



The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY Newsletter

Spring 2002

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MGH SURGICAL SOCIETY

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IMPORTANT DATES

MGH Surgical Society Reunion
June 6-8, 2002

MGH Department of Surgery
Annual Reception
October 7, 2002, 6:00 p.m.

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

A MESSAGE FROM THE PRESIDENT

The Massachusetts General Hospital Surgical Society is now almost three years old and I am pleased to say that, so far, the organization is doing well. As of this date, we have 363 active and 98 retired members for a total of 461.

All of us in the Department of Surgery at the MGH are very much looking forward to the forthcoming meeting of the society on June 6th - 8th. As you have read in previous mailings, the reunion will begin with a cocktail reception on Thursday evening, June 6th on the Wang Terrace at the MGH. Friday morning, there will be the first of two scientific sessions in the O'Keefe Auditorium followed by a lunch. Included in the Friday morning session will be a business meeting of the membership and election of new officers and council members. Friday afternoon, for those interested, there will be tours of the JFK Library. A black tie reception and dinner will be held on Friday evening

at the downtown Harvard Club. The final scientific session will be held on Saturday morning, again in the O'Keefe Auditorium.

I believe that you will find the scientific program to be very broad and interesting. There will be approximately equal participation from present members of the MGH Department and individuals who are now located at other institutions. Please see the program below.

Finally, there will be a very interesting panel entitled "Conflicting Demands of General Surgery Residency and Subspecialty Fellowships" moderated by Les Ottinger with David Rattner, Barbara Smith and Charlie Ferguson as panelists.

I believe that Mike Margolies who is in charge of the program has done an excellent job and I know that you will enjoy your visit to the MGH and Boston. Most especially, I am sure that you will enjoy seeing your old friends.

Jerry Austen

Presenter	Organization	Topic
John C. Baldwin	Dartmouth	Mentoring Medical Students for Careers in Surgery
Hermes C. Grillo	MGH	The Churchill Residency
Hatem A. Abou-Sayed	UCSF	All things Must Pass: Survival and Revival in the MGH Surgical Residency
Joel D. Cooper	Barnes-Jewish Hospital	Should Surgical Innovations be Regulated
Joseph P. Vacanti	MGH	The Problem of Whole Organ Design and Fabrication to Solve the Organ Shortage
David H. Sachs	MGH	Transplantation Tolerance
Judah Folkman	Children's Hospital	Angiogenesis Inhibitors: A New Class of Drugs
Richard P. Cambria	MGH	Vascular Surgery at the MGH: Where We've Been and Where We are Going
Jo Buyske	Presbyterian Medical Center	Keep Your Knees Loose and Your Weight Low: Surfing the Changing Waters of Practice, Administration and Family
Gus J. Vlahakes	MGH	Total Artificial Heart Replacement: Current Status
Patricia K. Donahoe	MGH	Sex Cures Cancer
Francisco G. Cigarroa	U. Texas at San Antonio	From MGH Surgical Intern to President of an Academic Health Center
Michael P. LaQuaglia	Memorial Sloan-Kettering	The Role of the Surgeon in Pediatric Surgical Oncology
Leslie W. Ottinger	MGH	The Second Surgeon
Warren and Lucia	Prosperi Studio	The Making of the Ether Day Painting

EDWARD DELOS CHURCHILL
Pioneer, Educator, Leader in Surgery
By Art Baue



Edward D. Churchill was John Homans Professor of Surgery at HMS and Chief of Surgical Services at the MGH for many years. Residents referred to him as E.D.C. but privately called him “Uncle Peter” out of fondness and respect for him. He was their friend, defender and “uncle” – always supporting his residents and faculty. Friends called him “Pete”.

Churchill, born in Chenoa, Illinois in 1897, received B.S. and M.S. degrees in biology at Northwestern University, M.D. from HMS and trained in surgery at the MGH. He did research at Harvard with Drinker and received a Moseley Traveling Fellowship to Krogh in Copenhagen and observed Borst in Munich and Sauerbruch in Berlin. After two years at the BCH he returned to the MGH, becoming Chief of

the West Surgical Service at age 36. In 1948 the services were combined. Churchill became Chief of the General Surgical Services.

His pioneering contributions to surgery were many: first successful pericardiectomy for constrictive pericarditis in the U.S.; developing with Belsey the concept of segmental resection of the lung (the lingula), allowing operations for a dreaded childhood disease – bronchiectasis; and proved that many lung cancers could be treated adequately by a lobectomy. He operated upon the first patient with hyperparathyroidism with a sternotomy to remove a parathyroid adenoma.

Churchill made suggestions – never orders. He suggested that Beecher develop anesthesia, Stewart – hepatobiliary surgery, Lyons – surgical bacteriology, Benedict – endoscopy, Simeone – vascular disease and shock, Scannell – cardiac surgery, Francis Moore in surgical metabolism, McDermott – liver and pancreatic surgery, Waddell – the stomach, Shaw – vascular surgery, Grillo – general thoracic surgery, and Russell – transplantation. Immense accomplishments resulted from these leaders given responsibility for an area of study. Many who trained at the MGH during Churchill’s final years also made great contributions. Scannell said, “It was the nature of the man to catalyze the efforts of others.”²

During World War II as Surgical Consultant in North Africa, he developed the concept of delayed primary wound closure and early adequate debridement preventing infections in contaminated wounds. These were required by the military, great-

ly reducing morbidity and mortality.³

He noted that plasma was inadequate for the severely wounded. Getting no action from the Army on this he asked a New York Times reporter to break the story that Col. Churchill said blood transfusions are urgently needed. The story (August 26, 1943) broke the logjam to get blood transfusions.⁴ After the war, colleagues formed the Excelsior Surgical Society with one honorary member, Dr. Churchill.⁵

In 1946 he gave the first Martin Memorial Lecture to the American College of Surgeons on the subject, “The American Surgeon, AUS”.⁶ His Presidential Address to the American Surgical Association (ASA) was “Science and Humanism in Surgery”.⁷ As President of the American Association for Thoracic Surgery he presented “The Segmental and Lobular Physiology and Pathology of the Lung”. His Presidential Address to the Society of Clinical Surgery, “Pains in the Background or how Unintelligent can we get?”, reviewed questions on the American Board of Surgery (ABS) exam revealing how little surgeons knew about their surgical heritage. Churchill stressed surgical history, traditions and the real world of practical surgery.⁹ He was a Founder of the ABS and Editor of the *Annals of Surgery*.

Many believe that surgical education was Churchill’s greatest contribution. He developed the rectangular residency at MGH. Eight carefully selected young people became interns for a year and residents for four years of graded surgical responsibility. All were *eligible* for the ABS. No one was eliminated. All were welcome to take time
(continued on page 8)

EAST VS. WEST

By Robb Rutledge

In the 1930s and 1940s Dr. Arthur W. Allen personified the East Surgical Service, and Dr. Edward D. Churchill did the West. Each received undivided loyalty from his respective house officers. Although the competition between East and West was intense it was a friendly ethical rivalry of which the MGH could be proud. How did it start? How did it stop?

When the MGH opened in 1821 all of the surgical patients were cared for on one service. In 1846-1847 east and west wings were added to the original Bulfinch building, and surgical patients were assigned to the East or West Surgical Service accordingly. All of the rooms and

wards were numbered; East numbers were 16 and 31, while the West rooms were 28 and 29, all on the second floor.

There was no Surgeon-in-Chief then. The services were run by six visiting surgeons, three on East and three on West who rotated command every four months. The visiting surgeons were reappointed annually and the house pupils, one on each service, were senior medical students who served for one year.

During the last half of the 19th century surgical volume increased. Beginning in 1874 the house pupils were recorded as appointed to either East or West Surgical Service. In June, 1894, a South Surgical Service was formed (possibly so named because the new surgical building

in use then, but now replaced, was south of the Bulfinch building). Competition grew between the three services. Harvey Cushing was a house pupil on the South Service in 1896, and his older brother, who had been on the East in 1888, was shocked that Harvey did not follow him on the East. By 1900 there were nine visiting surgeons and nine house pupils, three for each of the three services.

In order to correct the faults of a leaderless system the entire MGH surgical service went through an extensive reorganization in August, 1911. The position of Surgeon-in-Chief was created for Maurice H. Richardson. The South Surgical Service was closed, and
(continued on page 3)

**MEMORIES OF
DR. ARTHUR W. ALLEN**
By Grant Rodkey



Of the many “Giants of Surgery” whose heritage enriches members of the MGH Surgical Society, none was more preeminent than Dr. Arthur “Jimmie” Allen. Born the son of a schoolteacher-pharmacist in Kentucky in 1887, he attended Georgetown College and Johns Hopkins Medical School. There he was advised by Dr. John M. T. Finney to come to the MGH for further training. He became a “House Pupil” in 1913. He was caught up in the tradition and discipline of surgery as it was exemplified in the lives of Maurice Richardson, Charles Allen Porter and – especially – George W. W. Brewster. He later described this regimen as more militaristic than he found in the Army of the United States in World War I! House Officer stress is not entirely a con-

temporary phenomenon!

Dr. Allen founded the Vascular Clinic and was one of the founders of the Fracture Clinic at MGH. Rising through the various ranks of the Attending Staff, he became Chief of the East Surgical Service and Lecturer in Surgery at the Harvard Medical School 1936-48. During this period he became greatly esteemed for his teaching – which focused his great surgical skill, his clinical sagacity, his phenomenal memory, his habitual reading of current surgical literature and his deep interest in the professional development and maturity of his juniors. His associates included Drs. Joe Meigs, Langdon Parsons, Henry Faxon, Richard Wallace, Claude Welch, Gordon Donaldson, Philip Giddings, Grant Rodkey, Glenn Behringer, George Richardson, and John Burke. It was characteristic of his personal devotion that, on his deathbed, he said, “I regret only one thing – that I won’t live long enough to assure the success of Jack Burke”. With the Boss’s blessing, Dr. Burke managed well.

Dr. Allen had a discerning and disconcerting way of framing his questions which put his trainees on notice that he knew a lot about the subject, and that the answer was required at once to be accurate and complete. When Magruder Craig Donaldson was born, his father, Gordon (“Butch”) came into Dr. Allen’s office to relay the joyful news. “Butch,” he demanded, looking up, “Are they both down there where they are supposed to be?”

He was an eagle-eyed and incisively analytic observer. One morning after we had struggled through a difficult cholecys-

tectomy in a heavy man, in talking to the family, Dr. Allen seemed mildly distracted by the obesity of the wife and three children. As we walked down the corridor later he remarked, “The trouble with that woman is that she is just too damned good a cook!” On Phillips House rounds one morning he was trapped by a woman with a nonstop torrent of complaints about every aspect of her care. As we walked away he remarked sympathetically, “I know exactly how she feels: mean, menopausal and arthritic!” On one occasion he was summoned to the Phillips House to examine a newly admitted, retired, Nashua, New Hampshire surgeon. This gentleman and his wife had just completed a drive from California and he had a purple foot due to impaired arterial inflow. As Dr. Allen, Glenn Behringer and I walked away down the corridor he remarked, “That man has the world’s most dangerous combination: a young wife and a new Cadillac!”

Dr. Allen had a warm, generous nature and a ready wit. His thousands of patients adored him, and his friends among his surgical colleagues extended around the globe. He was President of the Boston Surgical Society, the Society for Vascular Surgery, the Massachusetts Medical Society, the Pan-Pacific Surgical Society, and the American College of Surgeons. He was Chairman of the Surgical Section of the A.M.A. and of the U.S. Committee of the International Society of Surgery. He was Chairman of the Board of Regents of the American College of Surgeons during 1948-51, the critical pe-
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East vs. West continued from page 2

the East and West Surgical Services were run by a permanent chief of service. The original chiefs were Francis Harrington on the East and Samuel Mixter on the West.

The next year Maurice Richardson died, and his son, E. P. Richardson was eventually named to replace him as Surgeon-in-Chief in 1923, and the Third Surgical Service was opened for him. When Charles Porter, then the Chief of the West, stepped aside in 1925, Richardson was made Chief of the West, and the Third Service was closed. In 1930 Richardson had an incapacitating stroke, and the following year, 1931, Edward D. Churchill was named Chief of the West service.

While these changes were going on in

the West Service, the East had several chiefs until Arthur Allen was appointed in 1935. During Allen’s and Churchill’s reigns competition between East and West reached its peak. In 1939 the White building opened, and both East and West had two floors each so they could consolidate their patients. The number of trainees and length of training were both increasing. House officers (name changed from house pupils in 1922) now had an MD degree. They were chosen by the East or West Service and always remained on that service.

The personalities of the East and West Services were as different as their chiefs. Allen ruled with a firm hand and was a superb technician. Churchill was a surgi-

cal scientist. East interns were noted for technical proficiency while West interns regarded surgery as a scientific discipline and were given more freedom. There were technical differences also. East used retentive sutures and closed with cotton. West used silk. The East irrigated the subcutaneous tissues with ether, while the West used saline. When all of the results were compared there was not real difference between East and West.

During and after World War II the separation of East and West was stopped. The house officers worked on both East and West Services during their ward service rotations. When Allen retired in 1948 no new East chief was named. Instead the Board of
(continued on page 8)

BUT SOME OF MY BEST FRIENDS PLAY MUSIC

By John Head

A frequent question is “why are so many doctors musicians?” Reverse this: “Why are so many musicians doctors?”

Young people play music long before they contemplate college and careers, often in grade school. A whole literacy, language and endeavor is acquired before algebra and Latin. Indeed, it helps in the learning of English and math. Like English, music reads from left to right, with notations of arithmetic fractions, pitch, speed, and loudness (many in Italian). Often young musicians become fairly accomplished by 6th grade and peak during high school and college. A lot of work goes into it. This is important. There are choices. After-school activities have to be limited to permit 1-2 hours/day of practicing. Schoolwork has to be done well in order to keep options open.

There was a recent conversation between Beverly Sills and Emmanuel Ax (one of our finest pianists) at Lincoln Center. Ax was asked, “When did you decide to become a professional performer?” He replied “I don’t know. My parents taught me to work hard and keep my options open. It just happened.”

The common thread is that young people, who grow up in families where music, curiosity and books abound and where career choices are kept open for years by hard work and enjoyment, do well.

During a wonderful summer at Chatauqua I received the offer of a seat in the St. Louis Symphony and a place at Harvard Medical School. My options were open. Already I was a fine musician, but became a doctor.

John Head

(Editor’s note: John Morrison Head has maintained a distinguished presence in Medicine and Music throughout his life. While in school he performed the Boccherini Cello Concerto with the Saint Louis Symphony Orchestra in 1943. During his college years at the University of Missouri he played concerts with the Stevens College Orchestra and the Scholarship Orchestra of Saint Louis. At Harvard Medical School he organized a String Quartet in Vanderbilt Hall and began his surgical training at the Massachusetts General Hospital in 1950. He has served as Professor of Surgery and Vice-Chairman at Dartmouth Medical School as well as Chief of Surgical Service, Veterans Administration Hospital, White River Junction, Vermont. Retired now he has cofounded the Upper Valley Music Center concentrating on young musicians.)

MGH INTERN CLASS – 2002-2003

Emily Christison-Lagay	Harvard
Pierre de Delva	Emory
Nathaniel Evans	Stanford
Peter Fagenholz	NYU
Danielle Gottlieb	UCSF
Anthony McCluney	Harvard
Scott Regenbogen	UCSF
Liam Ryan	Columbia

MGH ALUMNI EVENTS OF NOTE

- **Joe Fischer has returned to Boston from Cincinnati. He has been named the Mallinckrodt Professor of Surgery at Harvard Medical School and Chair of the Department of Surgery at Beth Israel Deaconess Medical Center.**
- **The S. Bert Litwin Chair in Cardiothoracic Surgery at the Children’s Hospital of Wisconsin was established in October, 2000.**
- **Jay Vacanti, the John Homans Professor of Surgery at MGH, was one of six HMS faculty members elected to the Institute of Medicine of the National Academy of Sciences in October, 2001. On election members commit to volunteer on committees engaged in a broad range of health policy issues. Dr. Vacanti’s research is on tissue engineering for reconstructive surgery and organ fabrication for transplantation**
- **Roman and Littlefield Publishers Inc., USA have just released Sen. Bill Frist’s new book, When every moment counts, a paperback about bioterrorism.**
- **William Abbott has been appointed as the Harold and Ellen Danser Professor of Surgery at Harvard Medical School. Dr. Abbott recently stepped down as chief of vascular surgery at MGH, but will continue his longstanding research into the biology of vascular prostheses and pursue more recent interests in hospital resource utilization and academic surgical development.**
- **Edward M. Barksdale Jr. has been awarded the 2002 Chancellor’s Distinguished Public Service Award by the University of Pittsburgh. Barksdale was cited for public service efforts including child advocacy, mentorship, public health education, and for promoting community practice among medical students.**
- **Douglas J. Mathisen, chief of thoracic surgery at the MGH was recently named the first Hermes C. Grillo Professor of Thoracic Surgery at Harvard Medical School. The Grillo Chair was established through the generosity of Dr. Grillo’s associates, friends and patients to ensure that the finest and most able physicians are recruited and retained by the Unit to direct its pre-eminent clinical and research programs.**

DESIGNING AND HARNESSING CHANGE

By Andy Warshaw

Business as usual? No way! It would be easy for one of the best surgical Departments anywhere simply to coast. After all, conventional wisdom dictates that “if it ain’t broke, don’t fix it.” On the other hand, we figure that the rest of the pack can pass us if we stand still. Change is a given, and we should lead it – and even invent it.

The principal underlying theme of the changes of the past few years has been to migrate from individual surgical activity, defined by the discipline of that surgical Division, to multidisciplinary integrated programs across Divisions and Departments. The goals are to design and deliver better, more sophisticated patient care, enhance education, and stimulate and test new ideas. Implicit is eventual financial integration of practices in order to align incentives across contributing disciplines. We will be alert as well to opportunities to include the other hospitals in the Partners HealthCare System. The new programs fall into two bins: those for delivery with a well-defined focus and those creating broad new integrations which have the intent of creating new paradigms.

Among examples of the first category is the Weight Center, which uniquely brings together surgeons at the MGH and Newton-Wellesley Hospital, internists and gastroenterologists, pediatricians, psychologists, social workers and dieticians; surgical volume at the MGH is up 150% in the past year, driven in large part by the successful introduction of laparoscopic gastric bypass. The Thoracic Aorta Center is manned by vascular and cardiac surgeons, cardiologists and interventional vascular radiologists; its newsletter has highlighted our development of endovascular stent grafts and participation in national trials. A new clinic addresses the problem of chronic unhealed wounds: using new techniques and biological agents such as growth factors, its nurses and physicians (eventually to include vascular, plastic, trauma/burns surgeons; dermatologists; podiatrists) have already proven the ability to shorten healing time and dramatically reduce costs. The clinic is struggling to keep up with recent growth of more than 10% per week. One of our newest ventures has been the formalizing of a medical-surgical thyroid and parathyroid joint venture, which brings together general, oncologic and otolaryngologic surgeons and endocrinologists for multidisciplinary endocrine teaching rounds, to participate in studies of the genetics of endocrine neoplasms, and to promote introduction of less invasive techniques for diagnosis and treatment. This is a good example of coordinating strong but separate units in the MGH community to reestablish us the premier program in the region.

The grandest venture in the deck is the conception and design of a Vascular Diseases Program. Initiated in discussions between surgery and cardiology and nearly three years on the drawing boards, the vision is to bring together our existing clinical

strengths, the rapidly evolving endovascular revolution, and the exciting discoveries coming from developmental biology and genetic manipulation. After the leaders of surgery, cardiology, radiology, neurology, and nephrology reached basic consensus, Dr. James Mongan, MGH President, took on leadership of the effort. A five-year plan has been written and accepted: it lays out the goals of pathway-driven multidisciplinary care, clinical trials to evaluate new techniques and devices, device development, and outcomes research. The Program can become the vehicle for innovative multidisciplinary training and for stimulating relevant basic research. Consequent to the new processes of care, we anticipate lowering the cost of care by identifying which tests and procedures prove most cost-effective. The opening up of the cardiac catheterization lab to surgeons has already increased its utilization rates and promoted expansion of endovascular approaches to occlusive disease without the need to build costly new operating rooms. A governance structure is in place with an oversight Board comprising the relevant Departmental leaders and a Steering Committee of the participating Division and Unit chiefs.

A similar program to bring together and promote the components of trauma care is well along in planning. Its major goals include fine-tuning the complex care of the multiply-injured patient, building an outcomes-research program, improving billing and collection processes, and identifying opportunities for cost-reduction by sharing personnel and resources. An anticipated problem of a successful program will be how to accommodate increased patient volume that might be attracted to our already full institution.

Change may be driven and may be more easily accepted during leadership transitions. During the past three years, four new Division Chiefs have been appointed: Kenneth Tanabe (surgical oncology), David Torchiana (cardiac), David Rattner (general/GI), and Richard Cambria (vascular). Other significant new assignments have been given to Michael Margolies, who assumed administration of the Surgical Clinic; Robert Sheridan as the Clinical Director of Trauma; William Abbott as Associate Medical Director for Surgical Performance Management and Head of the Wound Clinic; and William Hoffman as Director of the Cardiac Surgical Intensive Care Unit.



(left to right) Jack Burke, Bill Abbott and Andy Warshaw celebrating Jack's 50 and Bill's 40 years of service to the Department of Surgery and MGH on Ether Day 2001.

A CENTURY OF DISASTER MEDICAL RESPONSE
BY MGH SURGEONS

SUSAN M. BRIGGS, MD, MPH, FACS

Historically, academic medical centers have been an important medical asset during wartime and natural disasters. From World War I until the present time, Massachusetts General Hospital surgeons have played a significant and ever-expanding role in meeting our nation's disaster medical needs.

In World War I, the director of the MGH, Frederick Washburn, organized Base Hospital #6 to assist in meeting our nation's wartime needs. The professional staff, composed of physicians and nurses from the MGH, functioned for about fifteen months in France caring for over 4000 patients.

When the war ended, a reserve unit was established. The unit, however, was essentially inactive until 1940. At the beginning of World War II, the War Department asked many academic institutions, including the MGH, to mobilize professional staffs for active duty. The MGH unit was assigned the title of the 6th General Hospital and organized under the leadership of Dr. Thomas Goethals, an obstetrician and member of the MGH staff for over 30 years. 123 members of the MGH active staff of 312 entered the armed services. The 6th General Hospital included 40% of the active staff of physicians, 48% of the physician graduates and 33% of the nursing staff. The 6th General Hospital was activated on May 15, 1942 and served in both Casablanca and Rome. The novel use in World War II of ancillary surgical groups, two person teams (surgeon and anesthesiologist) that could be mobilized rapidly and sent to a forward installation, has become a model for contemporary military and civilian disaster medical response.



Claude Welch operating at the 6th General Hospital in Rome, being observed by the chiefs of the surgical service, Horatio Rogers and Marshall Bartlett.

The MGH also has a rich history of medical response to man-made disasters other than war. On December 6, 1917, a munition ship exploded in Halifax harbor, which had become the hub of the Dominion of Canada due to the demands of World War I. The explosion, the largest man-made explosion until the Hiroshima bomb, killed over 2000 and injured over 9000 individuals. Most of the immediate relief came from Boston, including medical personnel such as the renowned surgeon Dr. William E. Ladd. Every year, Halifax presents Boston with a giant Christmas tree to show that their help will not be forgotten.

Contemporary disasters follow no rules. No one can predict the time, location or complexity of the next disaster, especially disasters resulting from terrorist acts such as the World Trade Center bombing on September 11, 2001. The complexity of today's disasters demands civilian and military partnerships as the key to

successful disaster medical response, especially given the threat of weapons of mass destruction (nuclear, biological and chemical). The National Disaster Medical System (NDMS) is the congressionally mandated Federal Disaster Plan for the US. It is designed to mobilize military and civilian medical assets in the event of a catastrophic event. The NDMS involves three programs: 1) designation of hospital beds; (2) Disaster Medical Assistance Teams (DMAT); and Specialty DMATs in Trauma, Burns and Pediatrics. As a result of the MGH's professional expertise, MGH was asked by the Department of State and the Office of Emergency Preparedness (Health and Human Services) to establish the first of two international trauma teams for the NDMS. The International Medical Surgical Response Team (IMSuRT) is designed to provide a rapidly deployable medical and surgical response team for international emergencies to assist in the extrication, treatment and evacuation of US victims and assist host countries in the care of casualties. The IMSuRT is designed to participate in all four aspects of disaster medical response: 1) search and rescue, 2) triage and initial stabilization, 3) definitive medical care and 4) evacuation. The medical team utilizes a deployable rapid assembly shelter (DRASH) with the capacity for triage and initial stabilization, operative intervention, and critical care.



Medical Tent at Ground Zero

Due to the anticipation of mass casualties, the advance team of the IMSuRT was mobilized during the World Trade Center bombing at Ground Zero. Although fatalities outnumbered casualties at Ground Zero, the IMSuRT was an important component in the care of the rescuers (approximately 600 per day), in conjunction with DMATs from other cities. The IMSuRT also responded to the need for ICU/Burn nurses to care for over 30 critically burned patients at Cornell Burn Unit.



Ground Zero

The IMSuRT was developed to allow greater capacity for definitive care in mass casualty incidents and continues a long tradition of MGH surgeons responding to disasters nationally and internationally.

LETTERS TO THE EDITORS

Dear Dr. Rutledge,

I suggest that there is a minor error in our summary of the life of Edward Gilbert Abbott. In the past, Abbott's lesion has been mistakenly termed "hemangioma." You state that he had a "large congenital arteriovenous malformation involving his left neck..." Indeed, it was a vascular malformation. However, my reading of Dr. George Heywood's admission physical examination and other descriptions suggest that the vascular anomaly was a venous malformation. (see Mulliken and Young, *Vascular Birthmarks*, W. B. Saunders, 1988, Pgs. 16-18) For those of us focused on the treatment of vascular anomalies, there are major differences in etiology and management between AVM and VM.

Perhaps, to avoid controversy, the generic term "vascular malformation" could be used in official descriptions (although I am quite certain it was VM).

John Mulliken

Editor's note: John Mulliken quite correctly points out that the lesion on Edward Gilbert Abbott's left neck most likely was a venous malformation, not an arteriovenous malformation. This is his field. A safer term for me to have used would have been a "vascular malformation". I thank him for pointing this out.

Dear Editors,

Staying busy in Forth Worth but as I reached 50 (December, 2001) I have decided to forego vascular access procedures and all procedures that require goggles, lead aprons, robots, or lasers. I am enjoying more endocrine surgery and neck procedures – and being home at night.

My children, my strong wife, and my farm remain the great joys of my life. One son is in law school, middle daughter is in college at the University of Virginia, youngest, 18-year old son is anxious to go to medical school. Our experimental garden is always a source

of enjoyment and great surprises. We have also taken more time off for scuba diving and travel.

I have just recently become involved with mission surgery in Guatemala. This March was our third trip to a small village hospital. We do 100 to 125 operations over a week. My wife and daughter joined the team this year.

Looking for a partner and looking forward to 2002 MGH reunion.

John Crawford

Dear Jack and Robb,

The renewed interest in anthrax and its possible use as a biological weapon have recalled to mind a patient I encountered during an emergency room rotation in 1947. Emergency room medicine had not evolved into a separate specialty in those days and the surgical residents at night were the first echelon on duty in the E. R. About 2:00 a.m. the charge nurse roused me to care for a patient with a very large carbuncle on his back and shoulder up near his neck. The center of the lesion was all of 20 cm in diameter, as I remember, and there was a very extensive area of surrounding edema which was hard and brawny and of a brownish hue. The central eschar was blackish surrounded by some oozing vesicles. I did a gramstain of a smear from the exudate and saw gram positive rods, some of which contained intracellular spores. The diagnosis of anthrax seemed clear.

The patient told me that he was a stevedore. Because of the heat in the hold of the ship, he had stripped to the waist while unloading hides. After culturing the wound exudate, I started an intravenous of penicillin to which the anthrax bacillus was reportedly sensitive. Surgical rounds in those days began in the E.R. and I easily convinced my fellow residents of the accuracy of the diagnosis. By 7:00 a.m. the patient was desperately ill and toxic. He died during the ensuing day.

Dr. Benes, who was the chief bacteriologist at MGH, became very interested in the strain of *B. anthracis* isolated from my patient because it was completely resistant to very high doses of penicillin. Dr. Benes told me that it was the first penicillin resistant strain of anthrax thus far isolated. The organism was forwarded to the Center for Communicable Disease in Bethesda, Maryland.

It might be of interest to look in the diagnostic file in the record room at MGH to determine how many cases of anthrax have been seen at the hospital over the years. As a long time admirer of Physicians for Social Responsibility, I was greatly disappointed when the Bush Administration failed to support the international moratorium against the use of biological weapons. One can only pray that our nation will never resort to the use of so-called "weapons of mass destruction."

Cliff Straehley

Editor's note: Anthrax infection is not a category of reference at the Massachusetts General Hospital so it is difficult to give an exact number of cases seen here. In addition to the case Cliff Straehley records I have seen an infection in a hand injury of a worker in a mattress factory using horse hair. A survey of the surgical staff and infectious disease service has produced none other indicating that Anthrax infections are rarely seen here.

Dear Editors,

Paul Russell, Gerald Austen, and Andrew Warshaw have been great chiefs following other great chiefs like Churchill, Allen, Meigs, Cope, Sweet, Linton, and many more. We are all better because of them.

I got old and retired from surgery about 10 years ago leaving four MGHers in our group better than I, such as Preston Gada, Dick Myers, Woody Cannon, and Brad Drury. We have had lots of fun and done some good.

Isaac Manly

Churchill continued from page 2

off for research at the MGH or elsewhere, but it was not required. A sixth year – The Chief Residency – was usually for those with academic aspirations.

Churchill did not want a School of Surgery. Moore, in an obituary to Churchill said, “If there was a school (of his) it would be the ‘School of Clear Thinking in Matters Surgical’”. The development of the surgical education program at the MGH was described by Grillo. Residents presented triumphs, problems and bad results at Grand Rounds. Churchill defended them.

The Ward Service in the White Building was the residents’ service. Attending surgeons were available to help if asked, but the residents and interns did the operations and did them well. At attending rounds each week, the Resident presented each patient at the bedside for review and comment; then on to a meeting room for an M&M conference. Deaths and complications were reviewed and recorded as: 1) error in diagnosis, 2) error in management, 3) error in technique, or 4) patient’s disease. Almost never was a complication or death called patient’s disease. It was almost always an error.

Some residents were critical of Churchill for not planning their careers. His door was always open and Ruth Meehan could always get you an appointment. He did not call you to ask what you wanted to do; he thought you should do that yourself. But he was a great facilitator, giving advice if you had ideas. The MGH program was not a professor and chairman's school, even though many chose academic careers. He was proud of all of his residents, no matter where they emphasized their careers – private practice, community, academic, or university. Virtually all MGH educated surgeons contributed to teaching programs. Some became department chairs or chiefs in their hospitals. All made a contribution; that was their heritage. No one knows how many chairmen or

chiefs came from the MGH. This was not important.

Churchill tried to retire early. After a small stroke he stopped operating and submitted his resignation to the Harvard Corporation. They did not accept it. Fortunately, for many, they asked him to carry on as a leader of the program.

He became concerned about excessive specialization, which could lead to mediocrity, emphasizing the breadth of general surgical training first, after which one could focus on a particular area while maintaining wide capabilities. He objected to general surgery defined as the operations a surgeon did in the morning – a single region being specialty surgery, two or more regions, including the belly, being general surgery. Churchill wrote in 1950, “Have some general surgery, the March Hare Specialty Board said in an encouraging tone. Alice looked all around the country and found nothing but specialty surgery. ‘I don’t see any general surgery’, she remarked. ‘There isn’t any’, said the March Hare Specialty Board.”¹¹ What would Churchill write or say today about increasing specialization?

It was an incredible privilege to have such a pioneer and leader as our Chief. Churchill summarized his beliefs and teachings in his Presidential Address to the ASA, “In times of change there is need for wisdom, both in the external social order and within the profession. Spokesmen who loudly proclaim measures based on self-interest will not be tolerated. A holdfast in science is essential, but this represents only a part of the strength of surgery. By maintaining the ancient bond with humanity itself through charity – the desire to relieve suffering for its own sake – surgery need not fear change if civilization itself survives.” His citation from the MGH read, “A man of many talents, his contributions to thoracic surgery, to the education of young surgeons and to military medicine have earned him the gratitude of a nation.” Dr. Churchill retired in 1962 and died in 1972, while on a walk in the wood

that he loved in Stafford, Vermont.

(Editor’s note: Art Baue was one of Dr. Churchill’s last residents finishing up as the East Chief Resident in 1961.

Art has had an outstanding career. He was Chairman of Surgery at Yale from 1975 to 1985. He then returned to his native Saint Louis where he has been Professor of Surgery at Saint Louis University and Vice President of the Medical Center. He was Chief Editor of the AMA Archives of Surgery and has had a special interest in the problems of multiple organ failure.

Art and Rosemary now live at Fisher’s Island, New York. They have three married children and six grandchildren. Art is a Life Trustee at his alma mater, Westminster College, and Rosemary is an active Congregational minister.

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Trustees recreated the position of Chief of the General Surgical Services and appointed Dr. Churchill Surgeon-in-Chief. East and West were combined for the records but remained separate teaching services and continued to be friendly rivals.

The East and West chief residents saw to it that the competitive spirit was maintained. The West Service wore pins proclaiming “West is Best”, and both services held raucous Change Parties in the Moseley flats. There, many ties were clipped off and some furniture was destroyed. The service making rounds in the South Solarium on White 12 could find itself locked out. One might notice goldfish swimming in the patient’s IV bottle at Grand Rounds. One of the highlights of another Grand Rounds featured a pianist, a patient of Ed Hamlin’s, who had just had a limited resection for Dupuytren’s contracture five days earlier. He first demonstrated his pre-operative limitations by playing Chopsticks and then followed with long series of chords to show off his postoperative skills. It was a wonderful time.

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The East and West remained separate teaching services until 1994. Partly because of the fragmentation of general surgery and partly because of outside pressure for every third night coverage, they were combined into a single service with a single chief resident. Many of us still have pleasant East-West memories of an era that has now passed.

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riod during which the ACS developed agreements to share hospital standards and inspection with the American Medical Association and the American Hospital Association to form the Joint Commission on Hospital Accreditation. The College had taken on this inspection-accreditation of hospital function at the time of its founding in 1913 having been prodded into the idea by the gadfly of the MGH, Dr. Emory Amory Codman. At the time Codman said, "It is the tail that will wag the dog!" From 1953 to 1958 Dr. Allen was president of the Boston Medical Library, instilling new life into that venerable Boston institution which enabled its joining Harvard Medical School to form the Countway Library of Medicine in 1964.

Dr. Allen received many accolades. He was awarded the honorary degree of Doctor of Science from Georgetown College in 1943 and from Harvard in 1952. The King of Norway conferred upon him the Knight's Cross First Class of St. Olaf's Order in 1946. He was made Honorary Fellow of the Royal College of Surgeons of England in 1947, and of the Royal College of Surgeons of Edinburgh in 1950 when he gave the Hunterian Lecture and, with Mrs. Allen, was received by Queen Mary. He was an Honorary Fellow of the Royal Society of Medicine of England and a member of the French Academy of Surgery. In 1953 he was made Trustee of the MGH by gubernatorial appointment. He received the Bigelow Medal of the Boston Surgical Society in 1956. In the end, he was appointed by the Governor of Kentucky to be an Honorary Kentucky Colonel – the genuine article!

But all of these accomplishments were secondary to his devotion to the responsible care of his patient, and to his zeal to provide them with the best and most up-to-date treatment available. To this end, he attended surgical meetings, conducted clinical research, read constantly the cur-

rent surgical literature and quickly incorporated the best of science into the art of his surgical care. He had his own surgical nurse, the renowned Miss Marie Chandler, and his first assistant was always one of his trained associates. He developed routines for every procedure which were memorized by each team member so that the operations were done with maximum skill and efficiency and with minimum waste effort and conversation. I-Es organizational skills were so great in these details, that I have never seen such art and efficiency in surgery since his death.

Dr. Allen's most enduring legacy – and the one which he would have prized most – is his influence on the science and the humanity of his younger brothers in surgery. Of these, the MGH Surgical Society is the most cohesive group. Most of his direct trainees have moved onward, but their accomplishments and spirits remain as our inspiration.

After Dr. Allen's death on March 18, 1958 a committee under the chairmanship of Bishop Henry Knox Sherrill raised approximately four million dollars which were used to build and name the operating suite in the Bigelow building. Bishop Sherrill's memorial plaque read "Arthur Wilburn Allen, 1887-1958: Master Surgeon, Esteemed Teacher, Beloved Friend". At the time, I was somewhat dubious about the permanence of this memorial, since I felt that when the Allen Suite required renovation a new donor and a new dedication would probably be forthcoming. Also, I thought that a suite of operating rooms conveyed very little understanding of Dr. Allen's personality and interests.

For these reasons, I began collecting funds from patients and other interested individuals to establish the Arthur W. Allen Residents' Training Fund. This fund is to be used under the direction of the Chief of Surgery to enhance the learning opportunities of the Surgical Residents. Dr. Joel Cooper became the first Arthur W. Allen Scholar in the MGH when the fund was used to help pay for his year in England to study thoracic surgery. As we all know, this had a dramatic payoff, and it would have delighted The Boss! Through the years, this small dribble has accumulated a total value as of June 30, 2001 of \$952,324. Thus, Dr. Arthur W. Allen remains very much alive among us.

Addendum: Robb Rutledge, being left-handed, recalls that Dr. Allen was rather tough on left-handed residents, urging

them to make themselves ambidextrous. Robb heard that Dr. Allen had been born left-handed, but had been forced to change during his childhood. That may well have been true, as that was the com-mon practice when he was a boy – and even continued during my childhood. Dr. Allen felt that in the close confines of an operating team, a left-handed member caused a loss of operating efficiency.

His message resonated with me. At the age of 10, as a result of an 8' fall, I sustained a compound dislocation of the right elbow with division of the brachial artery and compound fractures of both bones of the lower forearm. It required 2 years before I had functional use of the arm again. In the meantime, I had to eat, dress, write, work and play the piano with my left hand. As a result, I became almost ambidextrous, and have found this skill useful in my surgical career. Therefore, I also have urged my left-handed residents to make themselves more skilled in use of the right hand by eating, dressing and performing many other tasks of daily life with the right hand, all of which tasks will always occupy more time than operating. I am a firm believer of the plasticity of the brain and its ability to adapt to the demands put upon it in any stage of life.

(Editor's note: Grant Rodkey is a distinguished surgeon and health system analyst whose contributions to the Massachusetts General Hospital began with surgical training in 1943 and continue today. He has been president of the Suffolk District Medical Society, the Massachusetts Medical Society, founding Chairman of the AMA/Specialty Society Relative Value Update Committee of the American Medical Association and president of the Boston Medical Library from 1988-1997. He describes himself "remotely" as a rancher and lumberjack but continues active in surgery and teaching as Senior Surgeon at Massachusetts General Hospital and Chief of General Surgery, Veterans Administration Hospital Boston Health Care Systems.

**WE LOOK
FORWARD
TO SEEING
YOU IN JUNE**

