

# The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY Newsletter

Fall 2007

Volume 8, Issue 2

## MGH SURGICAL SOCIETY

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*It is a pleasure to record that Dr. Leslie W. Ottinger has joined the Editorial Staff of the MGH Surgical Society Newsletter*

### A MESSAGE FROM THE PRESIDENT

When a department chairman is replaced, the competition is intense. There will be winners and losers. Losers may become winners later on.

An example of this occurred in the Pathology Department of the Charite Hospital in Berlin in 1856. Johann Meckel, the retiring chief died of intestinal tuberculosis. There was heavy competition to succeed him, with at least six pathologists vying for the position. Two emerged from the pack and became finalists.

The first finalist was Rudolf Virchow, a 35 year old Berlin graduate, who was currently the Pathology Chairman at Wurzburg. He was a rising star whose only weakness was his reactionary political beliefs.

The second finalist was Theodor Billroth, a 27 year old Berlin graduate. As a youth, Billroth had been a slow learner who was more interested in music than medicine. He was considered a failure as a general practitioner and now was splitting his time equally between being a teaching fellow in the Pathology Department of Charite Hospital and working as a surgical assistant to Bernhard von Langenbeck, the leading surgeon.

After several months, the King declared Virchow the winner and appointed him Chairman of the Pathology Department at the Charite.

Billroth was awarded second place. He said, "I considered this decision a voice of destiny calling me to serve surgery faithfully". He then went into surgery full time. His relations with Virchow were proper but distant. He turned down pathology appointments at Wurzburg and Gottingen but was unable to get a surgical appointment. Finally in 1860 he was selected to be the surgical chief at Zurich, and his surgical career "took off".

In 1867 he was the first choice to be the Surgical Chief of the Second Surgical Service in Vienna. When in 1882 von Langenbeck tried to get Billroth to return as Chief of the Surgical Service at Berlin, Billroth declined. He remained in Vienna to enjoy his surgical career and his musical life with Johannes Brahms.

Billroth's loss to Virchow early in their careers was a frustrating defeat, but everyone became a winner in the end. Virchow became the world's leading pathologist. Billroth became the leading surgeon.

Robb Rutledge♦

### MGH Surgical Society Annual Reception

Monday, October 8<sup>th</sup>

6:00 to 8:00 p.m.

New Orleans Hilton  
Grand Ballroom C

## SAVE-THE-DATE

FOURTH MEETING  
OF THE  
MGH SURGICAL SOCIETY

June 13-15, 2008

Friday	Reception, Liberty Hotel (former Charles St. Jail)
Saturday	Academic program and clambake
Sunday	Academic program, photo Accommodations, Liberty Hotel



DR. DANIEL FISKE JONES

For a few years after I retired, I taught second year HMS physical diagnosis at MGH. One morning, a student returned to the review session after her interview with a patient whose chief complaint was gangrene of the toe. There were many vascular problems to talk about but the student's main findings were that the patient thought that his surgeon, Glenn LaMuraglia was St. Michael and Dr. Gerald Austen was God. I went back to see the

patient with the students and confirmed her interview. Interestingly the official chart did not mention the patient's delusions, probably because no one had asked him. More disturbing was the possibility that a surgical resident did review his mental status and didn't find anything unusual.

This startling episode made me wonder if during my residency, I too had wandered into similar murky swamps of delusions about my colleagues and teachers.

Certainly, when I started my internship in 1958, almost fifty years ago, our chief Dr Edward Churchill was not a Christian God, but easily could be compared to Zeus or Jupiter. His demeanor was indeed quite ethereal, rising above mundane problems to see the greater truth. Despite his stature, he, like Zeus or Jupiter, had an uneasy truce with the Gods about him, men of great stature such as Sweet, Robert Linton, Leland McKittrick, "Butch" Donaldson, Claude Welch, Marshall Bartlett, and Joseph Meigs. There were at that time busy younger Gods such as Gordon Scannell, Earle Wilkins, Bill Waddell, Hermes (such a coincidence) Grillo, George Nardi, and Bob "Hawk" Shaw. Perhaps our recent chief residents like Jack Burke and Hardy Hendren could be compared to Angels or demi-gods who were the link between us mortals in the trenches and the Gods on White 5. There are terrible gaps in this scheme, of course. Where did Oliver Cope fit in? Some say he already thought of himself as God so perhaps that was enough.

One can argue about whether our MGH surgical society was patterned after the Nordic rather than the Greco-Romano system but to me it seems a culture of Heroes. Our meetings, retirement parties, and legends bubble over with brave accomplishments, quasi-religious rights of passage, and an inordinate sense of duty. We are not a religion, but a band of warriors, fighting off disease, rising to heights of grandeur with magnificent saves and technical virtuosity that very few other professions can claim.

Most groups of heroes have a mystical origin and I have always wondered who preceded the Churchills, Sweets, Lintons, McKittricks, and Meiges. We have a biological continuity in George Richardson whose father Edward Richardson and grandfather Maurice Richardson were clearly original heroes like the Giants of creation as described in many cultures.

Of course there was the great surgeon, Dr. Arthur Allen, whose exploits were clearly worshiped by disciples such as Grant Rodkey, Claude Welch, Butch Donaldson and Glenn Berringer. We heard over and over again "Well that's the way Dr. Allen did it." He was so revered that some residents created a counter culture around the "perfectness" of Dr. Allen to handle with humor the mistakes and blunders which befall all of us. If we clumsily tripped or spilled food at mealtime or a clamp missed its mark or a blood vessel suddenly spurted over the surgical field, it was common to hear "Well that's the

way Dr. Allen did it". We tried by the humor of opposites to make our God like heroes more human and to make our own frightening situations more manageable.

Other myths followed. It was better to be "lucky than good". The lucky surgeon usually had better results, enough to make Dr. Codman proud. During my residency we also created an imaginary predatory bird called the Condor who periodically had to be fed hopeless patients or he would unexpectedly strike and kill cases who would normally have done well. Some floors had a stuffed condor perched on the nurses' desk. The price for the sin of hubris was great indeed.

In the mist of the murky mystical past was a definite primordial Giant, a surgeon called Dr. Daniel Fiske Jones, often known as "handsome Dan". Sweet, who most of us thought was the ultimate technical surgeon and a cool aristocratic character, worked for Dan Jones. McKittrick, another technical genius, also "carried Dr. Jones's bag" for a few years. Both spoke of Dr. Jones with great reverence and were proud of their apprenticeship years with the great man.

Aside from the comments by Drs. Sweet and McKittrick, I knew nothing of the man. I later discovered that Dan Jones was a brilliant surgeon who visited local hospitals in a chauffeured Pierce Arrow carrying him and his assistants. If surgery was to be done that day on a special and usually wealthy patient, his luxurious auto was followed by another large chariot with scrub nurses and other helpers.

In his autobiography, Claude Welch speaks of Dan Jones as an extremely able technician who championed the Miles resection for carcinoma of the rectum. Gordon Scannell states in his book about Dr. Churchill that the great chief almost went to work for Dan Jones but decided instead on a strictly academic career. George Richardson recalls that Dr. Churchill admired Dr. Jones greatly but disagreed with his autocratic methods of teaching residents.

It was early in my career that I had first hand experience with Dr. Daniel F. Jones's reputation. In 1965, barely into my new practice on the North Shore, I was called late on a snowy Saturday to a small local hospital. I had never been there before and was ushered into an ancient operating room where I found a young man in his early thirties writhing in agony. He and some friends were working on a heavy backyard project and he was crushed in the abdomen by a fork lift against a concrete wall. His shock was extreme; thready fast pulse, faint blood pressure, and he had a rigid belly. Worse still, he was cyanotic and without sensation from the waist down to his toes. There were no femoral or any other leg pulses. The usual hospital anesthesiologist was unavailable, the nurse anesthetist didn't know how to intubate and there were no vascular instruments other than a Harken clamp. Motivated by pure fear of the patient's immediate demise, I was inwardly in total panic but placed two fifteen gauge needles in the poor man's veins, gave him a liter of saline, intubated him after some anectine and pentothal, found some vascular sutures in my car, and proceeded to operate with the help of an old general practitioner who was at least 80 years old. Except for having to open the abdomen with scissors because the nurse dropped the scalpel on the floor, things went well. The blood filled abdomen was due to a repairable tear in the confluence of the middle colic and superior mesenteric vein. The distal ischemic injury was due to a crush without rupture of the abdominal aorta, causing the (Patton continued page 8)



In the fall of 1962, I was enjoying my experience as Dr. Robert E. Gross' (pictured left) Chief Resident in Cardiac Surgery at the Boston Children's Hospital (CHMC), as the culmination of a two year experience there in pediatric surgery. Fellow residents in surgery during those two years included Erik Gundersen, George Harkins, Jud Randolph, Alan Birch, Bob Replogle, Jud McNamara, Angelo Eraklis, Tony Lindem, Menelaos Aliapoulos, and Bob Filler, among others. During that period Hardy Hendren left the surgical staff at Children's to start a pediatric surgical service at the Massachusetts General Hospital. Jud Randolph had just come on the staff, after completing his residency at MGH and Children's.

On a given Friday morning, the operating schedule had begun. Dr. Gross, as usual, had about six cases scheduled. He liked to start with minor cases, and then proceed to the more complex procedures. Operating in the room next to where I was closing an ASD, to be followed by another (at that time, it was Dr. Gross' frequent practice to type and cross match

two patients with the same ABO blood group, prime the pump with blood, and then wheel the Kay-Cross oxygenator and pump into an adjacent room to be used on the next patient, as well, employing the same blood prime!), Dr. Gross was dilating a urethral stricture in a 20 year old young man, in whom he had repaired a hypospadias anomaly years earlier. In those days one used a battery operated light for the cystoscope, several of which were not in working order. After finding one that did, Dr. Gross began to use filiform dilators, one of which became detached from the follower, remaining coiled in the bladder. Despite many attempts (accompanied by battery pack and light failures) at extraction through the cystoscope, Dr. Gross was unable to remove the filiform dilator, an experience which was associated with mounting frustration. I looked up to see Dr. Gross come into my room, gloved, and sweep up a handful of surgical instruments from my Mayo stand. He ran back into his room, rapidly prepped and draped with towels the supra-pubic area of this patient, and made a transverse skin incision. Well, Bess Lank, his favored nurse-anesthetist, had started the case, assuming it would be a short one, with a less than full cyclopropane tank. Simultaneous with the skin incision, the cyclopropane ran out, and the patient began to awaken. Being a 200 pound fellow, he thrashed about, as Dr. Bob Smith, Chief of Anesthesia, rushed in with another tank of cyclopropane. One of the patient's legs flew upward, despite several staff working to restrain him, and shattered the large lens covering the operating room light. Glass flew everywhere, with no serious consequences, as anesthesia was re-established, and Dr. Gross proceeded to retrieve the filiform through a supra-pubic cystotomy. As he was closing the incision, the phone on the wall outside the room began to ring. Dr. Gross, annoyed, began to shuffle his feet and quietly asked for someone to answer it. Marie Dresser, his long time scrub nurse, looked frantically around to find someone to help with this task, but to no avail. With continued ringing, Dr. Gross finally broke scrub, and surged out the door, simultaneous with Mildred "Connie" Coniaris, the OR supervisor, rounding the corner, on the dead run, shouting, "No, Dr. Gross, Nooo..." Now to fully appreciate what happened next, a little vignette\* involving the idiosyncrasies of Dr. Gross might be in order. Dr. Gross assumed responsibility for much of the maintenance work about the OR. He kept a carpenter's tray close by, with the various tools required to fix the air conditioning\*\*, or repair doors, windows or the pump-oxygenator. He hated noise or chaos, and one day, not this Friday but another day, the door that separated Dr. Gross' room, room 3, from that (room 2) of Dr. Donald Matson (Chief of Neurosurgery) had warped, such that as the circulating nurse went back and forth to the autoclave, between the rooms, the door would go thump, thump, thump. When Dr. Gross had finished his case, and while Dr. Matson was in the middle of a craniotomy, he brought his carpenter's kit to the site, took down the door to Dr. Matson's room, took out a plane and shaved the door down. He replaced the door on its hinges, gave it a shove, it was silent. Dr. Gross took a broom, cleaned up his mess, and left a startled Dr. Matson. Now, to return to our story, when the phone would not stop ringing, Dr. Gross brought his tool kit to the phone, carefully unscrewed the box on the phone, found the clappers that went between the bells, took out his side biting clippers, clipped the clappers off, and replaced the box. That phone never rang again. Dr. Gross, having silenced the phone, calmly returned to his room, re-scrubbed, and, as I remember, completed his surgical schedule without further interruption.

As surgical residents at Children's, we were in awe of Dr. Gross, (we referred to him in the third person as "The Chief") not just for his accomplishments, but also for his concern for his house staff who he treated as if they were members of his family. He could be stern, when we erred, but never without understanding and a subtle sense of caring and humor, even when things seemingly couldn't get worse. An example involved one of the junior surgical residents who rotated to Children's from the Brigham (he shall go nameless to protect the innocent). He was fastidious in his care of his patients, but less so in the care of his uniform. We wore white uniforms and white buck shoes, which in this particular house officer's case, were often wrinkled and scuffed. Dr. Gross, on more than one occasion, had chided him about his shoes. Dr. Gross, himself, always wore a fresh, crisply starched and ironed coat with hair combed perfectly. On a day that I remember (and to which Dr. Judson Randolph was an eye witness), the resident had just completed a procedure, and ambled out of the OR, through the lounge and in to the Doctors' dressing room, where he found Dr. Gross, sitting on a low stool carefully applying white polish to the resident's shoes, having opened his locker with a master key. As Jud recalls, the resident fell to his knees, pleading with Dr. Gross, to let him shine his own shoes. Dr. Gross ignored him, completed the job and carefully placed the young man's shoes back in his locker. I believe that particular resident, as well as his peers, thereafter, paid greater attention to his uniform.

\*Contributed by Dr. Robert Replogle

\*\*My first night on call in the hospital, I was paged to come to the OR to assist Erik Gundersen with an appendectomy. As I entered the OR suite, I found Dr. Gross, in starched white coat, on a step ladder, only partially visible as he worked inside an air conditioning unit with Jean Lootz handing him various tools, as needed, for a repair that had eluded the hospital maintenance crew. (Daggett continued on page 7)

## A MESSAGE FROM THE CHAIRMAN



### End of an Era – Start of a New One

June, 2007 marked the graduation of the last Surgical Chief Resident at the MGH. Jason Hall (*pictured left*) turned in his beeper and moved to the Lahey Clinic, where he began a fellowship in colorectal surgery. Thus ended a key component of MGH surgical training, developed by Edward Churchill after World War II, which evolved in its later states from a PGY6 resident into a junior faculty position with responsibility for directing the com-

combined East-West ward services (now called the Churchill Service). Jason, like his predecessors over 60 years, used the opportunity to fine-tune both his surgical and administrative skills.

It has always been a great job, personally consuming but ultimately a highly-valued capstone on the building of consummate surgeons. So why has it gone, following a similar dissolution at the Brigham and Hopkins, among others? The ultimate answer is that this “extra” year of training no longer meets the needs of today’s surgical training paradigm. The practice of surgery has progressively evolved into subspecialty niches which increasingly require advanced training and additional certification. Seventy percent of surgical residents nationally now seek fellowship training. At the MGH all our graduates for the last several years have chosen fellowships. The Chief Residency, once a prize to fight for, is now a super-numerary year that candidates feel they cannot afford when facing further training time and growing debt. Regretfully perhaps, they have declined the offer. Simply said, other priorities have trumped the job. Ave at-que Vale, chief residents.

The impact on the Churchill Service is great. The Chief Residency was not only about the training of an individual, but also about managing a major segment of the hospital’s surgical services and being the educator of a dozen residents at a time. The Resident provided attending-level supervision of patient care, in and out of the OR, for nearly 2000 patients per year. The Churchill Service provides an alternative environment to the private general surgical services, one in which residents at all levels perceived that they had a greater measure of independence in which to apply the lessons learned and to grow and mature. That opportunity has been cherished, and we will strive to preserve its values.

A new structure for the Churchill Service is unavoidable. Concomitant with the absence of the Chief Resident to serve as an attending of record (required by hospital by-laws), there are ACGME requirements and public demands for increased supervision of trainees. There is clear intolerance of learning by trial and error or through mistakes that could have been avoided by the oversight of experienced faculty. We are accountable to our patients as never before.

Unlike the Brigham and Hopkins, which disbanded their ward services, our solution has been to meld the Churchill Service with the Division of Trauma, Emergency Surgery, and Surgical Critical Care (TESSCC), led by George P. Velmahos, MD, PhD, MSEd. George is a skilled and committed teacher who has recruited a faculty (Hasan Alam, MD and Marc deMoya, MD) similarly committed to resident (and medical stu-

dent) education. They understand and respect that the Churchill Service fits in a different niche and serves a different purpose than the private (Baker) services. Because there is an in-house faculty surgeon 24/7 to fulfill the requirements of a Level I Trauma Center, there is always an attending to provide advice, back-up, and hands-on help as needed. There will be three teams of residents, each affiliated with one of the faculty, each led by a PGY5 who will manage his/her own collection of patients. The principle is to provide what I call “supervised autonomy”, which allows the resident to formulate the plan of action as long as it can be justified and is effective. The coming together of the Churchill and TESSCC services began last year as a transition with Jason Hall.

The new, combined service will also emulate an emerging paradigm of Acute Care Surgery (ACS). As surgeons become more sub-specialized and their scope of practice becomes compartmentalized, there are fewer general surgeons who can or want to meet the needs of the broad general surgeon of old – either in academic health centers or in community hospitals. The concept of the Acute Care Surgeon is to a large extent a throwback to provide broad urgent surgical care for what “washes up on the beach”, whether during the day or in the middle of the night. For now it is an excellent means of preserving maximum value for the Churchill Service.

Nonetheless, there are challenges and unresolved questions. What are the proper limits of ACS? What patients who come to the Churchill Service and who historically were managed by the ward service should in the future be referred on to other specialist units – i.e. non-trauma vascular and thoracic cases; complex oncologic cases; and those cases which we encourage to be concentrated according to expertise in the newly established departmental subspecialty programs? What about non-urgent routine problems? How to maintain the flow of patients from the clinics, health centers, and consult services? With only three faculty surgeons in the TESSCC Division at present, there is a manpower shortage which in time must be met with additional recruitment. We are fortunate as well that senior surgeons Ashby Moncure and Michael Margolies will continue to provide supervision in the surgical clinics.

This train was visible long before it pulled into the station, and we have been preparing for its arrival. The tracks lead from here into territory which is as yet only partially charted. We are ready for the adventure.

Andrew L. Warshaw ♦



*Class of 2007: Back row (l to r) Ara Feinstein, Adrian Maung, Dax Guenther, Jason Hall. Front row (l to r) Peter Minneci, Kate Deans, Andy Warshaw, Grace Wang, Ashok Muniappan*



Presented at the Partners HealthCare System, Inc. Annual Retreat in April of 2007

Good afternoon everyone. My name is Ara Feinstein and I am a seventh year General Surgery resident at MGH.

Yes, you heard correctly, seventh year.

Thank you, Dr. Weinstein, for inviting me to speak. One of your slides reminded me of something the senior resident told me my first terrifying night on call: "Call me if you need help...but I will take it as a sign of weakness."

These years have been an unparalleled adventure, and one that I find others to be quite curious about. When I catch up with old friends or meet new people, I often endure a barrage of questions. Usually, it's the same questions, over and over again. So, I thought I might take this opportunity to answer them for you.

I think the most common question I get asked is, "Why does surgery residency take so long?" This is often phrased in different ways, my least favorite of which is, "when are you going to be a real doctor?"

The reason is simply – surgery is hard. That notion is lost on our society. Surgeons are victims of their own success. Procedures once considered to be small miracles are now thought to be routine, because patients go home the next day, or better yet, don't come into the hospital at all. But the ability to select the right procedure for the right patient, the technical ability to safely and quickly carry it out, and the diligence required to take care of them afterwards is a lifelong learning process. Sometimes I think my residency should be even longer.

On second thought, maybe not.

The next most common question I get asked is, "Is it just like Grey's Anatomy?"

I don't know the answer to that question. I've never seen it. For some reason, I just don't seem to have a lot of time for TV...but, from what I've heard it involves lots of really good-looking people who have torrid romances and occasionally perform surgery. Sounds deadly accurate.

I often get asked how many hours a week do you work?

Let me make this clear: I work 80 hours a week! Not a minute more. Ever.

But I was actually a resident before the law mandating an 80 hour work week, and I once counted a 136 hour span over seven days. There are 168 hours in a week, which means I spent 32 hours at home. But before you think that I was being "abused", I should mention that was the week I spent as senior resident on the Burn Service during the Rhode Island Nightclub Fire. As New England's major Burn Center, we took the sickest survivors and we worked around the clock. Each one of those hours made a difference for me, my education and most importantly, the patients.

Still, I agree with the idea of reducing work hours for residents. Despite regulations, I hope residencies continue to be defined by a spirit of service and learning. The challenge in my mind will be continuing to train doctors who understand sometimes we need to put the patients' needs before our own, and that good care is not given at the convenience of the physician.

The next I get asked is, "Do you get paid?"

Yes, people actually have the nerve to ask that question, or even worse, people ask, "How much do you get paid?" There is no good answer for such a rude question, but the truth is, that unlike residents of years past, we get paid pretty well.

Unless, of course you break it down into an hourly wage. That is just depressing. But one of the nice parts of being a surgery resident is that you don't have a lot of time to spend money, so it's usually not an issue!

I'm from Arizona; so friends and family from home are always asking me if I'm freezing, or they ask how I stand those Boston winters. I always say it's no problem – because for a surgery resident, the weather is 70 and fluorescent every day of the year.

Finally, people often want to know what the best and worst parts of my job are.

The worst is easy. Over seven years, I have missed weddings, Bar Mitzvahs, birthdays and countless other moments that were important to those close to me. I am so lucky to have friends and family that have been understanding of these absences. But those sacrifices have also been made easier by the countless others, from fellow residents to nurses, to the page operators and security guards – everyone who helps ensure that the care at 3:00 a.m. is as good as the care at 3:00 p.m. If I cannot be with my friends and family, at least I can be in a place where I am truly needed, surrounded by people who are as dedicated as I am.

The best part of my job as a surgery resident is that I feel like I have truly learned what is important in life. Again and again I am taught the lesson that as long as we and those whom we love are healthy, no problem is insurmountable. I have had billionaires as patients that I am sure would give it all away to spend a few more days as healthy as most of the people in this room.

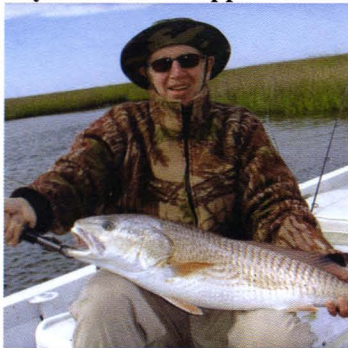
So if I can leave you all with a message, it's that surgery residency can be harrowing work, and although we are not as attractive as the actors on Grey's anatomy, we still manage to lead fulfilling lives and do some really interesting operations, all in under 80 hours a week. It's hard for others to understand that unlike other jobs, what you put in cannot be measured in hours, and what you get out of it cannot be measured in dollars. Working to take care of people whose health has failed them is both a privilege and a constant reminder that as long as you feel good, life is full of possibilities. Thank you.



*(Editor's note: Ara Feinstein, a graduate of the University of Arizona (Summa Cum Laude) and Yale University School of Medicine, began his internship at the MGH in 2000. While a medical student he had been a research fellow in the Division of Trauma and Surgical Critical Care at the University of Miami and later returned to that unit in 2003 as an NIH Research Fellow, also earning a Masters in Public Health at the University of Miami. Having completed his surgical residency at MGH, he has opted to resume life in the warm weather of Miami as an Assistant Professor in the Trauma Division.) ♦*

(Daggett continued from page 3)

When in the course of my residency at Children's, which was in the middle years of my surgical training at the MGH, I found myself having trouble paying our bills, with a family to provide for and only a modest stipend, which was the rule in those days. I made an appointment to see Dr. Gross, and described my plight.



Which one is Daggett?

He said, Bill, how much do you need? I thought that a loan of about \$5000 would get us through the next year. He immediately wrote out a personal check for that amount, and said to come back if further need arose. Years later, having joined the surgical staff at MGH, I wrote a check to Dr. Gross for \$5000 and sent it along to him with a note of thanks for his support in earlier years. A week later, I received in the mail, the check, returned, with a handwritten note from Dr. Gross, who wrote, "Dear Bill, Give this to some young person who is in need. Sincerely, Bob Gross."

*(Editor's note: Bill began his surgical internship at the MGH in July of 1958 after receiving his M.D. from the University of California School of Medicine, San Francisco. He was the West Resident in 1967-68 following which he joined the surgical staff at the MGH and the faculty of the Harvard Medical School. He is now Senior Surgeon at the Massachusetts General Hospital and Professor of Surgery Emeritus at the Harvard Medical School. Bill has had a distinguished career in both clinical cardiac surgery and cardiac surgical research. He was one of the original members of the cardiac surgical team and has made a major contribution in the teaching of*

*surgical residents and the development of cardiac surgery. When Bill is not mentoring HMS students, he has continued his long-time interest in fly fishing and upland game bird hunting with his English setters.)* ♦

#### Events of Note

- ◆ Congratulations to **John C. Baldwin** on his recent promotion to Clinical Professor of Surgery, HMS.
- ◆ Congratulations to **James Burns** on his recent promotion to Assistant Professor of Surgery, HMS.
- ◆ **Cristina Ferrone** Instructor in General and Gastrointestinal Surgery, received funding from Veridex, LLC for her project "Measure of circulating pancreatic adenocarcinoma cells in patients with pancreatic adenocarcinoma". Dr. Ferrone was also awarded the Karin Grunebaum Cancer Research Foundation Faculty Fellowship for 2007 for her work in the immunology and immunotherapy of pancreatic cancer.
- ◆ **Denise Gee** has joined the Division of General and Gastrointestinal Surgery in the practice of minimally invasive and bariatric surgery. Dr. Gee graduated from Boston University School of Medicine, performed her residency at Boston University School of Medicine, and has recently completed her Fellowship in Advanced Laparoscopic Surgery at MGH.
- ◆ **Alan Goldstein** was selected as the American Pediatric Surgical Association Foundation grant award recipient for 2007.
- ◆ MGH Transplant Surgeon **Martin Hertl** was awarded the Department of Surgery Faculty Development Fellowship.
- ◆ **Matthew Hutter** gave the keynote address at the Meeting of the National Surgical Quality Improvement Program, sponsored by the American College of Surgeons and attended by more than 400 surgeons, nurse, and managers from the U.S. and Canada.
- ◆ **Mark Katlik** delivered "Principles of Geriatric Surgery" as the Whitehead Visiting Professor at Emory at the invitation of Bill Wood. Then he was the visiting lecturer at Northwestern and Wisconsin where Denny Lund was his host. Mark is currently the Director of Thoracic Surgery at the Geisinger Health System, Pennsylvania.
- ◆ Congratulations to **Joren C. Madsen** on his recent promotion to Professor of Surgery, HMS.
- ◆ Congratulations to **James Markmann** on his recent promotion to Professor of Surgery, HMS.
- ◆ **Jim May** gave his presidential address to an audience of 450 people at the American Association of Plastic Surgeons in May, 2007. The address was entitled "Gain Without Pain: The Dawn of Elective Surgery" and focused on the ether anesthesia experience at the MGH.
- ◆ **Jeff Meyers** joined the Department of Surgery and the Mass General Hospital for Children as the Chief of Pediatric Cardiac and Congenital Cardiac Surgery in July 2007. Dr. Myers was Director of Pediatric Cardiothoracic Surgery at Le Bonheur Children's Medical Center in Memphis, Tennessee where he relocated with his family following the devastation of Katrina. Prior to that he was the Chief of Pediatric and Congenital Cardiac Surgery at Tulane University Medical School in New Orleans, Louisiana. Dr. Myers is leading the efforts to develop the Pediatric Cardiac Program of the MGHfC in collaboration with Michael de Moor, MD, Chief of Pediatric Cardiology. Dr. Myers also plans to continue his existing clinical trial work at the MGHfC while also developing a laboratory effort in basic and translational research.
- ◆ **Christopher Morse** will be joining the Division of Thoracic Surgery on July 25, 2007. Dr. Morse performed his residency and thoracic surgery training at MGH. Dr. Morse completed a fellowship in minimally invasive surgery for benign and malignant disease of the esophagus at the University of Pittsburgh. He will split his clinical activities between MGH and North Shore Medical Center, working with Drs. Allan and Donahue. Dr. Morse will help to develop a more robust program of minimally invasive thoracic surgery at both institutions and he will also participate in the Thoracic Oncology Clinic of the MGH Cancer Center.
- ◆ **David Shahian** joined the staff at MGH in May 2007. He will serve as Associate Director of the Department of Surgery's Codman Center for Clinical Effectiveness in Surgery and as Research Director for the MGH Center for Quality and Safety.
- ◆ Congratulations to **Barbara Smith** on her recent promotion to Associate Professor of Surgery, HMS

*(Patton continued from page 2)*

intima to shrivel up into the common iliac arteries. Simply tacking the intima back to the iliac bifurcations fixed that problem before permanent clotting downstream and on the way out I found a blunt injury hole in the small bowel, one and one half feet from the ligament of Treitz. Fortunately all peripheral pulses returned. It was a “lucky” save and I held the “condor” off one more time. I cannot exaggerate my inner fear during this episode and thanked all my mentors and fellow residents who helped me become a surgeon.

After bringing the good news to the anxious family and arranging transfer to Salem Hospital where there was an MGH surgical resident, I reviewed the case with the old general practitioner who was a skilled assistant. “Great job” I recall him saying. “I thought the young fellow was a goner. You remind me of the surgeon who came here more than 30 years ago in a Pierce Arrow and a huge limousine carrying all his help. His nurse couldn’t find the scalpel, so he opened everything with scissors. We copied him for twenty years until someone told us it was a mistake. I think his name was Jones, Dan Jones. What a magnificent individual, good looking fellow.”

Indeed Dan Jones was a magnificent individual. Born in Minnesota, he came east to graduate with honors from Harvard College in 1892 and then HMS in 1896. He then became a house pupil or intern at the MGH and soon after that went to work as a surgical apprentice to Dr. Maurice Richardson, a most prestigious job. Jones’s progress in the early 20<sup>th</sup> century was meteoritic. Soon he was teaching graduate courses at the MGH and his reputation was so strong in a few years that he was appointed head of the Harvard Surgical Unit in France during 8 months of WW1. Soon after that he was a member and later President of the American Society of Surgeons, a regent of the American College of Surgeons, a member of the American Society of Clinical Surgeons, President of New England Surgical Society, as well as President of Boston Surgical Society. He also became Chief of the Fracture Service, an Attending in the Vascular Clinic, the surgeon in charge of colon and rectal tumors, and finally Chief of the East Surgical Service in the late 1920’s. Some have stated that his apprentice McKittrick was expected to be the next chief of surgery after Dr. Edward Richardson’s demise in 1931. One wonders of the intrigue in the surgical department at that time.

Dan Jones died in 1937 as one of the most important surgeons in the country. He had just returned from Sweden with a group of distinguished American professors. Two very important bishops of the Episcopal church presided at his funeral. Sweet, Fred Lund, Shields Warren, George Brewster, David Cheever, and McKittrick were some of the eulogists. Dr. Sweet said in conclusion: “To those few of us who have had the invaluable privilege of working intimately with him in his practice, the loss of this truly great man is irreparable.” His pallbearers included most of all the best surgeons in Boston but it is noteworthy that Dr. Edward Churchill was not among them, even though Dr. Churchill had been chief at the MGH for 5 years. At his death Dr. Jones was an Overseer of Harvard, an elected honor accorded only to the most generous and prominent of its alumni.

It is not easy to exactly uncover what made Jones so good. Certainly everyone talks of his technical ability and his passion for curing colon cancer. It is clear he was financially successful and had great respect among his peers. He was a great sportsman, gentleman, and social smoothie. It is likely too that he was a great teacher if only by example. Drs. Sweet and McKittrick were two of the finest technical surgeons in the country. I suspect Dr. Sweet’s surgical virtuosity and cool aristocratic manner was patterned after his mentor Dan Jones. The mere idea that Dr. Churchill would consider working for Dr. Jones instead of choosing an academic career is a tribute to Jones’s stature.

But the best insight I could find about Dan Jones came from his own writing, a speech as President of The New England Surgical Society, given in 1927. In it, he lamented that the new “diagnosticians” were telling the surgeon what operation he should do for what disease and for what indications. I sensed his struggle with the idea that anyone would challenge the position of the surgeon, his intimate knowledge of pathology, his technical ability, his need to respond to a crisis. He tries hard to give credit to anesthesia and asepsis in the history of surgical advances. But in the end, his words ring clear and true. Dr. Jones stated “It is my conception of the surgeon that he is the final and supreme authority...to make a general summing up of the situation for the patient...and to handle the particular problem. It is difficult to see how any other person than the surgeon can handle all these requirements and I believe it is his duty.” And so it is the duty of surgeon and it is also his or her burden, for the work of a surgeon hero is never done. He or she must always be ready for the next conflict, the next save, and perfection, however long and patiently sought, is never entirely possible.

*(Editor’s note: Born in Cambridge in 1932, Tony Patton grew up in Arlington and won a Harvard National Scholarship to attend Harvard College and HMS (As a matter of coincidence, Dan Jones was a prime force behind the establishment of this scholarship. Tony began his MGH internship in 1958 and also spent one year in England working under famed thoracic surgeon, Mr. Jack Griffith. After completing his residency in 1964, Tony established a practice in thoracic and vascular surgery on the north shore of Boston. He was active in a number of committees and societies, and became chief of thoracic and vascular surgery at North Shore Medical Center. Retired in 1995, he filled his time with teaching basic skills to 2<sup>nd</sup> and 3<sup>rd</sup> year HMS students and writing and lecturing on a variety of historical subjects, many written for the HMS Alumni Magazine where he currently serves on the Editorial Board. He has been on a number of charitable boards and is proud of being an original incorporator of the Hospice of the North Shore. He and his wife Christine have been married over 55 years. They have 3 children, one son in administration at the MGH, and two daughters who are both professors of comparative religion. Chris and Tony Patton live between their home (circa 1756) in Danvers and their Boothbay, Maine home where they are very active in land conservation. Tony is President-Elect of Boston Surgical Society for 2007 and will be President in 2008. Post Script: Tony is not directly related to General George Patton of WWII fame. It is also untrue that while at Harvard playing varsity hockey, he led the Ivy League in penalties. (It just seemed that way). In the category of interesting coincidences, Drs. Earle Wilkins and Frank Wheelock were Patton’s primary caregivers when he was injured his senior year after a crash into the boards.)♦*



## Letters to the Editors

Dear Editors:

I remember Dr. Taylor quite well. He was near the end of his career when I scrubbed with him. He made many famous comments. He was larger than life in some ways, but it was Bill Rogers, one of the most decent people the MGH appeared to tolerate, who made Taylor's surgery successful.

Most of the behavior of eccentrics, like Taylor, would not be tolerated now, and shouldn't have been tolerated then.

Times have changed, and we are all better for that.

Joe Barrie '65

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Dear Editors:

Another Grantley Taylor anecdote:

When I had trouble clamping a perforating artery during one of his no nonsense mastectomies, he put down his scissors and said, "It's about time to convene a committee on hemostasis".

John Burrington

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Dear Editors:

Another "Grantley":

He took George Richardson apart about a case at Grand Rounds – publicly embarrassing George.

George, several days later, sent him an olive branch (I think – anyway a peace symbol). Few days on George got a message to pick up a package at the front desk. He did, opened it, and found a bottle of "Old Taylor".

Robert Coe '55

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### In Memoriam

**Frederick G. Shaffer**

Dear Friends:

The last publication with comments about Dr. Grantley Taylor brings back wonderful memories. I was lucky enough to help Taylor on many occasions in the OR. He was a favorite surgeon of ours because he let us do all the operations while he just watched. I must add also that his nails were not always short enough nor clean enough because he loved gardening. He was a good teacher and we all loved him. I like to say that the general opinion of the residents was more or less the same regarding the "Visits"; at the top of the list was Dr. Allen, Head of the East Service who was very mad when I made him late for one of his cases when I was doing a thoracoplasty at the Baker. We all agreed also that Dr. Oliver Cope as his song confirmed was so slow that we said he'd like to put a hemostat on every red blood cell. At the other end among our favorites were Leland McKittrick, Bob Linton and Richard H. Sweet. I was privileged and I am thankful to have been acquainted with such outstanding men. I must add that not only surgeons but internists like Chester Jones, a great gastroenterologist and Paul D. White, a very famous cardiologist I had the privilege of knowing closely because all of their patients that required surgery were referred to Dr. Richard Sweet whom I assisted for several years. Joe V. Meigs was a colorful gynecologist who liked to have a Pepsi Cola during his weekly staff meetings. One day he was surprised because we had filled half of the bottle with rum. Another unforgettable friend was Howard Ulfelder who was first Chief Resident of Surgery and later succeeded Dr. Meigs. He gave me good advice before I left for Guatemala, he said "Rudy, don't do a pancreatectomy on anybody during the first two years you start practice". I am happy to say that I followed his advice during my whole career at home. There are two hospitals in England, 40 miles away from each other, where pancreatectomies have a mortality of 2.1% in one and 55% on the other, in the second one, they did 5 pancreatectomies a year instead of two or three a week as they did in the other.

During Service Meeting, Dr. Allen once ran out of cigarettes and here is what happened: Our wonderful Chief Resident Ad Breniser was a heavy smoker, he would light a cigarette in the cafeteria before getting in the elevator and he would cut the burning tip with scissors as we arrived on the ninth floor. Well, that day, everybody

tried to offer Dr. Allen a cigarette but the one who had the longest arm was Ad's. When Dr. Allen pulled the cigarette out of the pack, he was surprised to see that it was second hand. Speaking of the Chief West Resident in Surgery, Addison was the best one could have had. He was a leader, a teacher and a real good friend. He would start rounds at the EW with a bang, hitting the revolving door with his hand. He looked like a race horse and his rapidity in the OR and in making a decision were equal to no other.

We did not call our "Visit" by their first names with the exception of Linton. He was a brave and capable surgeon who would tackle cases that had been called inoperable by other good surgeons. He got into lots of trouble and was always able to find a way out of trouble. He was also a good skier and that's where our friendship became extracurricular.

So as not to make this letter too long I plan to send another one in the future, but I cannot finish this report of memories without a couple of lines on my teacher and mentor, Sweet. Nobody called him Richard among the residents but Sir Richard; we all admired the rapidity and elegance of his gesture and I would like to emphasize that during the 3 years or so that I helped him I never saw a fistula either in the GI tract or bronchi nor complications after his thoracotomies. He was elegant outside of the OR also – wore a vest and a hand watch tied with a gold chain across the chest. I had the privilege of being invited to his home several times and was extremely grateful to Mrs. Sweet who asked me to stay and work with her husband. This MGH experience was very important for my future life; the temptation was great but I decided to return to Guatemala. You will hear from me soon again.

Best wishes.

Rudy Herrera '42

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### New Books

Robotic Radiosurgery  
Treating Tumors that Move with  
Respiration

Harold C. Urschel, Jr.  
Editor-in-Chief

Springer, Heidelberg  
2007

