The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY Newsletter

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MGH Surgical Society
Annual Reception
Monday, October 9, 2006
6:00-8:00 p.m.
Hilton Chicago

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

A MESSAGE FROM THE PRESIDENT

Second Career

In December 1959, Wilder Penfield delivered an address to the Canadian Club of Montreal that he called "The Second Career". Penfield said, "When a man reaches his sixties he should be released from heavy harness, but he should be given the opportunity of starting on a new or modified career. The nature of that career must depend on interest and ability. It should provide greater latitude of living and allow a variable or decreasing amount of physical labor."

Penfield used Sir William Osler as an example of a physician with a second career. Osler was the Chief of Internal Medicine at Pennsylvania and Johns Hopkins from the age of 35 to 55 years. When he retired from active practice at Johns Hopkins he moved to Oxford as the Regius Professor. This was a much slower paced position without the pressure of an active medical practice. Osler continued to make literary and academic contributions as the Regius Professor until his death at 70.

John Collins Warren, who lived a century earlier, is another example of a physician with a second career. When Warren was young he was intolerant of weakness or mistakes in himself or others. He had a positive fear of idleness and avoided reading for entertainment only. He was 68 years old when anesthesia was discovered in 1846. He retired as Professor of Anatomy and Surgery from Harvard the following year. His interests turned more to dissections and fossils. After retiring from all hospital work at 74, he assembled a mastodon skeleton in his basement. It is still on display in the American Museum of Natural History in New York City and is named the Warren Mastodon. He published his classic textbook, "Mastodon Giganteus" in 1852 and remained active with his dissections until his death at 78. His friend Oliver Wendell Holmes said, "During his last several years his professional austerity diminished and his pleasant social qualities found their natural expression."

Both Osler and Warren are good examples of physicians who had outstanding primary careers and continued to make significant contributions to society in their second careers. Each was prepared and possessed the skills to make the transition. They helped society as well as themselves.

Will we do as well with our second careers? It is worth thinking about.

Robb Rutledge♦

A MESSAGE FROM THE CHAIRMAN

Development of Surgical Subspecialty Programs

In the past several decades, surgery has undergone massive changes as a field. The explosion of new knowledge about disease processes, technology to diagnose and treat surgical conditions, and evolution from a technique-based craft to disease-focused disciplines have driven the development of surgical subspecialties which focus more or less narrowly on a subset of disorders that correspond and interact with medical and other non-surgical disciplines. This subspecialty focus, which has potentiated innovation, improvement, and quality, has caught the attention of patients and other consumers and increasingly drives the flow of subspecialty healthcare to defined centers of excellence at academic health institutions. The traditional Divisions of a Department of Surgery find themselves to an increasing degree out of synchronization with the changes in practice and the need for a matrix of providers drawn from a variety of groupings. One result has been unfruitful internal competition in some instances, rather than synergy. Another has been a relative failure to out-pace our regional competitors in growing market share.

The forces for change thus include:

1. Rapid advance in understanding and multidisciplinary management of diseases
2. Evolution of surgical subspecialties
3. Changing structure of graduate medical education toward subspecialty modules
4. Public demand for subspecialty expertise
5. Need to protect and capture market share in an increasingly competitive environment
6. Compelling requirement for effective marketing of our well-kept secrets (skills)

(Warshaw continued on page 6)

Giving Back by Robert Sloane '73

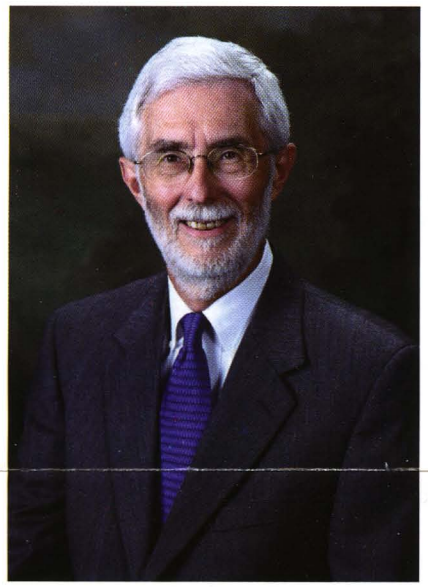
Surgery is a profession that involves giving of one's self and sacrificing personal agendas virtually every day. Friends and family adjust in a multitude of ways to the demands placed on the physician. Despite this life scenario, physicians, for the most part, see themselves as blessed and rewarded rather than abused and underappreciated. The term "giving back" has been used to characterize the desire to support society in the role of volunteer. The following are a few thoughts about volunteer work from a physician perspective.

The surgeon often thinks of volunteering as a retirement endeavor, and one can understand that thought, given the intense work schedule typical of surgical practice. However, the value of volunteering is lifelong, so think about volunteering throughout your career while your skills are at their peak. Skills at volunteering improve with practice, and some crossover skills such as networking may improve your clinical practice.

Family time is precious to any busy surgeon, but volunteering as a family opens opportunities to reinforce family values, perhaps educate family members to the nature of your work, and gain formative time with spouse and children. In addition, it's fun!

A volunteer doesn't need to travel long distances to have an impact. Local projects need assistance in as real a way as third world countries, and may accept it on a more convenient schedule and in ways that your family could more easily participate.

While it is natural to think of volunteering one's surgical talent, don't close your mind to the vast needs that exist in other areas. Forests need replanting and agriculture skills need teaching. Potable water is needed worldwide. Children need tutors in subjects you've mastered. The elderly need companionship when their family is distant or gone. Opportunities are truly unlimited.



As surgeons, we are used to personal problem solving, but there is no need to start by reinventing the wheel or going it alone. Countless volunteer groups exist at every level of endeavor, be it church, school, professional organization, children's home, free clinic, nursing home, city, state, national, or international. All groups need planners and support personnel as well as doers, so every conceivable job is available. Keep in mind that as a surgeon you are accustomed to being in charge, and that it is a very different but important skill to play the part of subordinate. You can join an existing effort and add value to it much more easily than initiating your own effort. The Internet has expanded the ability to locate and join these existing efforts. Benefiting from someone else's learning curve may make it an easier move to your own endeavor at a later time.

Volunteering is often a very humbling experience. Most people report learning more from the group they served than they felt they imparted. Examples of such lessons are discovering that people without material plenty experience joy, understanding that youth can instruct us as we try to cross the generation gap, and experiencing the feeling that comes after spending an hour in conversation with someone so senile that they won't remember you or the conversation shortly afterward. It isn't that these observations about life can only be made in the context of volunteering, but there is often more time to reflect on them in the more relaxed atmosphere that surrounds a volunteer effort.

Volunteering abroad often leads to culture shock, but surprisingly it is often more dramatic upon returning to the U.S.A. than upon entering a third world country. The contrasts are startling and lead many people into considerable reflection on our society, its positives, and its negatives. Once in the third world, our problem solving nature leads us to suggest "obvious" solutions to perceived difficulties, but coming alongside the population being served will be enlightening as to the depth of some problems and can potentially lead to more durable solutions within the restrictions of culture and resources.

It's been written that giving money to a project is more valuable than volunteering time. Especially for work abroad, considerable dollars are spent by volunteers on travel, which instead could be donated to purchase goods and services at the destination. This view overlooks the value of relationships that form and enrich the experience for everyone. Often the personal presence of the volunteer brings love and hope out of proportion to the dollar value of the service. In fact, it's the relationships and partnering that give longevity to the projects, a vital component once you realize that no truly worthwhile task can be accomplished in a single lifetime.

So, if you haven't already, get your feet wet. Give "giving back" a try. You'll never regret it.

(Editor's note: Bob Sloane has a unique surgical practice in Fort Worth. He is the only one that I know who is in the private practice of the 3 T's – trauma, thoracic, and transplant surgery.

He graduated from the University of Michigan in Ann Arbor in 1963, and then from Harvard Medical School in 1968. He took his surgical training at the MGH finishing as the West Resident in 1975. During his training he took a cardiothoracic fellowship at the Baylor University Medical Center in Dallas. This was a factor in his coming to Fort Worth to start private practice in 1975.

Bob believes in "Paying Back" and does volunteer work in Haiti as well as through his church and service organizations here in Fort Worth. He is active in the Texas Medical Association and is the current recipient of the Gold Headed Cane award which is given annually by the Tarrant County Medical Society to a physician who pursues the highest standard of excellent and integrity.)♦

IN MEMORIAM

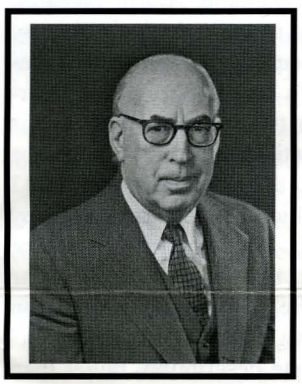
John Head *Charles McCann* *John Pitts*

Gregory Scott *Frank Wheelock*

C. Miller Fisher and the Birth of Extracranial Cerebrovascular Surgery by Ashby C. Moncure "60

(Editor's note: The following is a portion of the presidential address given before the New England Surgical Society on October 7, 2000 in Boston entitled "Tenax Propositi on Uncharted Seas" by Ashby Moncure. It relates the discovery of artherosclerotic carotid bifurcation disease, responsible for 30% of strokes in this country, by C. Miller Fisher, the long-time chief of the stroke service at the MGH. It was published in Archives of Surgery 2001;136:376-382.)

C. Miller Fisher came to the MGH in 1954 to rejoin his mentor, Dr. Raymond Adams, who had been named chief of the Department of Neurology 2 years earlier. Fisher was to become a central figure in its clinical activities when he became the leader of the stroke service. His extraordinary ability to observe and describe clinical phenomena expanded into the second half of the 20th century the tradition of the great physician-pathologists of the past such as Bright, Addison, and Fitz. This enabled Fisher to carefully define the various types of cerebrovascular disease which ultimately allowed a precise diagnosis and the possibility of intervention to favorably affect the clinical outcome.



How did Fisher, who had never lifted a scalpel, become the legitimate father of cerebrovascular surgery? I will relate to you this compelling story of careful observation and common sense superimposed on a background of scientific education.

C. Miller Fisher was born December 5, 1913, in Waterloo, Ontario. After completing medical school at the University of Toronto, he began his training in medicine at the Henry Ford Hospital in Detroit, Michigan. At the onset of World War II, he returned to Canada and was inducted into the Navy in 1940. While serving on a cruiser in the South Atlantic, his vessel was sunk by a German cruiser. He was rescued from the sea and spent 3 ½ years in a prisoner-of-war camp in Germany. He read widely during this time, trading cigarettes for books. He participated in a prisoner exchange in 1944 and resumed his medical career through a refresher course at the Royal Victoria Hospital Montreal, Quebec. During this course, he served on a rotation at the Montreal Neurological Institute and came to the attention of Dr. Wilder Penfield. Dr. Penfield suggested a career in neurology, which Fisher began pursuing in 1946. Dr. Roy Swank suggested to Fisher that he work with Raymond Adams at the Boston City Hospital, Adams being the chief of neuropathology at that institute under the formidable Derek Denny-Brown, Chief of Neurology. Fisher was to work on hypertensive encephalopathy because there was no effective treatment at that time for hypertension other than thoracodorsal sympathectomy, which was performed frequently at MGH by Dr. Reginald Smithwick.

While working in neuropathology at the Boston City Hospital in 1949, Fisher was to find that the correlation between pathologic findings and clinical diagnosis from autopsies in ischemic vascular diseases of the central nervous system was frequently incorrect. In 1950, 70% of ischemic strokes were incorrectly thought to be a consequence of vasospasm, and many were thought to be the result of spontaneous thrombosis of the middle cerebral artery. In one afternoon, Fisher found that 3 of 9 brains examined had large infarcts with no trace of vascular blockage. He formulated the hypothesis that an embolus might undergo lysis spontaneously, leaving behind the evident ischemic injury.

After a year in Boston, Fisher returned to Montreal to work as a neuropathologist at the Montreal General Hospital, the Queen Mary Veterans Administration Hospital, and the Montreal Neurologic Institute. His primary mission was to study the problem of strokes. At the time, patients who had had a stroke generally were not admitted to the hospital because there was no effective treatment. However, the practice of the Montreal General Hospital was to the contrary. Patients with strokes were admitted to the hospital and hence available for study.

In April 1950, Fisher examined an unfortunate veteran who had experienced a severe left hemiplegia 2 ½ years earlier. The patient said that in the weeks before his stroke, he had become temporarily blind in one eye several times. While Fisher was writing his note, the patient commented, "Isn't it funny I went blind in the wrong eye? I am paralyzed on the left side, and I went blind in the right eye." That fragment of history had no special meaning to Fisher and was probably interpreted as a hemianopic phenomenon inaccurately recalled by the patient. One week later, Fisher was to encounter another hemiplegic patient who gave an almost identical story. He said that before his stroke, he was in his favorite tavern and told his friends that he had just gone blind in one eye. They reassured him that everybody had experienced this. "Don't worry, it will be all right in a minute," he was told. And it was. It, too, was on the "wrong side." Fisher began to ask stroke patients about this symptom, and soon another patient gave a similar story. Fisher's interpretation was that the internal carotid artery was involved. At that time, the classic picture of occlusion of the internal carotid artery was a hemiplegia on one side and permanent blindness in the eye on the opposite side, actually a very rare event.

Fisher's initial patient with fleeting blindness in one eye prior to a completed stroke on the contralateral side was found to have carcinoma of the rectum with abdominal metastases, and he died on June 16, 1950. It happened during a weekend, and Fisher was out of town. On returning Sunday evening, he received a message that the patient had died and that there had not been an autopsy. Although it did not come easily to Fisher to make the request, he called the window to see if she would permit a postmortem examination at the funeral parlor. She readily gave permission. Arrangements were made with the funeral director and at 11pm, after visiting hours, he helped Fisher perform a limited autopsy, including the removal of the right carotid artery from the neck. Post-mortem removal of the carotid artery was usually forbidden by undertakers, who depended on it for embalming the head. This was one of the first cases, if not the first, of clinically diagnosed thrombosis of the internal carotid artery in which the artery was removed at autopsy. Fisher incised the internal carotid artery after removal and found obstruction at its origin (the typical site). In addition, this case included the potentially important fact that transient blindness might have provided a clue to the diagnosis before the stroke occurred (C. L. Fisher, M.D., written communication, January 13, 2000).

There had been infrequent ruminations of extracranial carotid occlusive disease in the past, ranging from Hans Chiari's observation in 1905 of the common occurrence of atheromatous disease within the carotid bifurcation, to Egaz Moniz and coworkers report of 4 cases of total carotid occlusion among 537 patients undergoing cervical and intracranial angiography in 1926.

(Moncure continued on page 8)

The West Service and the Reunion of 1962 by Leslie W. Ottinger '60

In 1962, on the afternoon of May 23 at about 2:00 o'clock, the ancient Somerville paddy wagon that doubled as the town ambulance backed up to the Emergency Ward doors. Discharged to the front entry hall was a 12 twelve year old patient. His name was Everett Knowles, and he was to become the subject of what must surely be the most noted of all MGH Ward Service operations. The procedure and subsequent course was described in a paper published in the Journal of the American Medical Association about two years later, the title of which was "Replantation of Severed Arms". The two authors were Ronald Malt and Charles McKhann. Long before this account, though, there was a much more detailed article about the operation in Look Magazine. It was written by Fletcher Knebel of the Look Washington Bureau. The title was "The Boy with the Golden Arm", and the author had, by interviewing all the participants, gathered and reported every available detail of the case.

"Eddy" Knowles had been hitching a ride home from school on a Boston and Main Railroad gravel car. Somehow his right arm struck the stone abutment of an overpass and was completely severed a few inches below the shoulder. The boy gathered himself up, clutching the detached arm in his sleeve, and set off for home on foot. Workmen on the Handy Card and Paper Company loading platform saw and intercepted him and called the Somerville police to take him to the MGH. He arrived about 20 minutes after the accident and was booked in, we are told, by Ferdinand Strauss, the Emergency Ward administrator, and his assistant Mike Hooly; two characters who will be clearly remembered by every EW surgery resident and intern of the period. They apparently quickly sent him to EW Operating Room One, the best equipped of the two small operating rooms off the rear hall. There, he immediately received the attention of two of the nurses, Mary Brambilla and Frances Brahms. They, after cutting off his bloody sleeve, were the first to discover the actual extent of the injury. Next called was L. Henry Edmunds, the senior EW surgical resident that day.

Just by chance, May 23 was a "West day" in the EW. But for this, the East Service, with its Resident, Hal Urschel, rather than the West and Ronald Malt, would have been responsible for Knowles' care, for at the time the two services had responsibility for surgical care in the EW in a day by day rotation.

The East and West teaching services of 1962 had their origin in the first half of the 19th century and were named for the wings of the Bulfinch building. Their evolution into the present single teaching service and the resultant effect on the education and personal lives of surgical residents is a separate and interesting bit of history in itself. In 1962, though, there were two completely separate ward services. The West Service occupied its own floor, the 6th, of the White Building. There, the East and West wings each contained 4 or 5 small wards of four beds each. One wing was for females and one for males. An intern was assigned to each. In addition, the South wing, with 8 or 9 single rooms, was generally used for the sickest patients. There were at that time no intensive care units in the hospital. A few single beds on White 12 could be used for special patients and those who needed strict isolation, and this is where Knowles went after his arm operation.

In addition to the two interns and the Resident, four other surgical house officers were assigned to the West service. Rotations were almost always of two months duration. There were two senior residents, ordinarily in their 5th year, one for the male and one for the female side. For the Knowles case, one of them, John Hermann was to have an important role. Then there was a middle year resident assigned to the clinic and "outfield", with the responsibility of seeing and following consults. In May of 1962, that was Lucian Leape, who also participated in the operation. Last, there was a resident, usually in the second year, with primary responsibility for the plastic and hand patients. All of these residents worked on an "every other night" schedule. The East Service, White 7, was exactly parallel, and there was a well established competition between the services - usually healthy but not always so. In addition, each service had a team of two residents who covered the Emergency Ward with a 24 hours on, 24 hours off schedule. For the West in May of 1962 they were Hank Edmunds in his third year, and Bert Litwin, in his second.

One should note that in 1962 there were as yet no separate services for Plastic, Burn, Vascular, Transplantation, Cardiac, or Thoracic surgery. They were all areas of rapid surgical progress but had not yet become subspecialties. Patients from all were to be found both on the private, the Baker-Phillips House service, and the wards. This was before Medicare and Medicaid and private insurance coverage was fairly spotty, especially for the "working" classes. Economic status was generally the determining factor between being a private or a ward patient. Direct involvement by the visiting staff in the care of ward patients had by 1962 largely diminished to just consulting and teaching. Still, under special circumstances, a visit did occasionally participate in or even perform an operation.

The two services did about the same number of cases each year - a number that was always slightly inflated for purposes of competition. For example, "ward" pediatric cases, while not actually looked after by the ward services, were sometimes included. In Malt's carefully preserved personal records for the West Service, there is a report on its activities for his year as the Resident. During that year there were 1343 operations, of which 25 were performed by the visiting staff. Among those listed for the Resident is the Knowles case. The name given to the operation was "Reunion of amputated arm". Malt chose "reunion" as a more accurate description, rather than the more usual "reimplantation" or "replantation". This will not surprise those of us who knew his passion for accuracy in the use of language. During his year there were 108 deaths, including EW and non-operative deaths, and 81 autopsies, a rate of 75%. Some of the other numbers are of interest considering the present range and frequency of operations on the ward service. There were 71 gastrectomies of one kind or another, with 40 subtotal gastrectomies and 24 hemigastrectomies with vagotomy. There were 106 open cholecystectomies, some combined with other procedures on the bile ducts. There were 28 lung resections, 13 cardiac procedures involving heart valves, 23 thyroidectomies, and 20 aneurysm resections. It is easy to see why the ward rotations, especially at the senior level, were so important in meeting the aim of the surgery program, which was of having every resident finish the five years as a well trained general surgeon

The responsibilities and authority of the Resident, the "Chief Resident", had progressively increased since the years after WW II when Edward Churchill put to-

(Ottinger continued on next page)

gether the modern, rectangular training program. By the 1960's the ward services had become nearly free standing and independent of the visiting staff. Assignment of the Resident was for 12 months. Almost always the job went to a 6th year person who had done research and also had his eye on an academic career. The Resident's job was a big one, with administration and teaching occupying most of his time. As I have noted, the Resident on the West Service from July 1, 1961, to June 30, 1962, was Ronald Malt. This was at about the time of Churchill's retirement, and Malt was probably the last Resident actually selected by Churchill himself. A graduate of Washington University and the Harvard Medical School, he had spent a year as an intern in surgery at the MGH, then two years as a Research Associate at the U.S. Naval School of Aviation Medicine. On returning to the MGH in 1958, he served for 3 years as an Assistant Resident in Surgery and then was given the Resident job on the West Service. The remainder of his surgical career was also to be spent at the MGH.

Each year a ward service came to reflect some of the individual characteristics of its Resident. Thus, many of the distinguishing elements of Malt's subsequent career at the MGH were already well known to residents who served on the West Surgical Service during his tenure as the Resident. As the West junior in the EW, and even after a night on duty, I quickly appreciated the wisdom of beginning rounds in the Over Night Ward in an immaculate pair of whites. The service ran on a precise schedule. There was an extensive and detailed list of standing orders that were used as a pattern by many subsequent Residents, including myself. Organization and precision were stressed and there was one right way to do everything. It was to be sought and applied by everyone from the student nurses to the senior residents. Ron Malt was a person of vast intellect and enormous energy. He was a devoted student of the craft of surgery. One of his colleagues who had been his resident listed as definitive characteristics his knowledge, wit, elegance, honesty and eccentricity. The West Service residents in 1962 came to understand all these well.

The conference in the EW about whether a reattachment of the arm should be attempted soon involved, in addition to Malt and Edmunds, John Head, who was the EW visit that day, and Jack Burke who apparently just happened to stroll by. There was knowledge of previous failed attempts to attach a severed extremity, at least one of these at the MGH. For it and some of the other cases, the results had been disastrous. But Knowles was young and healthy and the wound was relatively clean with little crushing of tissues, and there were no other injuries other than to some fingers on the other hand. The arm was packed in ice as the discussion in the rear hall took place. Malt made the decision to go ahead and began to organize a team to accomplish the operation. This ability of the ward service to bring residents and visits to the operating room quickly to work together was one of the key factors that lead to the successful outcome and could not have been accomplished at that time on the private service.

John Hermann, one of the West senior residents, was dispatched to the White Operating Room with the severed extremity. There he cleaned up the wound, identified the nerves and vessels, and performed an arteriogram. It showed an intact distal arterial system. The patient, Knowles, soon followed where he was taken in hand by Joan Flacke, an Anesthesia Resident, who did the case.

At that time, each Service had the primary use of two White Building operating rooms and a senior scrub nurse for elective cases. Private elective cases were done in the Baker and Phillips House OR suites. Judy Moberly, the regular West scrub nurse, began the case and was replaced sometime during the evening by Theresa Rivoire.

Restoring circulation was the first concern and it was decided to go ahead with this before stabilizing the reattachment by fixation of the bone. Malt had called a visit, Robert Shaw, to help out, no doubt both because of his surgical judgment, greatly respected by the residents, and his experience and skill in suturing vessels. With Malt and Hermann carefully holding the arm in position, Shaw restored the circulation by anastamosis of two brachial venae comitanteses and then the brachial artery. He was the only visit to participate directly in the operation. Now with the arm warm and pink, David Mitchell, an orthopedic resident, addressed the problem of bone fixation. A Kuntschner rod was driven up from the fracture site into the head of the humerous. The fracture was somewhat comminuted, but the distal fragment then could be impacted on the rod. The fixation was tenuous but judged satisfactory. Nerves were tagged for later anastomosis and the soft tissues approximated. Two areas of skin loss were left open to be closed five days later with split thickness grafts, and a dressing and a spica cast applied. Bradford Cannon and, I think William Harris, were among the visits coming to the operating room for consultation at one point or another. Lucian Leape had relieved John Hermann part way through the operation and he then dealt with the injury to the left hand, using full thickness skin grafts from the foot for coverage.

The postoperative course was more or less uncomplicated. Neurolysis and anastomosis of the four nerves were carried out four months later. With an extensive program of rehabilitation and several relatively minor additional surgical procedures, the final result was to be a functional and useful extremity.

Almost overnight the operation, which was thought to be the first reported successful reattachment of an extremity, and the primary surgeon, Ronald Malt, received national and even international notice. True, it was a dramatic achievement, and also the MGH publicity department was, even then, an active enterprise. But there was also another important factor. This was a time of rapid advances in surgery with much interest by the public in new procedures and accomplishments. I think that it was about then that a long article on advances in surgery was published in Time Magazine with a picture of Franny Moore on the cover and under it a quote that was, if I remember correctly, "They can operate if you are lucky". Malt had done an extraordinary job in organizing and directing the operating team and especially in quickly making a series of decisions about what was to be done and when. All the technical elements involved were well studied, but it was putting them together in an effective and timely way that led to the success. The knowledge, decisiveness, energy, and determination that characterized his involvement in the Knowles case were all to contribute to his subsequent long and distinguished academic career.

Of course, in a broader sense, major credit must also be assigned to the Ward teaching service itself. With capable, well trained, and resourceful surgical residents already in the hospital and ready to play any role and make any effort, the ward services were prepared to handle such a complex case as this at a time when the private services were much less able to do so. Due to this, even had Knowles come in the day before or day after, and Hal Urschel and the East taken on his care, or two months later, and then Tony Monaco and the West been responsible, although the details

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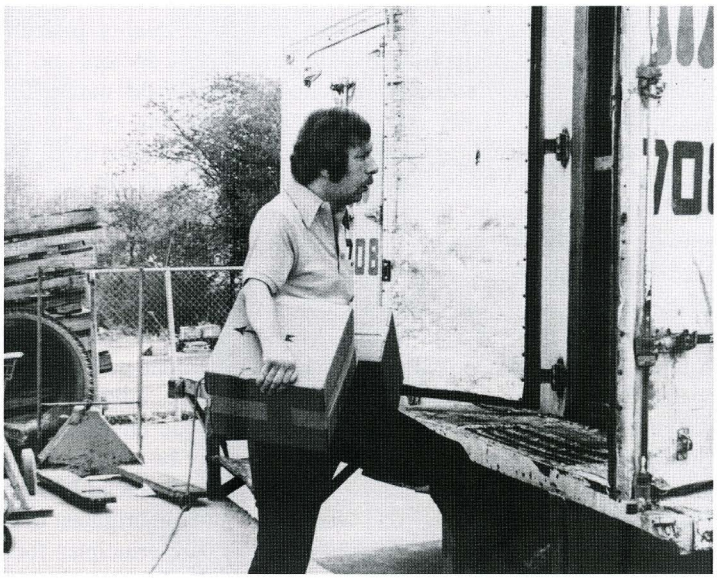
might have been different, the effort and outcome would likely have very been much the same.

Of course, for some of you, this has been at best a few interesting facts from a remote past. But for those of us fortunate enough to have gained our education in surgery during the years when the Churchill Residency had reached its maturity, the experience remains a most cherished one. As residents we had the sense that excellence in patient care, and the advancement of our surgical education and careers were central priorities of the Department. Our teachers seemed, and in fact generally were, master surgeons. The opportunities to develop surgical judgment and skills exceeded our capacity, no matter the hours and effort. And I am certain that for many of us, our years as an MGH resident remain a most treasured part of our career as surgeons.

As to now…Everett Knowles will or would be 56 this year. Despite an abiding interest by the many surgeons who participated in his initial and later care and vigorous attempts in recent years to locate him, his present whereabouts and condition remain unknown.

A comprehensive file of newspaper, magazine, and Hotline articles was kept by Ron Malt, the last one being from 1982. At that time it was reported that the arm "is remarkably strong and agile. Knowles can heft a 50 pound weight with the replanted arm". He was said to be employed driving meat trucks and to think nothing of lifting a 200 pound side of beef.

The last bit of information is from 15 years later. Gerry Malt reports, "In 1997 a very nice employee of the MGH post office who had a fondness for Ron mentioned to Margaret Wilkie and me that as he does not own a car, he sometimes takes a taxi and that he had Everett Knowles as his taxi driver on several occasions". Actually, from the articles one can tell that over the years the "boy with the golden arm" grew finally to resent the publicity that always accompanied his hospital visits. Perhaps this notoriety is one reason he eventually chose to disappear.



(Editor's note: Leslie W. Ottinger graduated from Rice University in 1953 and the Harvard Medical School in 1960. He entered the U.S. Navy as a Line Officer in 1953, being discharged in 1956. He served as an Intern in Surgery at the Massachusetts General Hospital and was Resident in Surgery in 1967. In 1974, he was appointed Associate Professor of Surgery at the Harvard medical School and appointed a Visiting Surgeon at the MGH in 1980. From 1968 until his retirement, he served as a distinguished Director of the General Surgery Program at the MGH, and has developed postgraduate courses in Trauma, Surgical Anatomy and in Gastrointestinal and Vascular Surgery. He has made outstanding contributions to the development and organization of the Surgical Training Program, and now serves as an honorary Surgeon at the MGH.) ♦

ARRIVALS AND DEPARTURES

Welcome Interns –		Good Luck Seniors -
Genevieve Boland	Jefferson Medical College	David Cooke – U of Michigan - Cardiothoracic
Kathryn Lee Butler	Columbia U Coll of P & S	Akemi Kawaguchi – Baylor – Pediatric Surgery
David Fink	U Illinois COM-Rockford	Larisse Lee – Columbia/Cornell – Vascular
John Kirkham	Columbia U Coll of P & S	Matthew Levine – UCSF – Transplant
William Kitchens Jr.	Harvard Medical School	Richard Pin – Johns Hopkins – Vascular
Johannes Kratz	Harvard Medical School	Maura Reinblatt – UCLA – Plastics
Angela Moss	NYU School of Medicine	Sharon Stein – Cornell – Colorectal
Harald Ott	University of Innsbruck	Matthew Williams – Duke - Cardiothoracic

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The current state of the MGH Department of Surgery falls short of addressing these external forces in a number of ways. The criteria for privileging surgeons are broad and largely un-edited: the principle is to allow unrestricted practice rather than to define and focus its scope. The face we present to an inquiring public, including our websites, is less detailed, attractive, and compelling than that of competing institutions (even community hospitals): our leadership and superiority are inadequately displayed. The utilization of our clinical materials – commonly the largest in the region – for academic productivity, clinical studies and trials, presentation at national meetings, and publication could be greatly incremented; we provide excellent clinical care according to national benchmarks, but we are not reaching all of our potential as academic leaders or adequately promoting the careers of our junior faculty.

The plan is to create disease or organ-focused subspecialty Programs in Surgery which focus the expertise of committed individuals as a nidus for interdisciplinary collaborations, increase

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case volume (especially of high-end and complex patients), promote individual and collective academic utilization of clinical material, improve GME and CME, and better attract external grant funding (including industry). It is anticipated that these Programs will facilitate personal growth and reputation, leading to faster academic promotion. By innovation and advancement of surgical knowledge the Programs can become a powerful marketing tool to the public and to individual and contractual sources of referral. I emphasize that the Program concept differs from a clinical practice or group and may overlap the clinical activities of various groups. Conversely, the Programs will comprise only some of the surgical activities of the Department while the rest will continue as at present. The establishing of Programs need not occur all at once but more likely will take place incrementally as the potential of each is demonstrated and as the critical mass of members is assembled.

The first goal of subspecialty program development is to improve quality of patient care. Quality of care, however defined, is what is going to be scrutinized by ever more web-savvy patients, data-rich insurers, and government regulators. If we are to prove we are the best, we need to measure our outcomes, continuously improve our processes, and report our success- i.e. get the message out. Surgeons who are low-volume providers with marginal outcomes or even high-volume providers with poor outcomes may need to be excluded from participation in the programs as their bad outcomes will tarnish the work of those who excel.

The second goal of subspecialty program development is innovation through improving the quality and volume of clinical research.There are a variety of impediments that must be overcome. These include lack of time due to financial pressure to generate clinical revenue, lack of incentive to be academically productive, the hassle factor of dealing with IRB's, and lack of infrastructure to deal with the mundane and tedious work or keeping the paperwork in order. With improvement in the quality and volume of clinical research, local and national recognition will grow and be a key foundation of the next two goals.

The third goal of subspecialty program development is to grow clinical volume in those areas identified in the MGH Strategic Planning process, as well as new opportunities that are on the near-term horizon. More effective marketing combined with high quality patient care, better access to MGH doctors and facilities, and improved local and national visibility achieved by reporting of clinical research should implement this goal.

The fourth goal of subspecialty program development is to foster the development of the next generation of young academic surgeons. Concentrated experience in a given area as well as clinical or basic research in this area should provide a more efficient pathway to academic and professional advancement. If we provide an unique environment for young faculty, we may be able to overcome some of the current financial barriers to recruiting the best and the brightest to Boston.

The principles for inclusion of a surgeon in a Program begin with active commitment and participation. Other entry criteria may include 1) valid subspecialty credentials 2) subspecialty fellowship or training 3) established substantial practice in the area of surgery 4) commitment to enter patients into the Program's database and involvement in its clinical trials or basic research 5) relevant scholarly publications (clinical, quality, safety, guidelines, process, etc). Surgeons from any Division who have the appropriate credentials will be eligible for joining the Program. Surgeons may choose to be members of more than one Program, but practical constraints and requirements are likely to limit effective participation to two or three Programs at most. There is no intent, however, to restrict the established practice or privileges of any surgeon, whether a member of a Program or not: any surgeon may continue to accept referrals and consultations commensurate with credentials and maintain and promote relations with physicians as usual. OR privilege lists will continue to be determined by the same criteria as at present. In most cases Programs will not cross Division lines (i.e. lung or endovascular surgery), and no competition or turf problem is anticipated. In some the members of a Program may be appropriately drawn from different Divisions (i.e. colorectal, liver/biliary/pancreas, esophageal). That this can be successfully accomplished has been shown by our Endocrine Center, Thoracic Aortic Center, and the Trauma Center.

Designation and Establishment of Programs will be based upon a proposal and plan which may originate from or be channeled through the appropriate Division Chiefs and submitted to the Department Chair for final approval. Leadership of a Program will be by appointment from the Department Chair in consultation with Division Chiefs. A Division Chief may or may not be appointed to lead a Program. The term of appointment will be limited to three years, renewable if the goals of the Program (clinical volume and market share, quality of care, clinical trials, quality and number of publications, web-site, outreach, collaborations, etc.) are being met. The Program Head will be accountable to the respective Division Chiefs and to the Department Chair.

Barriers to establishing the Programs are anticipated, not the least being resistance to change of any kind, failure to understand and accept the necessity for this evolution, and fear of loss of practice (and income). Financial integration or geographic colocalization are not integral to the concept or its initial realization, but there may come a later time of advantageous circumstances to consider an integrated model for some Programs. Most surgeons in this Department are de facto by training, choice, or evolution of their practice already in subspecialty programs (i.e. breast), but there are a few who have maintained a broad surgical practice which overlaps a number of the potential Programs. Nonetheless, it is acknowledged that there may over time be an appropriate tendency for migration of some activity to Program participants as a consequence of showcasing their focus on the specified area, as well as the desires of an increasing segment of the patients and insurers.

"General Surgery" has been undergoing constriction at academic health centers for decades already: the general surgeon no longer does vascular or thoracic cases (by and large), and sub-specialists do most of the breast surgery, trauma, melanoma, and even basic cosmetic cases, to name but a few examples. The development of Programs will recognize the realities of current surgical practice in an academic center, the increasing subspecialty end-points of residency and fellowship training, the requirements of the consumers, and the need to provide validated centers of excellence. Finally, and no less important, the Programs will promote innovation and advancement of the field, the MGH, and the MGH surgeons.♦

MGH Surgical Society
Annual Reception
Monday, October 9, 2006, 6-8 pm
Hilton Chicago

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Angiography of the carotid arteries was not being done in Montreal in 1950; the procedure was forbidden by Penfield because of its complications. Under Fisher's guidance, carotid arteries began being routinely examined during autopsies, and a surprising percentage of patients were found to have one or both carotids severely stenotic or occluded, many having histories of transient monocular blindness.

Patients at the Queen Mary Veterans Administration Hospital were asked about the occurrence of premonitory symptoms and were often found to have transient prodromal symptoms, reported by the patients or their families. The prodromal symptoms appeared to occur with thrombotic strokes at each of the cerebral arteries: middle cerebral, anterior cerebral, basilar, and posterior cerebral. From this discovery emerged the possibility that prodromal symptoms might provide an opportunity to intervene before the full stroke occurred, and tentative trials were begun in which anticoagulants were given at the start of premonitory symptoms. This was of great importance because the observation that a transient neurologic symptom frequently preceded a completed neurologic deficit afforded an opportunity to intervene, thus aborting the completed stroke.

The routine removal at autopsy of the carotid arteries from the neck was undertaken until 1100 pairs had been examined. Carotid disease proved to be common. At lunch at the Montreal General Hospital, Fisher discussed the surprising carotid findings at autopsy with a local vascular surgeon, Dr. R.R. Fitzgerald, who had recently returned from a vascular meeting in New Orleans, LA. This was during the period when aortoiliac vascular reconstruction for occlusive disease was gaining momentum, and the vascular surgeon related to Fisher the optimistic reports he had heard. Fisher thought that vascular reconstructive surgery might be effective in dealing with the localized mechanical problem, and in the discussion of his findings of his carotid autopsy series to the American Neurological Association, Fisher predicted that vascular reconstructive surgery might play a major role in the treatment of this disorder. He commented, "It is even conceivable that some day vascular surgery will find a way to bypass the occluded portion of the artery during the period of ominous fleeting symptoms. Anastomosis of the external carotid artery or one of its branches with the internal carotid artery above the narrowing should be feasible."

Shortly thereafter, on 3 continents, operative management of extracranial carotid occlusive disease was successfully undertaken. In Buenos Aries, Argentina, Drs. Raul Carrea and Mahelz Molins performed an excision of the diseased segment and oversewing of the proximal internal carotid artery. After dividing the external carotid artery, the distal end was ligated, and the proximal end was anastomosed end-to-end to the distal internal carotid artery, thus performing the procedure that Fisher has suggested. Carotid reconstruction was also undertaken by Dr. Michael DeBakey in Houston, Texas, with endarterectomy, and by Drs. Felix Eastcott and Charles Rob in London, England, with resection of the diseased carotid bifurcation and direct anastomosis of both the common carotid artery and the stump of the internal carotid artery. Ultimately, carotid endarterectomy was to be accepted as the preferred method of carotid reconstruction, its benefit having been universally accepted on publication of the findings of the North American Symptomatic Carotid Endarterectomy Trial in 1991. This trial, which documented carotid endarterectomy in symptomatic patients with 70% to 99% carotid stenosis, decreased the 2-year rate of ipsilateral stroke from 26% in medically treated patients to 9% in surgically treated patients.

Fisher's original synthesis of the clinicopathological syndromes of carotid occlusive disease as well as lacunar disease, cerebellar hemorrhage, and carotid dissection flowed from a prepared mind and a tenacious quest for confirmation of his premise by autopsy study. Atherosclerosis of both large and small arteries that supply the brain is the most common cause of ischemic stroke in North America and Europe. Appreciation of the clinical importance of carotid occlusive disease led to widespread angiographic study of the population of patients with transient ischemic attacks, allowing therapeutic intervention and the preservation of thousands of lives. Advances in noninvasive surveillance technology and imaging have extended the benefits of early intervention to prevent or abort ischemic stroke.

Fisher's career was marked by numerous significant contributions to the further understanding of many neurologic conditions. He added to the lexicon of our profession, authoring such descriptive names for clinical phenomena as "subclavian steal," "transient ischemic attack," and "skin sign." He was renowned as a bedside teacher, and his pupils collated the basic principles that emerged from the conduct of his practice. Caplan has summarized these into "Fisher's Rules."

1. The bedside can be your laboratory. Study the patient seriously.
2. Settle an issue as it arises at the bedside.
3. Make a hypothesis and then try as hard as you can to disprove it or find the exception before accepting it as valid.
4. Always be working on one or more projects; it will make the daily routine more meaningful.
5. In arriving at a clinical diagnosis, think of the 5 most common findings (historical, physical, or laboratory) found in a given disorder.
6. Describe quantitatively and precisely.
7. The details of the case are important; their analysis distinguishes the expert from the journeyman.
8. Collect and categorize phenomena; their mechanism and meaning may become clearer later if enough cases are gathered.
9. Fully accept what you have heard or read only when you have verified it yourself.
10. Learn from your past experience and that of others (literature and experienced colleagues).
11. Didactic talks benefit most the lecturer. We teach others best by listening, questioning, and demonstrating.
12. Write often and carefully. Let others gain from your work and ideas.
13. Pay particular attention to the specifics of the patient with a known diagnosis; it will be helpful later when similar phenomena occur in an unknown case.
14. Be a good listener; even from the mouths of beginners may come wisdom.
15. Resist the temptation to prematurely place a case or disorder into a diagnosis cubbyhole that fits poorly.
16. The patient is always doing the best he can.
17. Maintain a lively interest in patients as people.

(Editor's note: Ashby C. Moncure received his M.D. from the University of Virginia in 1960 and began his surgical internship at the Massachusetts General Hospital in that year. He continued as a Surgical Resident and in 1967 was appointed Locum Registrar in Thoracic Surgery by the Southwestern Regional

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EVENTS OF NOTE

- *Hugh Auchincloss Jr.* has been named the new Principal Deputy Director of NIAID. Hugh is the Founder and Director of the Juvenile Diabetes Research Foundation Center for Islet Transplantation at Harvard Medical School. He also serves as Chairman of the FDA's Subcommittee on Xenotransplantation.
- *A.Benedict Cosimi* delivered his Presidential Address entitled "Nobel Prize Winners in Surgery" at the 86th Annual Meeting of the New England Surgical Society that was held in Bretton Woods October 1-2, 2005. It was noted that this meeting had the largest attendance in the past decade.
- *Judah Folkman* received three awards in 2005 for his work in angiogenesis and the vascular endothelial growth factor. They were a Lifetime Achievement Award from the Pharmaceutical Achievement Awards Organization; the Grand Prix from the Lefoulon-Delalande Institue de France; and the Paul Kayser International Award for his retinal research.
- *Mark Hochberg* has been appointed Professor of Surgery at New York University School of Medicine and Director of the Surgical Education Center.
- *Richard Hodin* was appointed a full professor of surgery at HMS in October, 2005. His research is on the processes of intestinal epithelial growth and differentiation. His laboratory has identified a molecular switch that occurs in the gut during starvation, sepsis, and inflammation. He is studying the molecular mechanisms that are responsible for this gut mucosal dysfunction
- *Joren Madsen* has been named the first W. Gerald & Patricia R. Austen Distinguished Scholar in Cardiac Surgery.
- *Peter Rutledge* was installed as President of the North Texas Chapter of the American College of Surgeons at the meeting on February 24, 2006.
- *David Torchiana* was recently honored by Partners Community HealthCare Inc. for his contributions to health care. Torch received the Samuel O. Thier, M.D. Physician Leadership Award in recognition of his vision, integrity and ongoing commitment to ensure delivery of the highest standards of care.
- Andrew *Warshaw* has been elected President of the Society of Surgical Chairs. He has also been elected to the Council (President-designate) of the American Pancreatic Association.
- *William Wood* received the annual award from the Society of Surgical Oncologists for delivering the James Ewing lecture in 2005. His topic was "Trivializing the Value of Surgery in Cancer Control".

Letter to the Editor

Dear Jack and Robb,

It was a great disappointment to miss the reunion in June, which we had scheduled but had to cancel because of some surgery my Jane had at that time. It was, however, a great pleasure to see a few old friends at the reception here at the ACS Congress in SF last month, to which I was able to hobble.

The purpose of this letter is to submit for your consideration an anecdote, which I had proposed to present at the reunion. Some old timers might be amused by it.

Best wishes to all,

Ben Roe, East '50

Embarassing Moments

(Historical note: In the late 1940's the Chief of the East Service was Dr. Arthur W. Allen, a short but powerful and commanding Southern Gentleman, who was chauffeured around town to preside over a large private practice assisted by his team of Claude Welch, "Butch" Donaldson and Phil Giddings. Menial tasks of admitting, discharging and scheduling were always relegated to the underlings so the House Staff never dealt with him directly; thus the following anecdote was an unusual circumstance.)

It was a quiet Sunday afternoon as I was reading the funny papers in the old Moseley building (where House Officers were quartered) and the phone rang. The unmistakable (I thought) voice of my notorious prankster classmate, Hank Moorman, declared, "This is (Dr.) Arthur Allen. I am admitting a patient to the Phillips House and I want you to....", to which I instantly replied, :Screw you, Moorman" and hung up. Ten seconds later the phone rang again to repeat, "This is Dr. Allen". (gulp!) Without rancor he described his patient with intestinal obstruction and gave me instructions about admission and scheduling emergency laparotomy.

I was delighted with the unique opportunity of first assisting the great man, since the team were all off for the weekend. He patiently tolerated the second-class assistance and we proceeded amicably. Just as he had carried the incision down to the peritoneum Claude Welch appeared in the doorway in his business suit and holding a towel to his face. The abdominal film was visible on the view box and I was commissioned to recite the history and signs as I grasped my side of the peritoneum for Dr. Allen to incise. Only seconds before his knife pierced the membrane, Claude said, "Sounds like Acute Hemorrhagic Pancreatitis". Then as the cavity was entered a liter of reddish brown fluid gushed out of the wound. Dr. Allen stepped back from the table, threw the scalpel on the floor and – in just short of a scream – said Damn you, Claude!!!" and left me to close up.

It was a rare moment to see the mighty humbled by a subordinate. But it did not deter from my respect and fondness for a great mentor, who later offered me a job in his office when I finished by residency. ♦

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Hospital Board, Bristol, England. He returned to the MGH to become Chief Resident in Surgery in 1968. Between 1962 and 1964, he served as Captain in the United States Army Medical Corps. He was appointed Clinical Professor of Surgery at the Harvard Medical School and now serves as Clinical Professor of Surgery, Emeritus, and Senior Surgeon at the Massachusetts General Hospital. From 1969 to 2003, he was the Team Physician for the Boston Bruins Hockey Club. He has been President of all of the major Surgical Societies in New England and has contributed extensively to the MGH Clinical Surgical Services. He is an outstanding example of the General Surgeon caring for patient with General, Vascular or Thoracic Surgical problems.) ♦

The Massachusetts General Hospital
Surgical Society
55 Fruit Street
Boston, MA 02114

INFORMATION FORM
SPRING 2006 NEWSLETTER

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Request for honors, comments, personal notes, anecdotes, current activites, suggestions, etc.