheral Vascular Clinic, the first of its kind in the country. Allen asked Linton to join the staff of the clinic in 1931, which already included Leland McKittrick, James C. White, Henry Faxon and Linton's contemporary, Reginald Smithwick. Competition for surgical cases was intense and it was traditionally difficult for a young surgeon to establish his practice. But Linton was an opportunist and he looked for an area in which to build his reputation that was not of interest to others. Over the next 10 years he devoted himself to the study and treatment of venous disease. Surgical stripping of varicose veins had fallen into disfavor because of frequent streptococcal wound infections. By using meticulous aseptic technique, Linton was able to avoid wound infections that had plagued other surgeons and establish the safety of vein stripping. He studied the posthrombotic syndrome and ulceration. Based on cadaver dissections he demonstrated numerous communicating veins between the deep and superficial venous systems. He was the first to recognize that valvular insufficiency was more important than venous obstruction in causing the post-thrombotic syndrome and was the first to recommend ligation of communicating veins to promote healing of postphlebitic ulcers.

Portosystemic shunt operations appealed to Linton because they seemed to be a physiologically sound means to lower portal hypertension to prevent variceal bleeding. He performed his first splenorenal shunt in 1946, using the operation described by Whipple and Blakemore. He soon modified the procedure, by perform-

(Linton continued on next page 3)

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ing the venous anastomosis between the end of the splenic vein and the side of the left renal vein, thereby preserving the kidney. Further refinements included better exposure with a throracoabdominal incision and hypotensive spinal anesthesia to reduce blood loss. Although Linton was not the first to perform portosystemic shunts, his contribution, which became his trademark, was the refinement, perfection and popularization of procedures initially described by others.

By 1940 Linton's reputation as a vascular surgeon was established. He had become busy clinically and was a popular teacher among the house staff. In contrast to other attending surgeons of comparable age and stature, he always insisted that they call him "Bob". World War II presented a great opportunity for Linton. A number of MGH surgeons, including Churchill, left the MGH for service in Europe. Arthur Allen's career was prematurely ended by lymphoma, and Leland McKittrick succeeded him as Chief of the Peripheral Vascular Clinic. Linton was exempted from military service because of bronchial asthma, and consequently he and Reginald Smithwick were largely left on their own to run the Vascular Clinic. They were intense rivals, often arguing over trivial differences of opinion at Thursday morning vascular rounds, much to the amusement of the house staff. Linton envied Smithwicks' domination of sympathectomy for treatment of hypertension. As a consequence, Linton was forced to explore reconstructive vascular surgery, which was still in its infancy. In the long run, this would work very much to his advantage.

When the MGH surgeons returned from World War II, Linton was named to succeed McKittrick as chief of the Peripheral Vascular Clinic. In 1946 Irad Hardy, who had competed his training a few years earlier at the MGH, joined Linton. Although he did not have the designation "fellow" he was clearly a trainee. It was the beginning of postgraduate training in vascular surgery at the MGH, which has continued to the present time. Linton was convinced of the value of postgraduate training in vascular surgery long before the American Board of Surgery struggled with the issue.

In 1950, Linton performed the first autogenous vein graft at the MGH for a patient with a popliteal artery aneurysm. Four years later he performed the first reversed saphenous vein bypass for occlusion of the superficial femoral artery. Linton and his assistant, R.C. Darling presented their experience of 295 femoropopliteal vein grafts to the Society for Vascular Surgery in 1967. The cumulative patency at 5 years was 73%. Their publication established the durability of the saphenous vein graft. More than any other, the femoropopliteal bypass was Linton's operation. The outcome was directly related to the care and patience with which the procedure was performed. Linton had infinite patience. It was not unusual for him to redo an anastomosis two or even three times until he was completely satisfied. This insistence on perfection had a profound effect on a generation of house officers and fellows who assisted him.

I had the privilege of working with Dr. Linton toward the end of his career. I was amazed that he would tackle difficult re-do operations lasting 8 hours or more that made even the younger surgeons cringe. I recall that Dr. Linton always referred to the inferior vena cava as "Mr. Blue". After hearing this moniker several times, I finally asked him, "Dr. Linton, why do you call the IVC Mr. Blue?" He replied in his characteristic raspy voice, and a twinkle in his eye, "Because I respect him so much, my boy!"

Linton's reputation attracted many famous patients. On one occasion, he was treating Bob Hope's brother. Bob Hope came to visit his brother and joined Linton at his office, and they went together to the hospital and rode up in the elevator (Remember Linton's alopecia). After they got off the elevator, Linton overheard a nurse exclaim to a friend, "Guess what? I just rode up in the elevator with Bob Hope and Yul Brynner!"

Linton's greatest academic achievement was his atlas of vascular surgery. After nearly 20 years in preparation the atlas was finished just in time for the American College of Surgeons meeting in October 1973. It was a monumental achievement, best summarized by Richard Warren: "It is as if Michelangelo in his 70s had written a book on how to paint. Of all the great lights in the renaissance of vascular surgery of the last 25 years, in the eyes of a large number of people, his have shown the brightest."

The conclusion of his career came the day before Labor Day, 1974, when he and his wife were severely injured in an automobile accident on the Maine Turnpike returning from his summer retreat on Isle au Haut. They were subsequently transferred to the MGH, where Bob underwent a splenectomy, small bowel resection and, reduction of fractures. His recovery was complicated by respiratory failure requiring tracheotomy and prolonged mechanical ventilation. But the Linton spirit was indomitable and he slowly recovered. Eight months after the accident, Bob had recovered sufficiently that he was able to see an occasional patient in his office, but he would never again operate. His health slowly declined and he died in 1979. The following year, Emma Linton presented a gavel to the New England Society for Vascular Surgery, which had been made from the broken oar of a dinghy that her husband had used to row out to the mooring of his sailboat, the Antiquary. She continued to live in their house on Berkeley Street for a few years and then moved into elderly housing in Cambridge, where she died in 1984.

In 1976, W. Gerald Austen asked Linton for permission to establish an endowment in his name to be used to sponsor research and postgraduate training in vascular surgery. The Linton Fellowship was formally dedicated in June 1981and has continued to the present time Linton's four daughters donated a conference room in his name in the Bigelow building in 1990. His portrait hangs in the room, painted from a photograph showing Linton, in a typical pose, draped over an orthopedic frame at the foot of a patient's bed. (See figure) The photograph was taken by one of his patients, on a Sunday morning when Linton typically made leisurely rounds, taking extra time to reassure an anxious or discouraged patient.

Linton's career of more than 40 years spanned the full evolution of reconstructive vascular surgery. In a rapidly developing field, he had taken advantage of the opportunities to contribute to the understanding of venous disease, the treatment of portal

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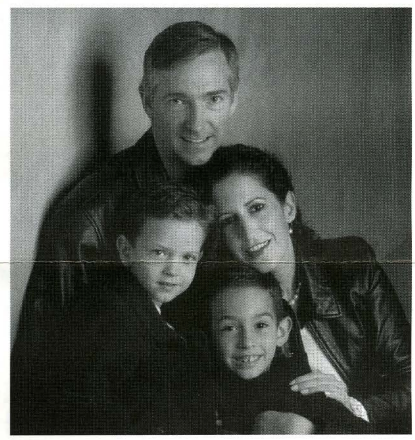
A DIFFERENT TRACK
By Peter S. Hedberg

"Well knock me down and steal my teeth" is what might have been overheard when I told my employees that I had won the Oweida Scholarship for my work as a rural surgeon. Colorful is certainly a way of describing the verbiage of many of our Sooner friends in this southern portion of the heartland. Yes, things are quite different in Oklahoma from our hometowns in Massachusetts (aka Mazzatushitts). Culture shock was a common phrase used when locals spoke with my wife, Leslie. But the experience has far exceeded our expectations and Les' longevity as an Oklahoman has far outlived my predictions.

I don't believe I could describe my professional experience in Durant any better than by reproducing part of the American College of Surgeon's 2003 Oweida Scholarship application essay. This says much of what is positive here professionally, but unfortunately skips the humor that my wife and I get such a kick out of. Thus, the following is an accurate, although somewhat dry account of our experience in Oklahoma. My own interest and love for rural surgery has grown stronger with time, and I have found it to be both exciting and fulfilling.

Seven years ago, my wife Leslie and I, both from Boston, endeavoring to find a different pace, type of surgical practice and rearing environment, set out for Durant, Oklahoma. This town of 12,000 residents is in the southeastern portion of the state; statistically the state's most economically challenged region. I filled an opening for a general and vascular surgeon here, although neither of us had any ties to Oklahoma. But my training in Boston gave me the knowledge and ability to perform general, vascular and general thoracic surgery in this small town. My goal was, and still is, to bring the best possible care to the residents of this small community.

Now after seven years of 24/7 call and well over 800 cases per year, it is certainly a different pace from what we were initially seeking, albeit the rewards are much greater than we expected. One of my earliest revelations upon beginning this practice was how much difference one could make in so many patients' lives by doing things I considered straightforward and routine. For example, prior to my arrival, many patients would have to travel 150 miles to Oklahoma City for a bronchoscopy or femoral-popliteal bypass graft. The burden of travel, especially for the elderly, can not be overstated, and frequently leads to the failure to receive needed care. I have also been able to provide services here that have not been available even at greater distances. I have had the unique opportunity as a rural surgeon to be involved with a fulfilling research study. In 2000 I was invited to assist with the FDA approval trial of the MammoSite device for delivering brachytherapy to post-lumpectomy breast cancer patients. During the ensuing two years I was deeply involved with the clinical study, leading to FDA approval of the device in May 2002. I was one of the first surgeons in the country to implant the device, and have continued to be active with the program, now assisting with training courses across the country. This device has caused an explosion of interest in breast brachytherapy as it allows



post-lumpectomy radiation to be delivered over only five days. Most important, it has a unique place in a rural setting, allowing some patients the option of breast conservation therapy, whereas if they had to choose between a six week course of radiation and a mastectomy, they might be compelled to choose mastectomy due to travel distance to the radiation facility. Remarkably, I have also had patients come to Durant for this surgery from urban areas, as far away as Dallas. In addition to the MammoSite, I have provided other services previously unavailable to local patients, such as the first hand-assisted laparoscopic splenectomy in the State of Oklahoma.

Trauma is a part of rural surgery that can not be referred electively to the cities. I have been active in the State's Trauma Advisory Council as one of the five regional chairpersons, developing a regional trauma system to work with the state's system. In addition, I serve as the Medical Director for the county Ambulance Service and city Fire Department. This is an area where efforts result in specific improvements in local healthcare that might not occur otherwise.

From the Massachusetts General Hospital to the Medical Center of Southeastern Oklahoma is certainly a path less traveled, but I am sure that I am, and my wife, children, and patients here are all better for it. Many older and retired urban colleagues have heard my stories and have commented that were they able to do it all over again, they would love the opportunity to do what I do, and truly make a difference to others. Most realize that if they had not been there for their patients, someone else would have usually taken over. That is often not the case here.

Staying involved with progress in surgery is critical to the satisfaction and continuing success of my goal to bring excellent medicine to this small town. One of the only significant detriments to a rural practice is the limited access to colleagues, continuing education and surgical fellowship. The Oweida Scholarship allows me to more comfortably continue my quest to maintain my knowledge and skills at the highest level, while spending valuable irreplaceable time with fellow surgeons.

Just over an hour from the suburbs of Dallas, Durant is less remote than many locales that might qualify one as a rural surgeon. Our two young boys are in schools that do not have gangs or major drug problems. The cost of living makes a good income even more comfortable. We have become quite happy living in this town that many wouldn't even notice passing through on the state highway (60 miles from the nearest interstate). Hunting, fishing and other outdoor activities (except snow shoveling) are in abundance.

Our vacations are frequently spent on the South Shore (Boston's) where the kids' grandparents and many cousins still live, and where we now have a near-the-beach cottage (available for rent!) We will likely not be here forever, but for the time being it has become a good home and a very good place to work. The people here are not only friendly, but also enormously appreciative of the service I provide. All things considered (business, family, time-to-retirement, etc.), I can hardly imagine a more satisfying professional experience.

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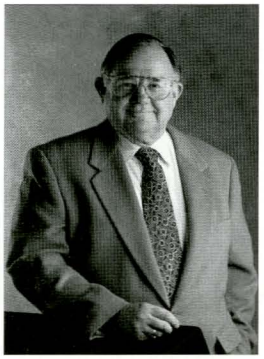
MGH AND MY OBSTETRICAL AND GYNECOLOGICAL CAREER

By John W. Grover



My professional connections with the Massachusetts General Hospital long preceded my Surgical Residency. In 1950-51, when I was a junior at Harvard College, I majored in Biochemical Sciences, and did a laboratory thesis on amino acids at the Huntington Research Laboratories. Dr. Joseph C. Aub was the Director of the Labs, and was a pioneer researcher on the pathological effects of Lead. Dr. Aub taught me by example that a good doctor cared for the whole person, not just the disease. I got my bachelor's degree *cum laude*, but my research was quickly relegated to the "Interesting, But Useless" file.

In medical school, I continued research at the Huntington, under the direction of Dr. Nancy L. R. Bucher, a microbiologist. I remember pleasant summer parties at Nancy's lovely home in Weston, and think of it every time I drive through the Tollbooths at the intersection of the Massachusetts Turnpike and Route 128 (now 95). That's exactly where her home was, and she was forced to give it up to progress. My research thesis helped me to qualify for an M.D. cum laude from HMS, and made me competitive in the first national use of the internship-matching plan in 1956. I was matched with the MGH in Surgery!

I first met Dr. Oliver Cope when I was at Harvard College, befriended by him during one of his seminars for pre-medical students. He became my advisor while I was at HMS, leading me to my eventual choice of a surgical residency as a basis for a career in Obstetrics and Gynecology. Drs. Aub and Cope were very good friends, related, I think, by marriage.

Coming out of HMS, I was fortunate to be awarded a Josiah Macy, Jr. Fellowship in OB-GYN, which helped to fund my postgraduate training. Ken Ryan, Red Lewis and Art Herbst also were Macy fellows.

I completed three years of surgical residency, working with and befriending many surgeons who would be important in my future. My most memorable surgical patient was a 42-year-old laborer admitted to the ER for anterior chest pain. He suddenly arrested with a flat ECG, and became unresponsive. I quickly began open cardiac massage (closed massage was not then in vogue). He quickly responded in a minute or two, and screamed, "God-dammit, Doc, get your hand out of my chest!"

One of my fellow residents was George Murphy. George was quite outspoken and flamboyant, an interesting foil to my then compulsively controlled personality. We became good friends, and Philippa and I eventually bought the tiny Murphy home in Watertown, along with their Siamese cat, Kije, whose vocal cords George had cut. George taught me his secret of how to get along with nurses, but it would be politically incorrect to quote him now. Suffice to say, I learned to treat nurses as real human beings, equally involved with me in the complex task of bringing healing skills to patients.

Clem Hiebert preceded me in a year of research in Cambridge, England. Dr. Honor Bridget Fell, our supervisor properly initiated us in the art of doing effective fundamental research on a shoestring.

I stayed in England for two years with USPHS support, studying basic aspects of embryogenesis. But more important to me in the long run than research was my participation in choral music in the Cambridge University setting; my love affair with music has lasted the rest of my life, whereas research-well, I've already mentioned the "Interesting, But Useless" file.

I returned from England in 1961 to begin my OB-GYN residency. I well remember my first experience in repairing an episiotomy at the BLI with a senior obstetrical resident supervising me. "The last time I sat in this position," I said innocently, "I was performing a combined abdominal-perineal resection." The senior OB resident quickly pushed me aside, saying, "Here, you'd better let me show you how to do this."

During my first year at the BLI, scopolamine and narcotics were used to manage labor pains, and "open-drop" ether anesthesia was used for delivery. This was rather dangerous, and rendered the mother irrational during labor, and amnestic for the birth experience. Maternal-fetal "bonding" was minimal. One night when I was on delivery duty, a multipara in early labor, a resident's wife, asked if I would allow her to labor without "Twilight Sleep". She used repetitive breathing and relaxation to manage her discomfort without narcotics during labor, and I was amazed. She was exhilarated at the experience and immensely proud of herself and her wonderful new baby. No bonding problems here, I thought.

As a result of that experience, I favored "natural childbirth" for my patients to manage the pain of labor and delivery. By the time I finished residency, I was an ardent advocate. This approach preserved the mother's perceptions, and did not depress the baby with medication, nor negatively impact maternal-fetal bonding.

On completion of OB-GYN residency, I rejoined many of my friends and colleagues in the Department of Gynecology in the Vincent Memorial under Howard Ulfelder, and delivered babies at the BLI. I was the first OB-GYN trained surgeon to be appointed to the MGH staff since the late 1940's. Dr. Jack Burke, still an active member of the MGH staff, states that he delivered the last MGH baby in the Phillips House late one night while the obstetrician was on his way to the MGH.

With Dr. Ulfelder's support, I opened an MGH clinic for patients from the North End who wished to have prenatal care at the MGH, with delivery at the BLI. I also cared for patients at the new "Bunker Hill" satellite health center in Charlestown. Several OB-GYNs joined the staff with me, including Arthur Herbst, Anne Barnes, and Larry Malone.

I continued my research interests, with a tissue-culture lab in the Vincent Memorial. Shortly after I settled in, Dr. Ulfelder asked if I would be interested in following another line of clinical research. He, along with Bob Scully and several others had clues that the pre-natal use of diethylstilbestrol to support problem pregnancies (then a therapy in vogue) might increase the risk of vaginal cancers in female offspring. But I was at heart an obstetrician, and declined. A year later, he made the same offer to Arthur Herbst as he joined the GYN staff, and the rest is history!

Once, a young female patient was admitted to the medical service after suffering a severe stroke, and remained unresponsive for weeks. When it was discovered that she was pregnant and beyond 20 weeks of gestation, they elected to care for her until delivery in the Baker Memorial. I followed her through a rocky clinical course, but the

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MARSHALL K. BARTLETT
By Edwin L. Carter, M.D.

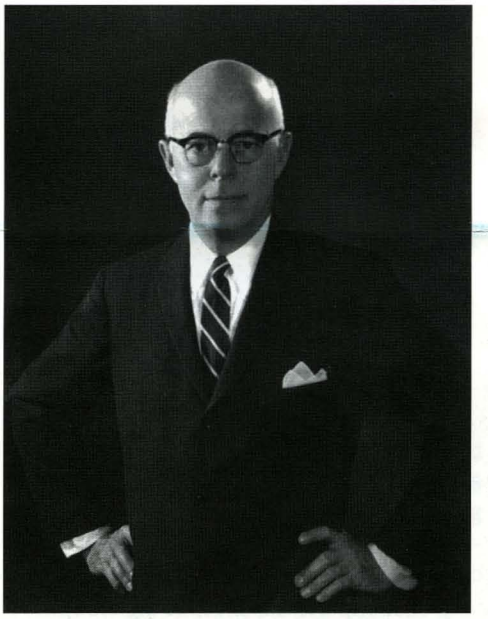
Marshall K. Bartlett M.D. was appointed to the surgical staff of the MGH in 1932 and was to serve the hospital over the next six decades. It was not customary in the 30's to maintain offices within the hospital and he joined the Back Bay practice of two well-known surgeons of the day, Dr. Richard Miller and Dr. Horatio Rogers. Having spent several years in training at the Free Hospital for Women, he had a keen interest in gynecology as well as general surgery and was appointed Consulting Surgeon at the Free Hospital in 1933.

World War II interrupted the growth of his surgical practice when he volunteered for military service and was assigned to the Sixth General Hospital. His overseas duty was spent in Italy in association with numerous other MGH physicians. In 1945 he was named the Acting Commander of the Sixth General Hospital. While in Rome his colleague Dr. Claude Welch developed acute appendicitis and he requested that Dr. Bartlett carry out the necessary surgery. Following an uneventful recovery it is reported that Dr. Welch expressed his gratitude for the job well done but said he did have one question – why was the incision in the shape of a B?

The war experience brought the MGH internists and surgeons much closer together than ever before. The ready availability of consultation and advice between them in the army engendered a strong wish to continue a similar approach after returning to Boston. This desire was instrumental in the development of the MGH Staff Associates and subsequent election of Bartlett as chairman. The organization combined the principles of individual practice with the advantages of group activities.

He became a member of the faculty of Harvard Medical School in 1946. The late 40's and early 50's brought affiliations with outside hospitals in Gardner, Leominster, Brattleboro, and locally the Faulkner, where he served as Chief of the Surgical Service from 1948 to 1955. He had a dual interest in clinical surgery and group practice issues. In 1953 he laid the foundation for the MGH Surgical Associates, which was subsequently to play a major role in enhancing the surgical staff relationships with one another and with the Department of Surgery. In addition to being a unifying force in surgery it was to become the model for all the other departmental groups at the MGH.

With the opening of the Warren Building in 1956, Bartlett, along with many internists and surgeons, moved his practice full time to the hospital. He developed a keen interest in diseases of the pancreas and was stimulated by the work being done in New York by Dr. Allen Whipple on pancreatic ductal pathology. He expanded on the concept of ductal obstruction as a cause of chronic pancreatitis and introduced the procedure of pancreatic duct exploration to the MGH in the 1950's. HMS recognized his outstanding contributions in 1964 with promotion to Clinical Professor. His peers in surgery further honored him when he was elected to and subsequently became president of the Boston Surgical Society, the New England Surgical Society and the Excelsior Surgical Society. He was Vice-Chairman of the American Board of Surgery, a Fellow of the American College of Surgeons and a member of the American Surgical Association.



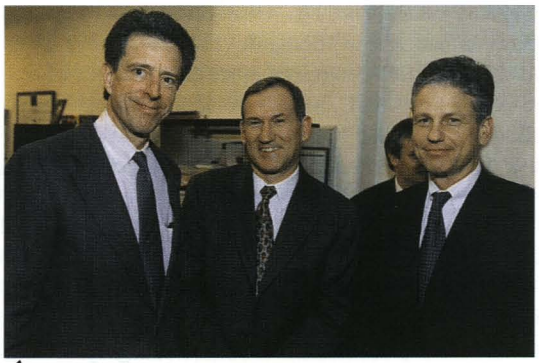
Dr. Gerald Austen, past Chief of Surgery, writes "I was always impressed by his superb clinical judgment, outstanding technical skills and great sensitivity and kindness to patients. When I became Chief of Surgery in 1969 and through my tenure in that role, Marsh was one of my closest advisors. He along with Claude Welch had started the group practice called the Surgical Associates and I was interested in further developing the concept to encompass all of the members of the Department of Surgery. In 1973 he was enticed to become Administrative Director of the Operating Rooms, a change from the previous arrangement in which the Nursing Department ran the OR's. Marsh did an incredible job of bringing diverse groups together to make the operating rooms function in a more effective and efficient way. In addition, very importantly, he became fascinated with the new concept of having a separate ambulatory care center area – this ultimately resulted in the present extraordinarily successful Same Day Surgery Unit with 10 operating rooms in the Wang building. In recognition of Marsh's many contributions to surgery in general and to the MGH in particular, the Marshall K. Bartlett Fellowship was created to support surgical residents during their one or two year research experience midway through their surgical residency."

In addition to his legions of grateful and devoted patients he enjoys the admiration and gratitude of innumerable surgeons throughout the country, having acted as mentor and advisor during their years of surgical residency. Dr. Leslie Ottinger, past Director of the Surgical Residency Program, recalls "For over three decades Marshall Bartlett's professional skills and personal qualities made him, for many, the most admired general surgeon on staff. He and his peerless scrub nurse, Ginny Wyman, always made the residents an integral part of the operating team. In this relaxed, yet precise setting, questions were welcomed and explanations freely volunteered. Residents were given a major responsibility in evaluating and managing patients on the floor and their ideas and opinions were carefully solicited and considered. He was an excellent visit, cautious, thorough, and supportive and a mainstay of G.I. Rounds. In all this, his seasoned knowledge, willingness to consider new and different approaches, and genuine interest in his patients and their welfare, made him, for many residents and junior staff members, the perfect example of what the modern surgeon could be."

Dr. Michael Margolies recalls his friend and teacher – "His written notes and consultations in the medical record were models of clarity and economy, with a clear focus on the nature of the problem at hand and the appropriate surgical treatment. There was a blessed absence of abbreviations, jargon and complex formats that sully the contemporary medical record. He exhibited the same approach in the conduct of operative surgery: graceful technique, few wasted motions, apparently unhurried, yet remarkably efficient. The discipline, which governed both his written work and operating room performance, was reflected in a most personable manner in the clinic,

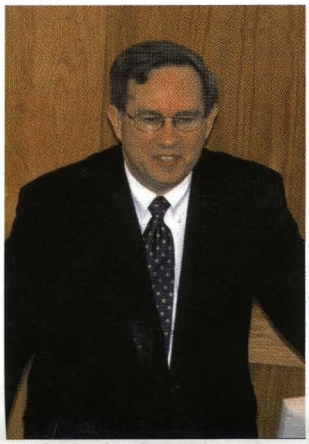
(Bartlett continued on page 10)

MGH ALUMNI EVENTS OF NOTE



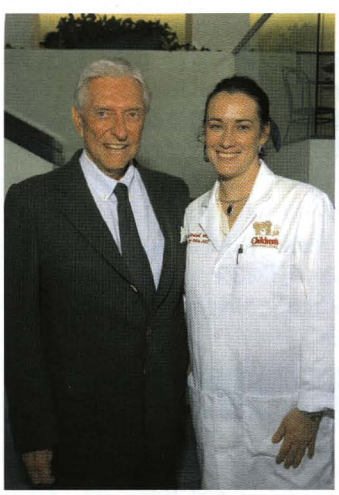
↑***Russell Ryan, Bob Shamberger*** and ***Jay Vacanti*** at a recent Richardson Tea.

↑The Boston IMSuRT Team led by ***Susie Briggs*** and including MGH surgeons ***Dave Lawlor***, ***Tom MacGillivray*** and ***Jay Schnitzer*** takes one last photo before departing Iran. The team was activated on December 26th in response to the Bam earthquake. During their four day stay the team provided triage, initial stabilization, and definitive care to 727 people.



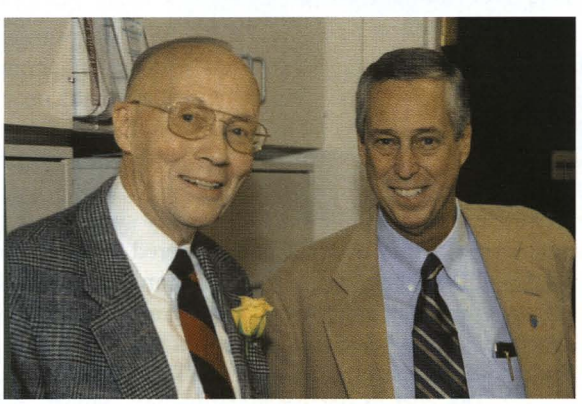
←The MGH Dept of Surgery welcomed ***Tom Dodson*** home to deliver his lecture, "Before the gates of excellence, the high gods have placed sweat" –Hesiod at Grand Rounds on February 19, 2004.

- ***John F. Burke*** received the International Surgical Society/Societe International de Chirurgie prize in 2003 in recognition of his work which has made the most notable and useful contribution to surgical science and in admiration of his efforts in educating young surgeons in clinical surgery and research.
- The ***M. Judah Folkman*** Professorship of Vascular Biology at HMS has been funded through a gift from Children's Hospital. Folkman is particularly recognized for his pioneering studies of angiogenesis.
- In April 2003, ***Hermes C. Grillo*** received the Henry Jacob Bigelow Award presented by the Boston Surgical Society for contributions to the advancement of surgery.
- ***Hermes C. Grillo's*** book, **Surgery of the TRACHEA and Bronchi** has been published by BC Decker Inc., London., 2004.
- ***Robert C. Shamberger*** has been appointed chief of surgery and surgeon-in-chief at Children's Hospital. He also becomes the Robert E. Gross professor of surgery
- ***Harold C. Urschel*** has been named the Chair of Cardiovascular and Thoracic Surgical Research, Education, and Clinical Excellence at the Baylor University Medical Center in Dallas.



↑ The Children's National Medical Center in Washington, D.C. has established the ***Judson G. Randolph*** Fellowship in Pediatric Surgery with more than a million dollar endowment honoring Jud for founding its pediatric surgery training program in 1964, and for his continued commitment to pediatric health care and education. Jud is pictured above with the 2004-2005 fellow, ***Dr. Danielle Saunders Walsh***, MGH '01.

→ ***Ed Carter*** and ***Andy Warshaw***, Ether Day, October, 2003 celebrating 50 and 40 years of service respectively to the MGH. Other notable anniversaries were ***Grant Rodkey*** and ***Frank Wheelock*** (60), ***John Constable*** (50), ***Mort Buckley***, ***Will Daggett*** and ***Tony Patton*** (45), ***Greg Gallico*** and ***Dave MacLaughlin*** (30) and ***Dave Rattner*** (25).



LETTERS TO THE EDITOR

Dear Editors:

In the Summer '03 issue of this newsletter, our President, Les Ottinger lamented the institution of duty hour limitation and called it "another unfortunate and misguided regulation." Dr. Ottinger claims that the movement to limit work hours is attributable to a belief that residents were, by tradition, abused by their residency programs. While some indeed may believe that such abuse occurred, I would argue that the reason for work hour limitation is based more on a concern for patient safety than on resident lifestyle.

In 1999, the Institute of Medicine presented a report; To Err is Human, claiming that 100,000 lives are lost each year in this country due to medical mistakes. This added fuel to the smoldering issue that was initially brought to public awareness by the famous Libby Zion case from New York in 1986 and a Dana Farber Cancer Center medication error incident of 1994. Since that time, a movement to increase patient safety has grown in public awareness and, by default, in government. Concern over resident working hours are an obvious offshoot of this increasing awareness and concern for patient safety and one might argue that it would be an educational issue now even in the absence of governmental intervention.

Dr. Ottinger points out that the resident work hour issue has been likened to that of regulating airline pilot work hours. This is clearly true although his claim that there is little similarity between the requirements for delivering surgical care and those of flying a commercial passenger claim is less valid. Both jobs require extensive training and experience; both require attention to detail; both require the ability to handle the unexpected - correctly and with one attempt, and both are associated with a high cost of failure -- death of a patient in the case of a surgeon or death of many passengers (including the pilot himself) in the case of airline pilots.

Numerous studies have indicated decreased attentiveness, impaired decision making and impaired performance of physical tasks in fatigued individuals. While few, if any, of these are done specifically in surgical residents, I see no reason to believe that a career choice would make such individuals immune to the physical effects of fatigue.

Lastly, the American College of Surgeons has studied the career choices and decisions of medical students and there is a clear picture that younger physicians have a different set of values than those of years gone by. Lifestyle has increased in importance in career choices and surgical residencies are being forced to adapt in order to attract the "best and brightest". While no surgical training programs want to accept candidates who are not committed to careers in surgery, the old style "every other night on call" approach would, under current expectations, fail to attract many individuals who could become (and currently are) valuable contributors to the surgical community.

I expect that the pendulum may eventually swing back to a less rigorous determination of what is considered to be an excessive workload and that there may be a bit more flexibility in work hours. Issues such as continuity of care, gradation of responsibility, structure of the educational environment, and the ratio of "service" work to "educational" work will continue to be debated and refined. The cost of postgraduate medical education (to both the government and hospital) and opportunity cost (to the resident) will come under increasing scrutiny as all three interests strive to get the most from their respective invested dollars. The aphorism that, "change is constant" must be accepted by the community of surgical educators. Dr. Ottinger points out that residency programs, as we know them, developed largely after World War II and that the best programs were the product of devoted and gifted chairmen and leaders. Many things have changed since then and the best programs -- particularly if they wish to remain the best -- must adapt as much, if not more than the others. They cannot be left at the trailing edge of incontrovertible cultural and demographic trends yet they must remain true to the missions of providing both quality education and quality patient care.

Richard I. Whyte, M.D.
Professor and Head, Division of Thoracic Surgery
Medical Director of Operating Rooms
Stanford University Medical Center

To the Editors:

I've enjoyed reading the Massachusetts General Hospital Surgical Society Newsletter, dated Summer 2003, especially the article by Brad Cannon on Plastic and Reconstructive Surgery at the MGH. It brought back many wonderful personal and professional experiences. Just yesterday Brad and I spent several hours with Countway Library archivist Peter Rawson reviewing and editing a symposium on Military Plastic Surgery presented at Johns Hopkins last spring. It was chaired by Dr. Robert Goldwyn with Dr. Milt Edgerton, Brad and myself as panelists.

Although oriented to the Brigham/Children's since my first day at Medical School in 1940, I took many courses at MGH. Dr. Joe Meigs had been my faculty advisor for my Boylston Society presentation on the then new Pap Smear. Surgery under Chief Resident Franny Moore in the summer of 1943 introduced me to Gordie Scannell, Tom Gephardt, and Addison Brenizer among others. Drs. Sweet and Allen impressed me with their friendly attitude; operating with them was a thrill. But because of Dr. Elliot Cutler's influence I selected the Brigham/Children's area for my internship.

It's been a privilege to be part of the MGH surgical family. Thanks for a superb publication.

Joseph E. Murray, M.D. (Emeritus)
Professor of Surgery, HMS
Chief of Plastic Surgery, Brigham and
Women's/Children's Hosp

EXCERPTS FROM LETTERS TO DR. WILKINS

"I was really charmed by your article on Dr. Sweet. You brought alive to me the legend of Dr. Sweet that many of us knew from afar during our MGH training years. Not only are you a master surgeon, you are also a master biographer. I was really charmed by your colorful description and anecdotes."

Mark S. Hochberg, Chief Executive Officer
The College of Physicians of Philadelphia

"Your article about our great teacher and friend was just read. You described Sir Richard beautifully and I am glad you were with him until the end. He often felt lonely and his life devotion and joy was really in the OR. You certainly enjoyed assisting him as much as I did. It was a privilege to be across the OR table with him and I have quoted him many times, especially when he put a single tie on the pulmonary artery."

Rudy Herrera

(Warshaw continued from page 1)

ward service, most residents now apologetically forego the opportunity to spend a sixth (optional) year as chief resident. While recognizing and admiring the extraordinary growth and maturation that accrues to the MGH super-chief, potential aspirants have either committed long before to a postgraduate fellowship or feel they cannot in the face of family needs and sometimes crushing debt justify an extra year of training that does not lead to a specific end-point such as an advanced certificate or a job. If we were to try to pre-empt the fellowship recruitment and signings, moving the timing of our choice and offer back from the fourth year to the third year of residency would lead to a three-year step back since most residents spend two years in research or other education between the third and fourth year of clinical training. The challenges to choosing a chief resident in the third year thus include (but, as the lawyers say, are not limited to) assessment of the individual so early in his/her development and possibly a change of mind by either party during the subsequent 4-5 years.

Consequently, we have a dilemma. The faculty, the residents, and the intern applicants value the experience of a ward service – which has depended on a chief resident (junior faculty member) to lead it, support it and make it run. But the supply line of chief residents has become dangerously thin. For the first half of the 2004-2005 academic year, we have a chief resident only because Jennifer Tseng (MGH '03), currently a surgical oncology fellow at MD Anderson Hospital in Houston, has been given accredited leave to return here for 6 months. We will have no chief resident for the following 6 months. We will bridge the gap in this instance through the servitude of a number of faculty surgeons who have indicated their willingness to "put on the white coat" again as surrogate chiefs. This is manifestly a stopgap measure which is highly unlikely to be replicated when those surgeons find out that the chief's job is 24/7, requiring them to forego their own regular practice and academic activities to do it right.

One alternative is to disband the ward service and privatize the patients, as the Brigham did several years ago. Another is to bring in a recent graduate from another program to take the job as chief resident, as was done for the first time ever at Johns Hopkins this year (and will need to be done again there in the coming year). Neither of these choices is acceptable: the importance of gradually increasing, supervised autonomy in the growth of surgical competence is indisputable. The effectiveness of an MGH chief resident has important roots in having grown up in the MGH system and in truly understanding the MGH culture. We must come up with a solution – and I think we have. However, as in any good serial thriller (how many remember "the Perils of Pauline"?), you will have to wait for the answer which is being developed.

Andy Warshaw ♦

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(Linton continued from page 3)

hypertension and was the first to recognize the superiority of the saphenous vein autograft. Of at least equal importance however, was his observation that vascular surgery was an unusually demanding specialty with very limited tolerance for errors in either judgment or technique. He admonished a generation of aspiring vascular surgeons with the remark, "More than anything else, to achieve good results, you must do it right!"

Cutler BS. Robert R. Linton: A legacy of "Doing it right.". J Vasc Surg 1993:19, 951-963.

Fig 1. Patient's view of Robert Linton. A portrait from this photograph hangs in Linton Conference Room.

(Editor's note: Like many of us Bruce Cutler is a disciple of the "Great Bald Eagle". Bruce made Linton the subject of his own presidential address before the New England Society for Vascular Surgery in 1993. His title was "Robert R. Linton, M.D., A Legacy of Doing it Right".

After Bruce graduated from Princeton and Harvard Medical School he took his surgical training at the MGH from 1966 to 1973. There is a two-year hiatus from 1968 to 1970 for military service primarily in action in Vietnam. After finishing at the MGH he took a vascular fellowship with Jesse Thompson in Dallas before going to Worcester in 1974. He has remained there and currently is a professor of surgery and Chief of the Division of Vascular Surgery at the University of Massachusetts Medical Center in Worcester.

Most of Bruce's research work and bibliography are related to peripheral vascular disease, but there is one notable exception. This is a book entitled, "It's All Relative, a Family Cookbook", edited by L.K. Cutler and B.S. Cutler. This turns out to be a family cookbook put together by Kim and Bruce as a wedding present for some family members. Five-hundred copies of the book were privately printed in 1991. It has 350 recipes. Most of those are Kim's, and the rest are by various family members – hence the book's title. None of them are Bruce's. Kim is the family cook. Bruce is the family vascular surgeon.)

ANSWERS TO THE LINTON QUIZ

1. **"GBE", AKA The Great Bald Eagle. "Linto" is also acceptable**
2. **Linen thread which he had visitors bring back from Scotland or Ireland. "Linton" is a fairly common name in Scotland and means "Linen maker"...draw your own conclusions!**
3. **Max Cohen developed superficial phlebitis. Dr. Linton, Caesar Villa his scrub nurse, and the patient came through unscathed!**
4. **With the edge of a Keith needle which he had his scrub nurse sharpen by hand with a whetstone.**
5. **One star because there can only be one star.**
6. **A Bethune bronchial clamp**
7. **He gold plated the handles several years before instrument companies adopted the same practice. Linton had surgery to repair disrupted ligaments in his knee from a skiing accident. When he awoke from anesthesia he found that his fellow had spray-painted his cast gold, just like the handles of his instruments!**
8. **Linton resurrected an old 22' sloop from the Stonington Shipyard in Penobscot Bay, and renamed her "The Antiquary" after his favorite single malt scotch whiskey.**

♦

MGH RECEPTION
Monday, October 11, 2004
6:00 to 8:00 p.m.
New Orleans Hilton

(Hedberg continued from page 4)

(Editor's note: Not many Phillips Exeter Academy graduates end up in Durant, Oklahoma. Peter Hedberg is one doing general, peripheral vascular and general thoracic surgery for a grateful community.

After a Boston birth and graduation from both Exeter and Colby College, Peter received his medical e3ducation at the University of Arizona in Tucson, graduating in 1989. He returned to Boston to take his surgical training at the MGH. In 1994-1995 he was the first chief resident when the East and West were combined into a single general surgical service. He spent a year in Norfolk, Virginia, emphasizing advanced laparoscopic technique before he took a "different track" to Durant, Oklahoma.

There is no perfect location or practice situation. Peter and his family are well aware of the strengths and weaknesses of their medical location. They have emphasized the former by bringing a highly skilled variety of services to a most appreciative community. They have minimized the latter by maintaining their surgical contacts and staying current with surgical innovations. He is a member of the Rural Surgical Subcommittee of the American College of Surgeons Advisory Council for General Surgery. Durant is a better place because the Hedbergs are there.) ♦

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(Bartlett continued from page 6)

with both patients and staff. He exuded warmth, concern, encouragement and calm control. Marshall Kinne Bartlett was an iconic figure who commanded the loyalty and admiration of surgical residents and those young members of the staff who were fortunate to act as his assistants. They inevitably absorbed some of his gentility into their own practices."

In 1982 he retired as Administrative Director of the Operating Rooms and took on the task of Administrator of the Surgical Associates. He continued in this position until 1992, completing 60 years of extraordinary service to the MGH.

Bartlett had recognized that teaching the craft of surgery was a valuable endeavor but was insufficient to fulfill the dimensions of a distinguished department of surgery. This led him to play a major role in changing the surgical service from one of mere apprenticeship to a venue of scholarly pursuit. In 1992 he was appointed Honorary Surgeon at the MGH and that same year the Marshall K. Bartlett Professorship was established at HMS as a testament to his accomplishments. At that time he commented, "This is the highest honor of my clinical career." Dr. Patricia Donahoe, Chief of Pediatric Surgical Services at MGH was named the first incumbent of the Chair and had the following to say – "For all young surgeons at the MGH Dr. Bartlett had the reputation of being a Surgeon's Surgeon, with exacting technique and attentive care to his patients before and after surgery. His meticulous dress and careful speech made one think twice before rounding in scrubs or reverting to slang. He was the epitome of culture. His careful analysis of his patients and his scholarly approach to gallbladder disease, pancreatitis, esophageal reflux, diverticulitis, and host of other surgical challenges made him the prototype of the modern clinical investigator. He was the model of the academic surgeon to which many young surgeons aspired. To carry his name into the future is both a challenge and a privilege. It is my eternal wish that I bring him no shame, but possibly some pride as I carry forward the name of the Marshall K. Bartlett Professor of Surgery."

Marsh died on December 14, 2002 at Beth Israel Deaconess Medical Center in Needham of complications following myocardial infarction, just about a month shy of what would have been his ninety-ninth birthday.

His legacy lives on in the many junior colleagues who will remember him as the ideal model of what every surgeon aspires to be.

(Editor's note: Edwin L. Carter, M.D. grew up in West Virginia, attended the Washington and Jefferson College and graduated from Harvard Medical School in 1953. He then began his surgical training as an intern in surgery at the Massachusetts General Hospital and completed his training in 1960. His surgical training was interrupted by service in the United States Navy as a medical officer. He was appointed to the surgical staff of the MGH, contributing in an outstanding way to the practice of general surgery and teaching. He was a long-time associate of Dr. Marshall Bartlett. Dr. Carter was appointed Visiting Surgeon in 1988 and now continues to contribute as an outstanding teacher and clinician to the Surgical Service as a Senior Surgeon.) ♦

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(Grover continued from page 5)

pregnancy went well. We spoke to her daily, just as if she were conscious. I induced labor and delivered the baby at 36 weeks gestation, with no change in the mother's status. The child acquired a bit of local notoriety as the "Coma Baby." Sadly, the mother died several days later.

Another of my own patients became severely dyspneic in mid-pregnancy. She was discovered to have a heart murmur suggesting an abnormal shunt. But tools were not available then to adequately diagnose her problem, and we carried her to term, with no certain cardiac diagnosis. Following delivery at the BLI, she rapidly went down hill, and I transferred her to the MGH. On the Sunday following her delivery, she asked me not to leave her, as she didn't feel well. Then she gave a sudden gasp, and died in my arms. Autopsy showed that she had a patent ductus arteriosis, and suffered from severe, chronic pulmonary hypertension. Unfortunately, even now most patients with this condition do not survive.

During my MGH years, I authored a book on venereal disease ("VD-The ABC's") aimed at educating young people. I also helped to produce several educational obstetrical films, which emphasized family-centered natural childbirth, and the new "Leboyer" approach to delivery, where the newborn is handled gently, and placed in a calming warm bath shortly after delivery. I helped to write a book about the Leboyer method, called "Gentle Birth."

Because of the archaic laws in Massachusetts related to birth control and abortion in the 1960's and 1970's, I became active publicly, espousing my generally liberal views. I was a member of the Governor's Council on the Status of Women for a year. But I finally gave up much of my public activity and my research in order to focus more on clinical practice, out of financial necessity.

In 1979, I was chosen to become the first full-time chairman of Obstetrics and Gynecology at Lutheran General Hospital in Park Ridge, Illinois, near Chicago. LGH, a young and ambitious community hospital affiliated with the University of Illinois offered me a unique opportunity to develop family-centered, patient oriented maternity. With strong clinical services in place, our hope was to develop a new OB-GYN residency.

Art Herbst had a great deal to do with my being drawn to LGH. By 1979, he already had been Chairman and Head of the Department of Obstetrics and Gynecology at the University of Chicago for several years. Knowing that Art and Lee were doing well in Chicago made it much easier for us to

(Grover continued on page 11)

(Grover continued from page 10)
consider moving to the Midwest

Lutheran General was on the verge of important developments in many areas which would make it one of the premier community-based tertiary teaching hospitals in the country. The challenge for me was to help to bring that about.

As the OB-GYN Chairman at LGH, I had dreams, but no hospital based supporting staff. I found that starting a new program in a community-based hospital in the early 1980's was more difficult than I'd thought. Unlike at MGH, where well-qualified doctors were knocking on the doors to get in, candidates who were able to commit themselves to administrative and educational development were not easily found.

But within a year I had recruited two generalists, a Perinatologist, and a Reproductive Endocrinologist. A GYN Oncologist, though not full-time, would provide clinical oncology services and teaching.

Unfortunately, the Perinatologist turned out to be an egomaniac, who within his first year with us mounted an effort to replace me as Chairman. The next Perinatologist was dismissed within his first year for non-performance.

Our third Perinatologist, a more experienced clinician who wished to move from an inner-city hospital joined us in 1982, and became one of the keystones of our developing full time staff. The Reproductive Endocrinologist rapidly developed his programs, while the Oncologist gave us a great deal of support.

By 1982, the core program was strong enough to warrant an application for a new OB-GYN residency program. With support from the University of Illinois, we submitted our first proposal, patterned after their inner city residency program. Not surprisingly, since new OB-GYN residency approvals were in short supply our proposal was rejected. But the recommendations of the Committee seemed supportive. Our next proposal, more attuned to our own suburban, largely private hospital with a patient centered, family oriented environment, fully staffed with both regular and tertiary specialists committed to teaching did the trick. Our OB-GYN residency was approved in 1983, as one of only two new OB-GYN residencies approved countrywide. We were justifiably proud.

Over the next 15 years our programs grew steadily. Our Perinatal staff expanded, and in combination with an active Neonatology group became one of the most respected high-risk maternity and neonatal programs in the Chicago area.

The endocrinology and infertility section grew as well, and our IVF program opened in the early 1990's. Advanced laparoscopic surgery was introduced, and we were well ahead of the surge of interest in complex minimally invasive outpatient gynecologic surgery.

A hospital-based interdisciplinary Oncology program developed in the early 1990's, giving us a more effective GYN cancer program, working in conjunction with medical oncologists and radiologists. The LGH Cancer Center now is an active referral center and a hotbed of clinical oncological research.

As I neared retirement in 1997, I experienced the most significant negative events in my career at LGH. By 1994, it was apparent that the original community-based GYN Oncologist was endangering some of his patients. As chairman, I led an unsuccessful effort to restrict or remove his hospital privileges. Case-management and outcomes were gathered and presented to the Medical Staff leaders. The Medical Staff, dominated by community-based physicians was too threatened to let a Department Chairman exercise that power.

A year later we provided even more documentation of his unsuitability, but failed again. My credibility as Department Chairman was effectively called into question by the staff at large, even though my attempts to remove a fellow member were justified. I chose to resign as Department Chairman in 1995, in order to extricate myself from this difficult situation. I continued to care for patients until I retired fully on my seventieth birthday on June 21, 1997.

The new Chairman of OB-GYN chosen to replace me lost no time in eliminating the impaired Oncologist, who by that time was clearly seen by everyone as a danger to his patients. C'est la Vie!

One of my most rewarding birth experiences involved a labor one Christmas Eve in the mid-80's. Along with a patient's husband, her mother and father, and both of her In-Laws were in the delivery room. One of the grandfathers-to-be was a clergyman. We all sang Christmas Carols between contractions, and gave out with choruses of "Push! Push! Push!" when her cervix was fully dilated. The baby was born early on Christmas morning, and alertly enjoyed his warm water bath. Some of us felt that we even saw him smile. None of us could escape the symbolism of such a wonderful birth experience on Christians Day.

Is there any wonder that I was an obstetrician above all else in my career? No temporal rewards can possibly exceed the joy that comes with childbirth, and to be a part of it is as addictive as marijuana, alcohol, or the strongest narcotic.

Overall, I feel very positive about my experience as the Chairman of a busy clinical department in a lively and thriving young hospital in suburban Chicago. I know that the programs we developed were important to the hospital, to the people of the area, and to the profession at large. I am pleased that new residents, many now female, fully trained in humane, family centered OB-GYN care continue to graduate from our program.

I am deeply grateful to Harvard and the MGH for their contributions to my training and clinical experiences, which gave me such a happy and productive early career in Boston. For fifteen years as an MGH Staff member, I was the "house obstetrician" to many of the Medical staff and resident's wives. When I return to MGH Surgical Alumni meetings, I am always touched by the now distinguished Surgeons and their wives who seek me out to share pictures and stories about the babies I helped them to bring into the world.

I'm also grateful for the humane attitudes, hunger for knowledge, and commitment to excellence that I absorbed during those years in Boston. These factors helped me immensely when I "metastasized" to the Chicago area.

In retirement, I'm happy to pursue largely non-medical interests that were long buried, obscured by the needs of my professional career. Some of my colleagues remember that I played my trombone in the MGH Lobby every Christmas. And a favored few may even remember the time that I led a largely inebriated "Conga" line around the Churchill's living room during a holiday party!

I've resumed playing my trombone, and belong to a community concert band, and am the "tailgate trombonist" in a Dixieland jazz band based at our retirement community, where age puts no apparent limitations on energy.

Watercolor painting has become a very satisfying hobby for me in the last several years; my talents though long latent probably reflect my years of surgical training. I

(Grover continued on page 12)

MGH DEPARTMENT OF SURGERY
WELCOMES
2004-2005 INTERNS

Zubin Bamboat	*New York University School of Medicine*
Brian Chapin	*Georgetown University School of Medicine*
Scott Damrauer	*Harvard Medical School*
Jonathan Fox	*Harvard Medical School*
Robert Fullick	*University of Texas Medical School at Houston*
Jason Gerrard	*University of Arizona*
Alex Haynes	*Wayne State University School of Medicine*
Rollin Hu	*Harvard Medical School*
John Kwon	*New York Medical College*
Ugwuji Maduekwe	*Harvard Medical School*
Timothy Millington	*Duke University School of Medicine*
Heidi Nakajima	*Harvard Medical School*
Babajide Ogunseinde	*Howard University College of Medicine*
Colleen Sabatini	*Harvard Medical School*
Andrew Scott	*Harvard Medical School*
Tristan Layton Harzell	*Duke University School of Medicine*
Parsia Vagefi	*Yale University School of Medicine*
Gregory Veillette	*University of Connecticut School of Medicine*
Erik Weiss	*Yale University School of Medicine*
Jason Wertheim	*University of Pennsylvania School of Medicine*

AND CONGRATULATES
2004 GRADUATES

Andrew Cameron	*Transplant Fellowship, UCLA*
Cristina Ferrone	*Surgical Oncology Fellowship, MSKCC*
Tracy Grikscheit	*Pediatric Fellowship, Univ of Wash, Seattle*
Amy Lightner	*Laparoscopy Fellowship, Kaiser, San Diego*
Ali Mahtabifard	*Cardiac, Univ of California, Davis*
Abeel Mangi	*Cardiac, Columbia University*
Christopher Morse	*Cardiac, MGH*
Michael Rosen	*Laparoscopic Fellowship, Carolinas Med Ctr*

Sir J. Keith Ross
1927-2003

Members of the MGH Surgical Society note with sadness the passing of Sir J. Keith Ross.

Keith Ross was a leader of the new generation of cardiac surgeons that had taken the drama out of cardiac surgery, and one of the team that performed the first cardiac transplant in Britain. His person series of 100 consecutive homograft aortic valve replacements with only two hospital deaths was, at the time, unrivaled. Then in 1972, to widespread surprise, came the call to leave London to go to Southampton. There he built up a first-rate team, demanded the highest standards, and insisted on a strict audit both of the short-term results and of the quality of life after cardiac surgery. The reputation of his department attracted young surgeons from abroad, in particular 32 consecutive from the MGH, one each 6 months for 16 years. ♦

In Memoriam

James M. Shannon

(Grover continued from page 11)

think fondly of Grantley Taylor, whom I remember as an "old curmudgeon" in his professional life. After his retirement, he became a marvelous and expressive painter, using oil as his medium.

Writing of all varieties has become a primary interest for me. I belong to an active writer's group, and I'm enthusiastic about the writing courses I've taken at the University of Iowa Summer Writing Festival. I'm working on a personal memoir, looking at the influences of World War II on my whole life. I enjoy writing poetry and short stories with medical themes, and have at least one novel simmering in the background. Boston and the MGH are naturally very prominent in the plot.

I look back on my life experiences and my research, clinical and teaching careers in obstetrics and gynecology with a great sense of personal satisfaction. I did accomplish a lot of things I'd hoped to do in the services of the health care of women. Even though there were some setbacks, the successes far outweighed the failures.

I don't think that Joseph Aub, Oliver Cope and Edward Churchill would feel at all disappointed in my professional career. I learned from them, as from Hippocrates, to "First do no harm", but in addition I learned to care for all patients as human beings, and to always strive to do my best in whatever I try to do.

(Editor's note: John W. Grover, M.D. is a native of West Virginia and served in the U.S. Navy at the end of World War II. He graduated from Harvard College and from the Harvard Medical School in 1956. After three years of surgical residency at the MGH, he interrupted his surgical training to spend two years in tissue culture research in Cambridge, England, returning to Harvard as a Josiah Mary Fellow to complete his Obstetrics and Gynecology residency at the Boston Hospital for Women in 1964. He then joined Dr. Howard Ulfelder's Department of Gynecology at the MGH where he reintroduced outpatient services. In 1979, he became Chairman of the Department of Obstetrics and Gynecology at the Lutheran General Hospital in Park Ridge, Illinois. There he developed a tertiary clinical service, an OB-GYN residency and a student teaching program in affiliation with the University of Illinois and the University of Chicago. John not only has made his mark by developing an academic teaching program in Obstetrics and Gynecology in a community hospital setting, but he is also fondly remembered at the MGH for his excellence in surgery, for his trombone and his very good humor.) ♦

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MGH SURGICAL SOCIETY REUNION

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