



# The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY

## Newsletter

Fall 2014

Volume 15, Issue 2

### MGH SURGICAL SOCIETY

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**Massachusetts General Hospital**

**55 Fruit St., WHT506**

**Boston, MA 02114-2696**

**TEL: 617 726 8254**

**FAX: 617 726 7593**

**mghsurgsoc@partners.org**

### **MGH Surgical Society ACS Cocktail Reception**

**Monday, October 27, 2014  
6-8 PM**

**Hilton San Francisco  
Continental Ballrooms 4 & 5**

#### Cardiac Surgery at the MGH 2014 by Thor Sundt

We are approaching the 60th anniversary of cardiac surgery at the MGH. While closed heart operations on the great vessels had been performed here and elsewhere before the introduction of the heart-lung machine, as were closed valvotomies and rarely open procedures under surface cooling, it was the clinical application of this device that enabled the field to blossom in its own right as a subspecialty of surgery. Dr. John Gibbon was inspired to devote his life to the development of such a machine while an MGH surgical research fellow after witnessing a patient die of pulmonary embolism. With laboratory experiments beginning in Churchill's laboratory in 1934, he realized his dream in Philadelphia with the first successful intracardiac repair under cardiopulmonary bypass in 1953. Quick to appreciate the implications of this innovation, Dr. Gerald Austen worked with Dr. Robert Shaw to construct such a machine here at MGH which was in clinical use by J. Gordon Scannell and John F. Burke in 1956. Soon a small group of true pioneers – Jerry Austen, Mort Buckley, Eldred Mundth and Bill Daggett – were focusing all of their efforts on developing the field of cardiac surgery. By the end of the decade of the 60's cardiac surgery at MGH was in full swing and a leading unit in the world. The division today owes not only its existence, but its reputation as a clinical powerhouse to these pioneers. Today there is virtually no institution with superior outcomes or broader clinical practice.

But times do change, and over the course of the last several years we have turned our attention, as have others in the MGH, to practice redesign as a means of further improving quality in all of its aspects as defined by the marketplace today. We aim to improve service timeliness and patient satisfaction while reducing costs, and do this while making our service a more desirable place to work for surgeons, nurses, advanced practitioners and other allied health professionals. With attention to eliminating wasted time, effort, and resources through greater teamwork and coordination among the surgical staff, we have made structural changes in the practice to enhance communication among our administrative staff. The institution of a centralized referral coordinator system providing patients and referring providers information on the availability of all the surgeons for consultation as well as OR availability empowers them to select the consultant that can best serve their needs. On our side, it helps to match demand to capacity thereby lessening wide variations in the OR schedule and attendant overtime and over-stress on the busy days. By filling in the "white spaces" of unused capacity, it also helps the institution run as efficiently as possible. There are challenges to be sure, including the preferences of some referring providers to speak to the same administrative personnel that they have interacted with for years. Our challenge is to maintain that high-touch, personalized service to the outside world while fostering an attitude of shared responsibility for shared resources internally.

This approach is based on the conviction that there is enormous leverage in true teamwork. If we are to succeed in our mission to provide superior clinical care while educating the next generation and advancing the field through meaningful investigation, we need to work together. It is impossible to escape the inevitable sports analogy that "great teamwork beats great individual efforts" every time. This is not to say that we do not have great surgeons, or that we undervalue individual skill; superior clinical abilities are the hallmark of the MGH surgeon. But just as the success of the group depends on the success of individuals, the success of each individual depends on the success of the group. By working together we can advance the careers of our younger surgeons, giving them the room to think and develop their academic careers while at the same time helping them to build busy and satisfying clinical practices. True teamwork benefits the providers as well as the patients.

Our collective attitude to resources is reinforced by our approach to OR scheduling as well, which is considered as block time for the whole service, not an individual surgeon. Although the scheduling software does not yet accommodate us, we plan our first case of the day in our scheduled room, but expect our colleagues in anesthesia and OR nursing to actively manage the schedule "on the fly" such that to-follow cases "stagger" into other rooms as dictated by the optimal timing for the OR suite as a whole. The process is still in evolution, but most surgeons find that they are able to get through their day more efficiently.

In addition to these structural changes, the division has added staff with special expertise in mechanical circulatory support, transplantation and minimally invasive valve surgery in recent years. With Gus Vlahakes and Tom MacGillivray as the cornerstones (continued on page 12)





*Class of 1958*

*Front row l to r: Mort Buckley, Jack Porvaznick, Dr. Churchill, Bill Daggett.*

*Back row l to r: Tony Patton, Lew James, John Madden, and Stan Bohrer*

*(Missing from the photo is Don Pearl)*

Dear Les, You have proposed a look back at the members of the MGH surgical internship classes for consideration of publication in the MGH Surgical Society Newsletter. I have interpreted this proposal to mean where are you, what have you done since completing training at MGH, and the like. Charlie Ferguson has done a superb job (with humor) summarizing his class, occasionally taking editorial license for those classmates displaying recalcitrance to providing the requested biographical material. Our class (1958) differs in a number of ways from Charlie's and the other later classes: In contrast to his 14 members (even larger numbers in more recent classes, as the Chief Residency has given way to specialty fellowships), our class had 8 members, six from HMS, and two "auslanders" – Mort Buckley from BU and myself from UCSF. A theme of our class, as likely so for many other classes, has been outreach or "paying back" often by leading teams in the US and other countries or in the military. We are largely retired now with some part time academic activity, but can relate what seem to be interesting careers. We have lost two of our class, Mort Buckley and Lew James, for whom we have submitted brief biographical sketches of their remarkable careers. Two of our class pursued other specialties, namely Stan Bohrer (radiology) and Lew James (pathology), while Jack Porvaznick and Don Pearl continued to hold high the flag of general surgery. John Madden ((plastic and hand surgery), Tony Patton (thoracic and vascular surgery) and Mort and myself (cardiac surgery) pursued surgical subspecialties. We have received contributions from each surviving member of our class, and will provide reviews of the remarkable careers of two of our class that we have lost namely, Mort Buckley and Lew James. Bill

**Stanley P. Bohrer** - As a member of the MGH surgical class of '58 who did not become a surgeon, I may be an 'odd man out'. How did this happen? Early in my residency I developed what was thought to be a psychiatric illness and was in McLean Hospital for several months during which time it was determined that I had viral encephalitis. While there I became friendly with the MGH radiologist covering the hospital. When I was discharged, Dr Larry Robbins (RIP), chairman of radiology at MGH kindly offered me a place in his residency program. It worked out well because I am a visual learner and loved the practice of radiology.

After completing my residency in Boston, I spent one year at the Hammersmith Hospital and Post Graduate Medical School in London. Before returning to the States, I agreed to spend several months at a new medical school teaching hospital in Ibadan, Nigeria, to help out a friend of my chief of radiology at the Hammersmith. The University College Hospital in Ibadan is a 500 bed teaching hospital of the University of Ibadan Medical School, a school started with the cooperation of University College Hospital, London. Leaving London, we drove our MG-B several months around eastern and Western Europe ending up in Casablanca, then took a freighter - with the car - to the Port of Lagos, Nigeria.

As my three months in Nigeria was coming to an end, I knew I had found my place. I had become fascinated by the Yoruba culture and art. I was challenged by all the diseases I had only heard of and not seen. I wrote prolifically on conditions like schistosomiasis, typhoid, tetanus, sickle cell disease, amoebiasis, Burkett's lymphoma, etc., etc. I signed on to continue and eventually stayed for 14 years being head of department for ten years. I started the first radiology residency program in Africa, was chosen president of the Association of Radiologists

of West Africa one year and also represented Nigeria at the International Congress of Radiology.

While in Nigeria I travelled the entire Country, north to south, east to west, many times. I also drove my 'beetle' to Ghana for a West African radiological meeting. During these years I was a visiting professor for brief periods in Ghana, Kenya and Tanzania. I was in Nigeria during several military coups and throughout the Biafran war (Nigerian civil war). I was arrested once by the army for taking a picture of a bridge. These were some exciting times to say the least.

In 1975 I took an earned sabbatical in Boston to get an MPH degree at the Harvard School of Public Health. During that year I also became a member of American Mensa.

I left Nigeria in 1977. After a year as visiting professor at the University of Rochester in N.Y., I still had the 'itch' to do more overseas work. I signed up with Project HOPE and was their program director in Cartagena, Colombia while teaching radiology residents. I then moved on as HOPE's program director in Quetzaltenango (locally known as Xela), Guatemala, a city in the western highlands (near 10,000 feet) close to Mexico. I was teaching radiology residents in the local medical school and set up the first x-ray technician training program. In my third year there, anti-government guerrillas sent me a death threat. They did not want HOPE in the Country. I left Guatemala, drove back to the States (driving through Mexico is always a blast!) and then finished my contract with HOPE working 3-4 months in Jamaica at Government hospitals in Kingston and Montego Bay (not exactly a hardship post!). I later took a short term 3-4 month position with Project Hope as radiologist at the Government hospital on the island of Grenada after the U.S. invasion of the Island to remove Cuban influence at the Medical School (with many American students), Hospital and much of the Island.

After Guatemala and Jamaica, in 1981, I took a position as Professor of Radiology at Wake Forest University School of Medicine in Winston-Salem, N.C. as a bone and trauma radiologist. During my 17 years there, I took three sabbaticals of 3-4 months each working as an international visiting professor for the Radiological Society of North America in Karachi, Pakistan at the Aga Khan University Hospital and Medical School, Vellore, India at the Christian Medical Center ( the largest mission hospital in the world, about 3000 beds ), and at the medical school in Quito, Ecuador. During this period I was honored to become a Fellow of the American College of Radiology. I wrote one book on the bones in sickle cell disease and over 100 articles for scientific journals. I retired in 1998 and worked part-time in the same department for a few years after that and then did volunteer work at a free clinic in Winston-Salem, the largest such clinic in the State. I continued for a number of years giving yearly seminars to students in biomedical engineering studying imaging.

Throughout my exciting journey, I circumnavigated the globe once - on the way to a meeting in Tokyo - with about 15 stopovers. I married once (1960), divorced once (1981), spoke about my African experiences twice at HMS alumni day (1975 & 1983), wrote about my early excitement and experiences in Nigeria (JAMA, Aug. 15, 1966), climbed Mt. Kilimanjaro once (1975), worked at the Kilimanjaro Mission Hospital and at a TB clinic in western Nepal briefly.

I am now fully retired as Professor Emeritus of Radiology, a big fan of Sudoku, still doing wood carving which I have done all of my life, and my new 'job' is daily exercise and fitness activities.

**Mortimer J. Buckley** - Dr. Mortimer J. Buckley attended the College of the Holy Cross and Boston University Medical School, later being named a distinguished alumnus of both schools. Mort was a cardiac surgical legend at the MGH, where he spent his entire professional career, having trained here, starting as a surgical intern in 1958, and finishing as East Resident. As Chief of the MGH Division of Cardiac Surgery from 1970 until his retirement in 1998, Dr. Buckley was a master technician of all aspects of cardiac disease, including valvular, aortic and coronary procedures, although he felt his greatest reward lay in giving an infant an opportunity to achieve a longer, healthier life. He was relentless in his devotion to teaching residents to become cardiac surgeons, and equally demanding in what he expected in return. As a scientist, Mort was an early innovator in the application of mechanical circulatory support, especially in the development of the intra-aortic balloon pump to treat patients with acutely ischemic and failing hearts. As a capstone to his brilliant career, in 1995 he was elected President of the American Association for Thoracic Surgery. The Cardiac Surgical Conference Room on Ellison 8, where he taught for decades, has been named in his honor, and where his portrait resides. Mort died in 2007 of complications of multiple myeloma. (See a more detailed discussion of Mort's life and career authored by Cary Akins in the MGH Surgical Society Newsletter, Fall 2009, Volume 10, Issue 2.) Bio prepared by Cary Akins, MD and Willard M. Daggett, MD

**Lewis P. James, Jr.** - Worcester - Distinguished pathologist, noted professor, legendary tailgater and beloved father, Dr. Lewis P. James Jr., MD, died on Tuesday, December 25, 2012, surrounded by members of his family. Dr. James loved the pursuit of knowledge and discourse. He had broad interests in subjects ranging from history, music, art, poetry and literary criticism to his chosen field of medicine. He was educated at Kingswood School, in West Hartford, CT, graduating in 1950, then attended and graduated summa cum laude from Yale College in 1954. At Yale, he was a member of Phi Beta Kappa and for the remainder of his life remained a stout supporter of all things Yale, in particular the Eli's football team. Following college, he attended Harvard Medical School, graduating cum laude and was awarded the Henry Asbury Christian Prize as the top graduate in his class. Dr. James then served an internship in surgery in 1958 at the Massachusetts General Hospital followed by a residency in pathology, rising to Chief Resident in 1963.

In 1966, Dr. James moved to Worcester to join the Department of Pathology at the Memorial Hospital. There, for over 30 years, he served as a pathologist and director of the blood bank. In addition to his work in clinical pathology, he had a lifelong interest in medical education, lecturing extensively at Harvard, Yale and Tufts Medical Schools, and later serving as an assistant professor at Northeastern University and professor of pathology at the University of Massachusetts Medical School. He served on the boards of directors of the Memorial Hospital and the Medical Center of Central Massachusetts and the New England Region of the American Red Cross. Dr. James was past president of the New England Society of Pathologists, and secretary and later president of the American Society of Clinical Pathologists.

*(James continued on page 8)*



CLASS OF 2014

DESTINATIONS

Joseph Bornstein - Colorectal Fellowship, Mt. Sinai Hospital  
William Kitchens - Abdominal Transplant Fellowship, Emory University  
Johannes Kratz - Cardiothoracic Surgery Fellowship, University of California, San Francisco  
Melissa Levack - Cardiothoracic Surgery Fellowship, Cleveland Clinic  
Deepika Nehra - Trauma and Critical Care Fellowship, University of Washington  
Fahad Shuja - Vascular Surgery Fellowship, Beth Israel Deaconess Medical Center  
Smita Sihag - Cardiothoracic Surgery Fellowship, Massachusetts General Hospital  
Eric Stanelle - HPB and Advanced Endoscopy/ERCP Fellowship, University of Kentucky



*Pictured l to r: Deepika Nehra, Eric Stanelle, Melissa Levack, Fahad Shuja, Dr. Lillemoe, Johannes Kratz, Smita Sihag, William Kitchens, and Joseph Bornstein*



WELCOME  
Categorical - PGY-1



Andrea Axtell  
University of California, San  
Francisco, School of Medicine



Christina Costantino  
Jefferson Medical College  
of Thomas Jefferson University



Grace Lee  
Harvard Medical School



Sophia McKinley  
Harvard Medical School



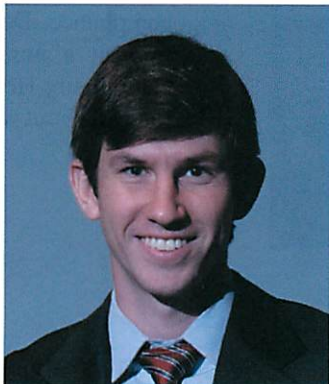
Asishana Osho  
Duke University  
School of Medicine



Seyed Ali Rabi  
Johns Hopkins University  
School of Medicine



Charles Rickert  
Washington University of  
St. Louis School of Medicine



Brooks Udelsman  
Yale University  
School of Medicine



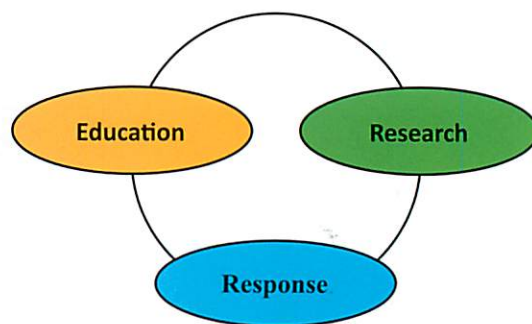
Maggie Westfal  
Tufts University  
School of Medicine



## GLOBAL SURGERY INITIATIVES 2014 Susan Briggs

Surgery has long been a neglected area of global health. The global burden of surgical disease is estimated at 15 percent of the total worldwide disease burden. Although diseases treatable by surgery remain a ranking killer of the world's poor, public attention and public health dollars most often target infectious diseases such as HIV, tuberculosis, and malaria. This outpouring of support has led to the development of public health resources across the globe. In turn, these resources have led to the growing recognition of the need for surgical care in low-and middle-income countries. Only recently has surgery been accepted as an equal partner in the fight against global health care inequity. (Excerpted from Harvard Program in Global Surgery)

The newsletter highlights the active role of the MGH Department of Surgery in global surgery (emergency and essential surgery initiatives). The Department of Surgery provides opportunities for residents, surgical staff and alumni to share their expertise with countries in need through research, education and surgical training.



### MALAWI



**Dr. Amy Fiedler**, General Surgery Resident, traveled to Embangweni, Malawi in January, 2014 and joined a team of medical personnel from several other academic centers. The team worked in Embangweni Hospital, a busy 150 bed hospital with an extensive catchment area. During her time spent in Malawi, she had the opportunity to perform operative procedures, teach medical students, and participate in a variety of community outreach programs in some of the far-reaching villages.

### INDIA



In March, 2014, **Dr. Tiffany Chao**, General Surgery Resident, travelled to New Delhi, India, on an externship with Consure Medical. Consure is a medical device startup founded out of the Stanford-India Biodesign Fellowship several years ago. The company has developed a novel fecal management system for incontinence. Tiffany focused on developing recommendations for clinical trial strategies and regulatory compliance. During her time in India, she also had the opportunity to visit a number of health care facilities, including Ballabgarh Community Health Center and Badshah Khan Government Hospital, to learn about workforce challenges in the Indian healthcare system.

### CUBA

**Dr. Marc DeMoya**, in conjunction with a multi-national group of ATLS instructors from Colombia, Brazil, Costa Rica, Uruguay and USA, helped initiate the first ATLS provider and instructor courses in Cuba. Dr. DeMoya is an attending surgeon in the Department of Trauma, Emergency Surgery and Surgical Critical Care (TESSCC). (left: *ATLS Course, Cuba*)





## BERMUDA

Having studied hereditary cancers in Bermuda since 1998, Kevin S. Hughes, M.D. suspected that mutations in certain genes – know as BRCA 1 and BRCA 2 – were making Bermudian women from particular families more susceptible to developing breast and ovarian cancer than the female population at large. In 2006, Dr. Hughes and Partners HealthCare International launched the Bermuda Cancer Genetic Risk Assessment Program in collaboration with the Health Insurance Association of Bermuda and the Bermuda Cancer and Health Centre. As the island’s first program for cancer genetic testing, the initiative identifies, educates and supports women and men who are at high risk. Once it has been determined that a patient is at high risk, Dr. Hughes develops a plan of care in collaboration with his or her local doctor. Genetic testing, earlier mammography, and more frequent clinical exams are all considered, depending upon the needs of the patient. *(right: Dr. Kevin Hughes and Leslie Shane, MS, RN)*



## • UGANDA

In March, 2014, the MGH Cancer Center sent a multidisciplinary team to the city of Mbarara in southwestern Uganda to explore collaboration with the local university and hospital to build a new national referral cancer center. The invitation was made by MUST Vice- Chancellor Professor Frederick Kayanja, on behalf of the Mbarara University of Science and Technology (MUST), the Mbarara Regional Referral Hospital (MRRH), and the Uganda Cancer Institute (UCI). The MGH Cancer Center team comprised James Cusack, MD (Director, MGH Global Surgery Initiative), Marcia Browne, MD (Medical Oncology), Thomas Randall, MD (Gynecologic Oncology), Elizabeth Bigger, MD (Medical Oncology), and Johanna Riesel, MD (General Surgery Resident and Paul Farmer Global Surgery Research Fellow). During the weeklong visit, the team visited Mbarara and the capital city of Kampala. In Mbarara, the MGH visitors attended tumor board and visited the operating theater at MRRH. The MGH Cancer Center Team also met with the leadership at the Uganda Cancer Institute and will continue to explore strategies for improving and expanding cancer care in this severely underserved country. *(Above: Dr. James Cusack and MGH Cancer Center Team)*



Dr. Johanna Riesel (General Surgery Resident and Paul Farmer Global Surgery Research Fellow) returned to Mbarara, Uganda to continue work on the electronic surgical database project designed to enhance quality improvement initiatives in the hospital. Dr. Riesel helped initiate this project on her previous visit to Uganda. She also spent time working with the new pediatric surgeon and the rest of the team, including time teaching the “surgical skills” workshop to the 5<sup>th</sup> year medical students.

*(Right: Dr. Johanna Riesel and Uganda physicians)*



*(James continued from page 3)*

During the late 1940's and early 1950's, Dr. James was a regular panelist on the NBC radio and television network program "Mind Your Manners", hosted by Allen Ludden. He served as a captain in the US Army Medical Corps from 1963 to 1965, at the 98th General Hospital in Neubrucke-Nahe. It was in Germany that he met then Lieutenant Colleen Corazza and began a partnership that was to last until her death 46 years later. Though a man of profound professional accomplishment, Dr. James was foremost a man devoted to his family and dedicated to his children and grandchildren. Whether on the beaches of Cape Cod, in the parking lot of the Yale Bowl or around the fire in Paxton at Christmas, he was most content when surrounded by his extended family.

**John W. Madden** – I came to HMS as a cell biologist interested in applying basic science to clinical medicine. When I observed who in the clinical areas were using basic science in their practice, I saw surgeons. (Vascular transplants in pediatric surgery, vascular and cardiac surgery at MGH, kidney transplants, and metabolic problems at the Brigham.) So, surgery it was!

At the MGH, other than some things I did with Jerry Gross, I did not see much real science. After consulting with my long time mentor at Yale, J.P. Trinkaus, over a bottle of whiskey, I applied for and received a NIH Grant for post graduate study.

After three years at MGH, I spent two years in the Department of Anatomy at the University of Pennsylvania studying cartilage cell induction systems. The work produced some results which are still useful. I did learn during those two years that I was much more interested in humans than fish or chickens. I went back to MGH.

During my first rotation back, I was required to run the "Hand Clinic". I worked up three to four patients and presented them to the hand experts. Other than Brad Cannon, I was shocked at our "experts." If this was the best they could do, they needed help! The patients, however, presented with fascinating biological problems. The success of tendon and nerve reconstructions depended entirely on the body's ability to form and remodel scars. Wound healing is really an embryological problem in adults. Extremity surgery involved vascular, neurological, plastic, and orthopedic techniques. Tissues were easily obtained for laboratory study. I was hooked! Brad Cannon became my consultant.

After Dr. Cannon and I discussed my work in Philadelphia, he suggested that I write an abstract for the Plastic Surgery Research Council meeting. When the abstract was accepted, Dr. Cannon offered to take me to the meeting in St. Louis.

When we got on the plane, Dr. Cannon said we had to save a seat for a friend who was getting on at our stop in Baltimore. The man who joined us was Erle E. Peacock, Jr. Erle and I spent the flight talking about my research.

A week or so after the meeting, Dr. Churchill called me into his office and told me that Dr. Peacock had called and wanted me to come to Chapel Hill to give a seminar on my cartilage work. EDC approved. I went.

Spring in Chapel Hill was red bud, dogwood, and basketball. Erle asked me to join him when I finished at MGH, and I accepted. I went to UNC as Assistant Professor of Surgery, Chief of the Hand Rehabilitation Center, and Resident in Plastic Surgery!

Over the next five years, Erle and I developed the largest connective tissues laboratory in the U.S., an entirely new approach to hand rehabilitation, and a new concept of Surgical Residency Programs. We wanted to expand the programs, and we took the opportunity to do so at the new medical school in Tucson, Arizona. I moved thirty-five people, one million dollars of lab equipment, all of my NIH Grants, and my Hand Center personnel to the University of Arizona.

We were very successful. Our research grants expanded. We received an NIH Grant for clinical research beds. We were able to support investigators in the Departments of Histology, Biochemistry, and Pharmacology. We recruited a stellar faculty in the surgical sub-specialties. The new Hand Rehabilitation Center attracted patients from all over the world.

After six years, the Dean of the College of Medicine, Monty Duval, decided to turn the University Hospital into a community hospital and fired Dr. Peacock. A subsequent federal lawsuit was decided in Erle's favor, and he was awarded almost a half a million dollars for Dr. Duval's illegal acts (and Monty did not become the U.S. Senator from Arizona).

The entire surgical faculty resigned. All but three of us left. Although I could not bring my laboratories, I took my entire clinical staff with the post graduate educational training programs in hand surgery and hand rehabilitation into private practice.

Dr. George Omer, Chairman of the Orthopedic Department at the University of New Mexico, found out about my resignation and appointed me Professor of Orthopedics at the University of New Mexico. Graduate students came to Tucson to study in my program.

At this time, I was very involved with the American Society for Surgery of the Hand (ASSH). I was a member of the Executive Council for eight years. We were able to establish Boards in Hand Surgery, expand the membership (formerly restricted to 250 members), supervise and certify fellowship programs, establish "The Journal of Hand Surgery", state a research grant program, and help start the American Society of Hand Therapists. I continued my studies of rheumatoid hand reconstruction and small joint mobilization. The educational and clinical work continued for twenty-six years. Twenty-five members of the ASSH came from our graduate programs.

The most amazing thing to me is how those incredible students and fantastically complicated hand patients found me in the Arizona desert, and why people sent me around the world three times 'on their nickel' just to hear me talk about what I was doing!

Thirty-five years ago, I was fortunate to find my "retirement home" and have lived there ever since. My wife Sherri and I live on a piece of ground that has been occupied for 1200 years. A pueblo about one hundred yards from our house was started in 800 A.D. In 1200 A.D. the pueblo housed 400 people, who farmed corn. In 1300 A.D., they all disappeared! We have found 1200 year old stone tools in our back yard, which were used by the native population.

When Arizona became part of the U.S., as a result of the Gadsden Purchase of 1853-1854, an American living in Tucson claimed the land because of the creeks and springs. He dug a stock watering hole (a one acre pond, which we still have) and started the Arizona cattle industry. At times, we have the only, natural, open water for fifty miles. This "watering hole" draws 220 species of birds (including eleven kinds of hummingbirds), bobcats, javelin, deer, raccoons, three kinds of skunks, and occasional bear and mountain lion, and too many species of rodents and snakes to count.

In 2011, I had one episode of hematuria and ended up with a grade three, stage four transitional cell cancer of my bladder. After a radical

*(Madden continued on page 9)*



*(Madden continued from page 8)*

cystoprostatectomy, I was told that I had six months to live – only if I have chemotherapy (cis-Platinum - - Are you kidding? No Thanks!) But here I am thirteen years later, disease free and living in paradise.

**Anthony S. Patton** - I entered the surgical program at the MGH on July 1, 1958 with some preparation. Since several of my clinical rotations were at the hospital, I knew the internal geography pretty well. In addition, since six of our band of eight were HMS classmates, I knew most of our colleagues. But in my inner heart, I was worried if I could do the job.

For one thing, unlike my classmates who were pretty much all academic giants, I had to work hard at medical school. John Madden, for instance, could quote all the pertinent surgical literature with ease. Lou James was first in our class. Mort Buckley, who had come from BU, was already locally known as a super star. It was suspected that Bill Daggett must also be some kind of demi-god to survive the scrutiny, exams, and interviews from 3000 miles away.

My confidence was severely shaken when the first day on the job, while we were in the cafeteria line for breakfast, someone bumped my food tray and I spilled coffee and orange juice all over my sparkly white suit. No one laughed out loud but there were a lot of giggles. No time to change so I had to spend the day explaining what happened.

On rounds on day two, Clem Hiebert, the chief at the time, found about 20 items I had mismanaged or forgotten. Maybe the stars were misaligned and the Gods were upset, and I wasn't going to make it.

My fears were further fueled by several encounters with Mort Buckley who I frequently met at the ritual late night snacks. Although conversations were usually jovial and centered on the mutual miseries of internship, Mort told me many times that I should not have been accepted into the program. It was another bold challenge to my already faltering ego.

But I soon found that I fitted in okay and found all of colleagues anxious to make things as smooth as possible. The main ethical value seem to do as much work as possible so as to even the load for everyone. I personally enjoyed the residency immensely, found the job only occasionally overwhelming, and looked forward to almost every day as a chance to see and often operate on a new case and sometimes to make a dramatic save.

But my enthusiasm about my work and long hours caused havoc in the rest of my life. Even though Chris and I were happily married, the stress on our lives was enormous. By 1964 with three little children and after 6 years of training behind me and running out of money, we felt it time to start practice.

The MGH residency and a year in England working as a senior registrar at a thoracic surgical unit in Devon had given me a tremendous amount of technical experience. I felt I was very lucky to have such a broad background in all aspects of surgery and had done almost every major operation many times with the exception of proximal pancreatic resections.

The choice of practicing on the North shore of Boston was a perfect fit. There were only a few who had their boards in thoracic surgery and very few did any serious vascular surgery. As all of us in the program, I was ready for almost anything.

I started out totally on my own with no salary, no office, and no secretary. But I knew how to work and had a lot of support. I often took call for Graham Pope, a highly talented and successful general surgeon.

After a few months and covering every accident room south of the New Hampshire border, I opened a real office and hired a secretary. By 1966 I was too busy as a general surgeon, so it was an easy decision to specialize only in general thoracic and vascular surgery. As a bonus, however, I was fortunate to be called by other surgeons to help in the complications of just about every other surgical specialty. The MGH residency had prepared me well for these often scary situations and I was lucky to pull off a few dramatic saves. I also kept a strong relationship with everyone at the MGH and when necessary, it was reassuring to know that I could send a patient in without question or embarrassment.

Fortunate for me as well, there were good solid MGH residency rotations at both Salem and Lynn Hospitals. I eventually gravitated to Salem because of their support of a strong intensive care unit and their help in developing a floor in the hospital dedicated to thoracic and vascular surgical patients. Many good doctors in other key specialties decided to practice there providing a healthy and enjoyable exchange of information.

Perhaps more important than anything we found a lovely old and affordable 1756 house in Danvers which was geographically close to everything. Despite all the hard work, I usually had breakfast with Chris and the children and rarely missed dinner even when on call during tough weekend coverage. For a while we were able to have live in help and Chris's life flourished as well as mine. She was on many charitable boards, including the Salem Hospital board of trustees, and won awards for new ideas in hospital publications, intensive unit support systems, and historical preservation. Our house was a constant center of meetings and parties.

In the late 1960's I helped organize a regional health organization and we received a generous federal grant. In the early 1970's I joined two others to start a strong Hospice Program. At the hospital, our chest and vascular unit flourished and with the addition of MGH graduate Dexter Lawson we had a strong clinical program, one of the busiest in the state. From the beginning it was our mission to share as much as possible of the technical experience of each case with the residents. Certainly one of the most satisfying aspects of my career was to help already highly capable MGH residents have further experience in complicated cases.

Some of our volume came from cases no one else wanted to handle. As an example, we saw a large number of esophageal ruptures and tears both spontaneous and iatrogenic. Despite our non-academic set up we published a few clinical papers and were often called upon to give talks at meetings.

Being involved in hospital or local medical politics, boards, chairmanships, chiefdoms etc. is not the same in community hospitals as in academia. One has little power "of hire and fire" so often only moral persuasion and peer pressure are the only tools of discipline. Despite this, one could sometimes make a difference in hospital direction or policy. One movement I perhaps helped was the union of Salem Hospital with MGH. The strong cooperation and consolidation of the cardiology, cardiac surgery, and thoracic surgical departments was started many

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*(Patton continued from page 9)*

years ago and the care on the north shore is much better because of it. None of this could have started without the strong surgical teaching program at Salem due to the MGH residents. But in 1996 I began to run out of energy. I finally had to retire because of some severe attacks of postural hypotension. But to our pride, MGH chest surgeons Dean Donahue, Jim Allen, and Chris Morse now run the practice.

I have found retirement pretty good fun. I already taught some before retirement but soon was more heavily involved, teaching first, second, and third year at HMS. I had also written articles but composed many more recently. I write about many topics but concentrate mainly on medical and other historical topics for local societies, newspapers, and for the Harvard Medical Alumni Magazine.

In 2008 I was elected President of Boston Surgical Society, an ancient dinner group of some 450 members. It was a big honor for me and I was quickly introduced to some of the intrigues of Boston medical politics. It was only a little peek into the not always polite side of academia, but made me glad I chose to practice in the suburbs. Our very own "classmate" Bill Daggett introduced me for the ritual speech at the annual meeting. For this kindness, I shall be forever grateful.

We live much of the year now in Maine and will move there completely eventually. Our children have been enormously successful. My son is a successful hospital administrator and both daughters are tenured professors of some note. One is at Harvard and the other is now the Dean of the Faculty at Duke. I sat for a few moments with Gerry Austen before a recent evening surgical event and he knew of the academic success of my daughters. Without any intent of humor, he said: "Wow, Tony, I am really amazed. You were never any kind of an intellectual. (after a pause) It all had to come from Chris." And so I thought, maybe in 1958 Mort Buckley was right that I never should have been appointed an intern at MGH. Whatever, it has been a pretty happy life for "someone of little mind". I am most grateful for the incomparable training, the chance to work with the very finest people, opportunity to fulfill a career in surgery, and the chance to live a happy life.

**Don Pearl** - Upon completion of my surgical training at the MGH I took a job on the faculty of the University of Kentucky. In addition to teaching, I set up a transplant program, and performed the first successful kidney transplants in Kentucky. I was voted the worst teacher on the faculty by the third year medical students, and best teacher by the surgical house staff.

After a year I moved to San Mateo, California, and entered private practice. However, I was soon drafted, and spent 1967-68 in Viet Nam. I was stationed in Nha Trang, and was chest surgeon for the 43rd Medical Group—one eighth of Viet Nam. This was at the peak of the war, the time of the Tet offensive. I was at a well equipped 400 bed hospital, and was the only board certified surgeon. We had five surgeons, two neurosurgeons, two orthopedic surgeons, an ophthalmologist, a urologist plus anesthesiologists, radiologists and internists. I saw my first case of bubonic plague there. I did all of the chest surgery and most of the vascular, and operated on many people with holes in them. We also operated on many civilians. One interesting case was a Montagnard infant girl with esophageal atresia. We made an incubator out of a cardboard box for her. She did well. When things were quiet, we rounded up local kids with cleft lips and I would operate on four or five a day. This was called winning the hearts and minds of the people.

After my time in the Army, I returned to practice in San Mateo. My practice consisted of a wide variety of chest, vascular and general surgery.

During this time I started racing sailboats in the ocean off San Francisco. I finally took the season's championship in the Midget Ocean Racing Association (boats 31 feet overall and less). Then I went to the Danforth Series (bigger boats). With a new boat I was dismantled in the first race, but soon got things together and won the Buckner in division and the Waterhouse overall as well as first to finish.

There were about 75 surgeons practicing in the San Mateo area. Any morning one could walk into the surgeon's lounge and come upon four tables of surgeons playing bridge, waiting for someone to call them for a consult. The thought entered my head "I'm making a good living here, but I'm not really needed." I became restless. My great grandfather had run a cattle ranch in western North Dakota in the days of the open range (before homesteading), and my grandfather had told me many stories of those days when I was a boy. I was curious about the area, and when a hospital there was looking for a surgeon, I took the position. The rural setting allowed me to do a wide variety of surgery, for which the unique training at the MGH prepared me. My last year in California I operated on six ruptured aneurysms without a death. In North Dakota I found I was the only surgeon in the state doing correction of pectus excavatum deformities. The oldest abdominal aortic aneurysm patient I operated on was 96. He did well.

During this time I took up breeding quarter horses. We ran about 35 head, and bred by artificial insemination. I also bought a vacation home near Bozeman, Montana, and often backpacked into wilderness areas to fly fish the high country. Fifteen inch cutthroat trout were easy to catch, and I ate fish every meal.

I am now retired in Sequim, Washington on the Strait of Juan de Fuca and spend my time with my charming wife Lotta, sailing our boat Pixie, and gardening.

**Jack Porvaznik** - During my residency years I decided to build my surgical career with the Indian Health Service, the newly formed division of the U.S. Public Health Service tasked with the responsibility to provide health services to the many Indian Tribes located on reservations throughout the western states and Alaska. Several studies had shown the poor to deplorable health conditions on Indian reservations, which eventually resulted in the transfer from the Bureau of Indian Affairs (BIA) to the USPHS. This new division was struggling to find physicians to provide services in the many remote reservation locations, and broadly trained general surgeons, ala MGH, were especially sought.

Of the 50 Indian hospitals, 10 were equipped to provide surgical services. My first assignment was to Tuba City (AZ), the westernmost, very busy and most isolated on the vast Navajo Reservation, where as the solo surgeon I found myself having to manage the entire gamut of "general" surgery including fractures, urology, C-sections, emergency burr-holes, etc. It was here that I so fully appreciated the broad training we received at the MGH.

Of particular note: - my months on the new MGH Pediatric Surgical Rotation were invaluable, not only because of the superb surgical

*(Porvaznik continued on page 11)*



*(Porvaznik continued from page 10)*

training with Hardy Hendren, but also because of the integration with the pediatric residents and visits. Infant mortality rates on reservations were significantly higher, and though I was the solo surgeon, I shared in after-hours general call (OD), much of which involved infants with pneumonia, gastroenteritis, meningitis, and the broad pediatric training carried me through some very trying nights.

At this time, there was not full acceptance of “anglo” medicine by the Navajo people, and when faced with illness, they often saw the Medicine Man first, later coming to the hospital with advanced surgical complications. A breakthrough came when an influential Medicine Man in our region had urinary obstruction from BPH. The relief he got from the Leadbetter-taught “combined prostatectomy and Y-Vplasty” along with our post-op opportunities to talk established a mutual understanding such that patients who previously first sought traditional Navajo Medicine, came in earlier for surgical problems and then returned to the Medicine Man for the necessary cure by the healing ceremony (Sing).

-Acute head trauma was particularly challenging as the nearest referral centers were many hours away by small plane, which often couldn't land anyway on our small dirt-strip adjacent to the hospital. How I valued the neurosurgery rotations when needing to do emergency burr-holes, preceded by a “1-shot” carotid arteriogram.

-The Chest Surgery rotation at the Middlesex San was particularly relevant: though the “epidemic” of TB in Native Americans was coming under control through case finding and INH, there was still a significantly higher incidence of both pulmonary and extra-pulmonary TB, so both the surgical experience plus the familiarity with the medical management was most helpful.

This broad MGH training had much to do with my later appointment as Senior Clinician Surgery (‘chief surgeon’) and EMS Medical Director for all IHS, with the responsibility to oversee all of our surgical hospitals and to improve the capabilities of our non-surgical facilities to assess, stabilize and transport. It also resulted in temporary assignments to Saudi Arabia, Egypt, and the Caribbean Basin islands to help develop EMS programs.

After 26 years in Reservation settings, I was appointed CMO for all of IHS, and promoted by Surgeon General Koop to “flag rank” (R. Adm.) as Asst. Surg. General USPHS. Though busy and demanding, I was able to maintain a clinical role as a surgical ‘visit’ at Bethesda Naval Hospital plus regular trips back to my home hospital at the Gallup, NM Indian Medical Center. The Washington experience was exciting, challenging, and rewarding, but I looked forward to returning to clinical medicine, and after 4 years at HQ I retired from IHS and continued my work in EM and EMS first in Appalachia, then on to St. Louis on staff at several hospitals and CMO for Spectrum EM.

In 2000 I took on the added role of Director of Clinics for a mission program in the central mountains of Honduras, and, along with my RN wife Eunice, regularly visited to see patients in the clinics and provide oversight and support. This led to a faculty appointment at West Virginia Univ. Med School.

My years with Joint Commission have kept me in direct contact with the changing face of medicine with visits to small rural hospitals and major medical centers around the country, and internationally.

**Willard M. Daggett** - Following two years at Boston Children's Hospital and my year as Resident on the West Service, I joined the staff of the MGH Cardiac Surgical Service at the invitation of Jerry Austen to “labor in the vineyards of surgery” with Mort Buckley and Eldy Mundth. In those early years I had a few issues with Mort, but in the long run he and I became good friends and admirers of one another's capabilities. In 1972 I led a team of nine (which included then surgical resident Toby Cosgrove and anesthetist, Demetrios Lappas) to initiate cardiac surgery at the University of Athens, Greece (Aeritaiion Hospital) at the invitation of Prof. Constantine Tountas, who was also Dean of the Medical School, and President of the University of Athens. This outreach project was followed by my colleagues, Mort, Eldy and Terry MacEnany continuing the effort there until we were able to recruit a Greek born surgeon, Chris Lolas, who had trained with Al Starr to take over the program – many anecdotes that we could share over a beer at the next reunion. In addition to my practice, we ran an active laboratory of CV Surgical Physiology, having trained during my resident years with Stanley Sarnoff at the NIH and Ted Cooper at St. Louis University. Our research at the NIH led to an award, shared with Mike Weisfeldt, of Young Investigator by the American College of Cardiology. Our investigations were aided by a seemingly endless stream of talented research fellows, who have gone on themselves to productive leadership positions in surgery, medicine and cardiology. Our research progressed and led to the demonstration that we could support aerobic metabolism in the cross clamped heart by physically dissolving oxygen in cold cardioplegic solutions. This led to prompt clinical application in that we could carry out complex cardiac repairs with safety even with prolonged cross clamp times. For this work I received an Established Investigator Award of the American Heart Association, and proceeded to work on repairs for post infarct ventricular septal rupture which achieved wide spread clinical application (until the more recent contributions of infarct exclusion by David and Cooley).

In congenital heart surgery, Mort was the leader, but I enjoyed the challenge of coarctation of the aorta, and accumulated a series of over 200 patients ranging from newborns to older patients in their sixties. Eldy left our group in 1978 for a practice opportunity in Philadelphia, and there followed a recruitment over the years of immensely talented young surgeons, who now successfully operate on complex patients that we would likely have shied away from in earlier years. I am gratified that our work on myocardial preservation has contributed to this ongoing success. I was promoted to Professor at HMS in 1978.

I retired from clinical practice in 2000 with over six thousand heart operations behind me, and after a period of adjustment, have come to enjoy a slightly less frenetic pace. My first years after retiring were helped by traveling as a consultant to teach cardiac surgical groups how to harvest the saphenous vein endoscopically, for use as a coronary bypass conduit. More recently, I have been a senior mentor to 7-9 third year Harvard medical students, which I find exciting and challenging (they are unbelievably smart!), and co-editing, with Les Ottinger, the MGH Surgical Society Newsletter. I serve on a committee collecting MGH anecdotes, aphorisms, etc. – all enough to keep my brain from rusting, but not too much to interfere with my hunting and fishing.

I am blessed with six grandchildren, and a tolerant and supportive wife in Rosemary. Our daughter Emily is 23 years old and has graduated with honors from Johns Hopkins University, majoring in computer science; she will this summer be applying for admission to

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*(Daggett continued from page 11)*

medical school. My three adult progeny from my first marriage to Margaret Taylor (we parted in 1986) are all thriving: Sue recently retired from Board Chair and Head of School at Foothills Academy in Colorado and is now the CEO of a chain of 25 restaurants in the west; Will, mental health therapist at UMass Medical Center, and Mary in practice (with husband Phil) of law in Las Vegas after fifteen years as a deputy district attorney there. Rosemary and I will celebrate our 25th anniversary next spring by co-celebrating with good friends on a barge trip through Holland. Bon voyage!

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**Addendum to “What Happened to the Class of ’76:** John Baldwin is currently the Advisor on Health Sciences, Texas Tech University system, having previously served as President from 2007-2009. He joined the class after serving two years in internal medicine, and his peripatetic nature is reflected in the rest of his career—after completing the general surgery residency he completed a cardiothoracic residency at Stanford, followed by serving as a staff surgeon at Stanford from 1984-1988. He then packed his bags and moved to Yale, where he served as Professor of Surgery 1988-1994 (and serving as a Lecturer in British History during this time as well!), followed by a move to Houston to be the DeBaKey Professor and Chairman from 1994-1998, then back to the east coast as Associate Provost for Health Affairs and Dean at Dartmouth 1998-2005, then to Boston as President and CEO of Immune Disease Institute, an affiliate of Harvard University, then to Texas Tech as President.♦

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*(Cardiac Surgery at the MGH continued from page 1)* of our clinical practice, and Jen Walker playing a key role in resident education, Josh Baker fostered spectacular collaborations with interventional cardiology around catheter-based interventions. He has been important to the establishment of a Pulmonary Embolism Response Team (PERT) that has been effectively rolled out internal to the MGH, and is hoped to be extended to a regional network. This group comes together virtually using web-based tools to discuss the optimal management of patients with massive and sub-massive pulmonary embolism including surgical embolectomy, ECMO support, suction embolectomy and catheter-based delivery of local lytics. He frequently collaborates with interventional cardiology placing percutaneous temporary mechanical support devices, and was responsible for the rapid expansion of ECMO support on the cardiac surgical services. As a part of this latter effort he worked collaboratively with the pediatric surgical service in unifying the approach to ECMO support.

More recently Dr. Jose Garcia has joined the staff. With a passion for transplantation and mechanical support, he has introduced new left-ventricular assist technology and concomitantly increased our cardiac transplant volume. He also has unique experience in the country in ECMO support of pre-lung transplant patients, which he effectively introduced to the MGH with Dr. John Wain. It is no longer a matter of curiosity in the Cardiac SICU to see a patient ambulating while on ECMO support! Dr Garcia also led the team performing the MGH’s first Heart-Lung transplant.

For our most recent addition to the staff we reclaimed two of our own general surgery trainees, Dr. Serguei Melnitchouk, after training in cardiac surgery at Columbia University and George Tolis after training in CT surgery at Yale and a cardiac fellowship at the Sinai in New York. The first step was to send Serguei to Germany to learn about minimally invasive valve repair which he is now introducing into our clinical armamentarium. Both Serguei and George have been a spectacular addition to the group.

Finally, we are delighted to have filled a number of our residency positions from within the MGH general surgery residency program into the 4+3 track. This pathway to board eligibility in both General Surgery and Thoracic Surgery provides extra exposure to cardiothoracic surgery during the general surgery years. The interest shown by our own residents in staying at MGH has been most gratifying to us all. *(Editor’s Note: Thoralf M. Sundt, MD, is a graduate of Princeton University and The Johns Hopkins School of Medicine. He trained in surgery at Massachusetts General Hospital and cardiothoracic surgery at Washington University. Following an additional year of training in transplantation and advanced cardiac surgery at Harefield Hospital, he joined the faculty at Washington University. In 2001, he relocated to the Mayo Clinic where he advanced to the position of professor of Surgery and vice chair of the Department of Surgery. Dr. Sundt returned to MGH in 2011 as the Edward D. Churchill Professor of Surgery and chief of Cardiac Surgery. In this position, he is working to advance surgical education and the academic profile of the cardiac surgical unit. His clinical focus is in process redesign, with the goal of improving patient-centered care, reducing costs and increasing efficiencies. He is currently Director of the Corrigan Minehan Heart Center and the Institute for Heart, Vascular and Stroke Care.)♦*

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• UKRAINE

Dr. Daniel Driscoll and Dr. Gennadiy Fuzay-lov made their 4th annual journey to Lviv, Ukraine for a two-week burn clinic held jointly with the MGH/Shrine and local burn specialists. In addition to seeing outpatients, they performed 22 surgical procedures. Drs. Driscoll and Fuzaylov, in conjunction with the non-profit organization Doctors Collaborating to Help Children, help support improved burn care for patients in Ukraine. On the 2014 trip, two residents Dr. Justin Knittel (anesthesia) and Dr. Arthur Turko (plastic surgery) participated in this global surgery initiative. (Right: *Dr. Driscoll, and Fuzaylov and the Ukraine burn team*)

