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**MGH
SURGICAL
SOCIETY
REUNION
SEPTEMBER
9-11th**

See details inside

The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY Newsletter

Summer 2011

Volume 12, Issue 1

MGH Surgical Society Reunion Program

Friday, September 9, 2011

6:00 p.m. – 8:00 p.m. Registration and Welcome Reception Liberty Hotel

Saturday, September 10, 2011

7:30 a.m. Registration and Continental Breakfast O'Keeffe Auditorium, MGH

Moderator: Dr. Andrew Warshaw

8:00 a.m. Welcoming Remarks Dr. Keith D. Lillemoe

8:10 a.m. Where we've come from Dr. Andrew L. Warshaw

8:35 a.m. Where we are going Dr. Keith D. Lillemoe

9:00 a.m. Advocacy Panel

Healthcare Reform: The Affordable Care Act Dr. Jeffrey Rich

Problems with Health Reform Dr. David Torchiana

Advocating for State Injury Prevention Laws Dr. Peter Masiakos

10:00 a.m. COFFEE BREAK

Moderator: Dr. Dennis Lund

10:30 a.m. Fetal Surgery Dr. N. Scott Adzick

10:50 a.m. Mozart's Healing at the MGH Dr. Claudius Conrad

11:10 a.m. Regenerating Organs for Transplantation - Dr. Harald Ott

First Milestones Based on Native Matrix

11:30 a.m. A Museum for MGH Peter K. Johnson

11:50 a.m. Photo and Luncheon Bulfinch Patio

Moderator: Dr. Edward Barksdale

1:00 p.m. Focusing on Quality in the Department is Surgery Dr. Matthew Hutter

1:20 p.m. Vascularized Composite Tissue Allotransplantation: Dr. Curtis Cetrulo

A New Paradigm in Reconstructive Surgery

1:50 p.m. The Evolution of Acute Care Surgery: Friend, Foe, or Dr. Carrie Sims

Financial Darwinism? Acute Care Surgery

2:10 p.m. Back to Boston Dr. Eliot Chaikof

2:30 p.m. From The General to General: Career Experiences in Dr. John Woodson

Surgery and Military Leadership

3:00 p.m. Hospital Tours

5:30 p.m. Buses leave from Liberty Hotel for clambake

6:00 p.m. Clambake

Sunday, September 11, 2011

7:30 a.m. Registration and Continental Breakfast O'Keeffe Auditorium

8:00 a.m. Business Meeting

Moderator: Dr. Richard Cambria

8:15 a.m. What the Conflict of Interest Purists Dr. David Rattner

Neglected to tell you

8:45 a.m. C. Miller Fisher and the Discovery of Carotid Dr. Ashby Moncure

Artery Disease

9:05 a.m. The Contemporary Management of Carotid Artery Dr. Bruce Perler

Disease: More than 50 Years after C. Miller Fisher,

the Controversy Continues

9:25 a.m. The Changing Waters of Surgical Education Dr. Jo Buyske

9:20 a.m. Churchill: "Bonds with the Oncoming Generations" Dr. Thomas Dodson

10:00 a.m. COFFEE BREAK

Moderator: Dr. Jo Buyske

10:30 a.m. Transplant Geography – From Boston to Bosnia Dr. James Markmann

and Beyond

10:50 a.m. 1811 Surgery in 2011: Volunteering with the Dr. Sharon Stein

Internationally Underserved

11:10 a.m. Back to the Future - MGH Cardiac Surgery 2011 Dr. Thor Sundt

11:30 a.m. I Haven't Had a Thing to Eat in Two Years Dr. John Ryan

12:00 p.m. Move to Bulfinch Patio for Farewell Luncheon



It's time for me to get off the merry-go-round. Time for some reflection on the past 14 years and maybe some rumination on the future.

Much has been accomplished. The clinical faculty of the MGH Department of Surgery has grown from 63 to somewhere close to 115 surgeons while the median salary has increased by more 75%. The annual research expenditures have increased from \$17 million to \$55 million in the face of NIH budgetary restraints, possibly putting us at the top of surgical departments in the U.S. We have expanded our clinical activities at the Newton-Wellesley Hospital and North Shore Medical Center, populated ambulatory centers in Waltham and Danvers, and developed new programs in Northern Massachusetts and Southern New Hampshire with our surgeons on site. The Division Chiefs have been given expanded responsibility for the management of their groups and the government has been with a Division Chiefs' Council.

The newborn Codman Center for Clinical Effectiveness in Surgery has grown to house NSQIP, clinical research, and what may be the most forward-looking and robust quality assessment and management function at the MGH. A migration from wet lab investigation to evaluative sciences is manifest in the number of faculty – and residents – who have trained formally in public health, clinical research, and clinical effectiveness.

Internal to the Department, subspecialty programs have been initiated in colorectal, endocrine, pancreatic, liver, foregut, endovascular and minimally invasive surgery among others. Major advances have occurred in tissue engineering, tolerance to transplanted organs, bioengineering, and basic molecular discoveries in multiple laboratories across the Department, too numerous to chronicle here. The surgical scientist is alive and well at the MGH.

The teaching program has been substantially enhanced by creating an Education Council which includes residents, expanding the cadre of program directors to five, adding a full-time professional education specialist, strengthening the 360° evaluation process of residents and faculty, and building a more structured didactic curriculum.

We continue to attract the very best interns and residents to our training program. In fact this year's match results were the best in my 14 years despite our still being on probation for inadequate compliance with duty-hour regulations in the past (long since fixed). There are probably a number of reasons for this success, including the depth and breadth of the clinical experience and the growing efforts of the teaching faculty, but most of all I believe it is the quality and esprit of the residents themselves, who are terrific surgeons, astute and caring clinicians, productive and innovative investigators, and self-propagating role models. Simply put, I am most proud of them.

Of course, all of these accomplishments and many, many more that would require a book to enumerate are the product of an immensely talented faculty who have parlayed superb care of patients into clinical volumes that are often the largest in New England while keeping their eyes on the academic ball. I doubt that there is any surgical department in the country that has more officers of national surgical organizations, grants funded, or clinical and scientific publications in premier journals.

And they could not have done their magic without the support of their staffs and a new phalanx of administrative managers and directors who coordinate clinical operations and research and deal with the burgeoning complexity of finance, billing, contracting, and regulatory oversight -- a crucial infrastructure which has been developed almost from scratch. I would certainly be personally remiss not to single out for my gratitude Suzanne Williams, my Executive Assistant, Deb Doroni, the Department's Executive Director, Phyllis Fairchild, the Department's Financial Director, and Ann Prestipino, my Senior Vice President. These four talented women ("the skirts" as I politically incorrectly branded them 14 years ago) have been not only my unwavering support but my friends. Many others, you know who you are. The days of being able to run the Department of Surgery with a pencil and a 3 x 5 card are long gone.

So what is over the horizon – it ain't necessarily the end of a rainbow. As the great American philosopher, Yogi Berra, said, "Prediction is hard, especially about the future." The good stuff will be more technology for minimally invasive surgery – robotics, computer and image-driven instruments and more targeted multi-disciplinary treatments. There will be more sophisticated simulators for training residents and faculty – and for evaluating skills. Multidisciplinary care, much of it based in disease centers, will extend and improve patient care. There will be more extensive and complex relationships with community partners, both at the physician and hospital levels, perhaps in accountable care organizations. Certainly some form of health-care system reorganization seems inevitable, bringing with it payment reform. There is a strong trend towards early specialization and sub specialization in surgical training, already occurring in thoracic and vascular programs, for example; the unanswered questions raised by this fragmentation are many, ranging from the challenges to provide a sufficient education (forget the service challenges like who will take care of patients when the resident workforce is reduced) to who will be the surgeon broad enough to oversee the patient, not just a body part. Will the acute care surgeon be the general surgeon of the future since there is already a growing shortage of the latter? These and many more challenges I leave to my successor, Keith Lillemoe. I also pass the pancreas to his capable hands.

I started out 14 years ago with a list of goals, a to-do list, and added many items along the way. I turn the list over to Keith with check marks against almost all, including my final high priority recruitment, Thor Sundt as Chief of Cardiac Surgery. I leave this office with greatly increased departmental resources and a balanced budget over my tenure.

I have closed my practice and passed my patients to the extraordinarily talented surgeons who have joined my group through the years. I will continue as Editor-in-Chief of SURGERY and continue as Treasurer of the American College of Surgeons and Chair of its expanded Health Policy and Advocacy Group. At the MGH I will become Senior Consultant for Clinical Relations.

So thanks to all. You allowed me to conduct this surgical symphony, and metaphorically we made some pretty great music together. As I have said to my patients, I couldn't have done it without you. ♦

Andrew L. Warshaw, M.D.



Introducing Keith D. Lillemoe, M.D., new Surgeon-in-Chief and Chief of the Department of Surgery at the Massachusetts General Hospital and the W. Gerald Austen Professor of Surgery at Harvard Medical School. Dr. Lillemoe joins us from Indiana where he served as Surgeon-in-Chief at Indiana University Hospital and the Jay L. Grosfeld Professor of Surgery and Chairman of the Department of Surgery at Indiana University School of Medicine.

Arriving at the MGH on May 1, 2011, Dr. Lillemoe succeeds Andy Warshaw who announced his intention to step down in 2010. For the past 14 years, Andy guided and strengthened the program that has long been considered one of the most renowned surgical services in the country.

Like Andy Warshaw, Keith Lillemoe is an accomplished general surgeon who specializes in pancreatic and biliary surgery. Before going to Indiana University in 2003, Dr. Lillemoe spent 27 years at Johns Hopkins University in Baltimore. He graduated from Johns Hopkins School of Medicine in 1978 and completed his surgical training at Johns Hopkins Hospital in 1985, after which he joined the staff of the Department of Surgery there, rising to the rank of full professor in 1996. From 1997 to 2003 he served as vice chairman and deputy director of the department.

Dr. Lillemoe's clinical interests focus on the treatment of benign and malignant pancreatic disease and his basic research interests are in the pathogenesis of pancreatic cancer and pancreatitis as well as benign biliary disorders. He has been the author or co-author of nearly 300 journal articles, 112 book chapters and 16 books. Dr. Lillemoe serves on the editorial boards of many of the major surgical journals, including serving as Editor-in-Chief of *Annals of Surgery*. He is editor of *Greenfield's Surgery: Scientific Principles and Practice*, a leading surgical text.

Dr. Lillemoe is a member of most major surgical societies and has helped lead a number of them in various executive roles, including as president of the Society of Surgery of the Alimentary Tract, the Society of Clinical Surgery and the Society of University Surgeons. Among his many awards and honors, most recently, Dr. Lillemoe was selected the 2010 Outstanding Faculty Member for the Department of Surgery Residency at Indiana University. During his time at Hopkins, he was presented with the Faculty Teaching Award on five occasions, and in 2003, the Hopkins Department of Surgery established the Keith D. Lillemoe Faculty Teaching Award in his honor. He is a native of Aberdeen, South Dakota, and earned his undergraduate degree from the University of South Dakota. ♦



We are also very pleased to welcome new leadership in our Division of Cardiac Surgery. Thoralf Sundt III, MD, began his new role as chief on February 7th. Dr. Sundt joined us from the Mayo Clinic, where he was vice chair of the Department of Surgery, director of the Cardiovascular Surgical Research Laboratory and a professor of surgery. He is familiar to many at the MGH, having trained here between 1984 and 1991. He succeeds Douglas Mathisen, MD, who will continue as chief of the Division of Thoracic Surgery.

Sundt earned his undergraduate degree from Princeton University and his Medical Degree from Johns Hopkins University School of Medicine. In addition to his MGH residency, Sundt also trained in thoracic surgery at the Washington University School of Medicine and completed fellowships at the National Cancer Institute and at Harefield Hospital in London. Beginning in 1994, Sundt held appointments with the Barnes-Jewish Hospital and Washington University School of Medicine until joining the Mayo in 2001.

Sundt's clinical focus is on acquired heart disease in the adult with particular interest in diseases of the aorta, including aortic arch replacement and repair of thoracoabdominal aortic aneurysms. His research interests include bicuspid aortic valve disease, human factors and medical errors. ♦



- (l to r)
- Robert Lancaster, MD**
Vascular, MGH
 - Danielle Gottlieb, MD**
Cardiac, Columbia-Presbyterian, NY
 - Alex Haynes, MD**
Surg Onc, MD Anderson
 - Zubin Bamboat, MD**
Surg Onc, MSKCC
 - Claudius Conrad, MD**
Surg Onc, MGH
 - Andrew Warshaw, MD**
 - Harald Ott, MD**
Thoracic, MGH
 - Genevieve Boland, MD**
Surg Onc, MD Anderson
 - Ugwuji Maduekwe, MD**
Colorectal Surg, Pittsburgh
 - Greg Veillette, MD**
Transplant, UCSF

CLASS OF 2011



Of the many fine surgical teachers during my training at the Massachusetts General Hospital, none was more important to my career than Stephen E. Hedberg. Pioneer endoscopist, superb clinical surgeon and involved citizen, Steve became ill at the height of his career and died much too young at the age of 54.

Steve's grandfather was a factory worker in Boston who assembled dispensing machines. Herbert Hedberg, Steve's father, attended Boston Latin School, Harvard College and Harvard Medical School. He trained in Boston in obstetrics and gynecology, and subsequently practiced in Worcester where his thousands of deliveries would provide multiple amusing encounters with members of the Hedberg family for many years after. Herbert was a sometimes stern, honest, moral man who passed these traits on to his son Steven Emanuel who was born in Boston in 1929. An inventor his entire life, young Steve transformed a glass blowing kit into a water pipe designed to lessen the harsh effects of his father's smoking habit. Steve attended Phillips Exeter Academy where he captained the rowing eight and graduated at the top of his class in 1948. He went on to attend Harvard College where in 1950 he was captain of the Harvard crew that won the Henley Regatta in England. Steve left Harvard after three years without a degree declining the college's invitation to return tuition free to gain his diploma. From time to time he pondered the offer saying he would have studied astronomy.

Steve entered the Harvard Medical School Class of 1955 whose roster included future surgeons W. Gerald Austen and Ronald A. Malt, and prospective cardiologist Roman W. DeSanctis. He became a surgical intern at MGH in 1955 and completed his residency in 1962 with an interim of service as a captain in the Army from 1959 to 1961. He was posted to the Walter Reed Army Institute of Research where he wrote papers on the adrenal stress response and vascular anastomotic strength.

As an intern Steve wrote a lovely essay, "He Must Be There," examining the rigors and responsibilities of that difficult first year of surgical training. He compares his long hours of work with those of his lay contemporaries whom he felt had chosen less demanding paths. Accepting the gratitude of a mother whose child he aided dampened his doubts and confirmed his decision to become a surgeon. Steve's letters to then Chief of Surgical Services Edwin D. Churchill during his time at Walter Reed describe in a poetic manner the excitement and frustrations of research, and his musings on what direction his life should take. He quotes a Sanskrit prayer challenging himself to learn to live in the moment. Other letters to Dr. Hermes Grillo, who at that time organized the residency program, chart his plan to return to MGH.

Steve married Elizabeth Wells Johnston in 1950 fathering five sons and a daughter before divorcing in 1967. In 1969 he married Elizabeth Helen "Betsy" Doyle and together they had two sons. She added stability and joy to his personal life. Betsy still works at MGH in a urologist's office.

In the 1950s and 60s at MGH it was common for junior surgeons to start practice working closely with more senior staff. The affectionate term was that you were someone's "boy." ("Girls" were of course almost non-existent). Internationally known surgeon Claude E. Welch offered young Hedberg such a position and Steve accepted building a practice in gastrointestinal, thoracic and vascular surgery. Dr. Welch encouraged his protégé to study and treat the difficult problem of gastrointestinal bleeding leading to Steve's interest and expertise in the nascent field of flexible endoscopy. Some years before in the early 1960s Dr. Churchill had encouraged Dr. Edwin Benedict to pursue this field.

"Blind Benny" as he was known visited a German surgeon who had moved from Munich to Chicago bringing with him a rigid gastroscope with a flexible tip. Thus Dr. Benedict obtained MGH's first instrument for examining the stomach. Steve Hedberg in the later sixties and seventies worked with Reinhold D. Wappler of the American Cystoscope Makers, Inc., (ACMI), adopting fiberoptic technology to construct some of the first flexible gastroscopes and colonoscopes. These instruments were a far cry from today's video digital technology. Viewing was done through an eyepiece and teaching through a side arm appendage. Scopes came with a device allowing for their suspension from the operator's neck that some of us still use today. These scopes became instrumental in diagnosing and treating with snares and electrocautery probes bleeding sources, tumors and polyps of the upper and lower gastrointestinal tract. Steve wrote about these techniques, studied with the famous New York endoscopist Dr. Hiromi Shinya and lectured nationally and internationally. Gastroenterologists of course also advanced this field, but Steve's early adoption for a (*Hedberg continued on page 5*)



He must be there

HE MIGHT be only half your age, and often there's still a trace of the college look about him. But something else is beginning to show in his face, too — a certain set of the jaw, a level glance of the eyes. It's the look of the man who knows he is needed.

And maybe that is why, even if you are older than he, and higher up in the world, you find a note of respect in your voice when you call him "Doctor."

To tell the truth, he's just getting used to that name himself. A few months before, he was a student. Now, as an intern, he's still junior to almost everybody, and the older doctors like to ask him, "How's the educated bellhop today?" He smiles at the old joke and hurries on. There's a report to be filed, a lecture to be attended, a human being in pain. Somewhere he is needed, and he must be there.

For a whole year he will hurry all day, and study half the night, and sleep in snatches with an ear always ready for the emergency telephone. For a year his life will

not be his own. It will belong to the old man who was stricken in the night, to the baby who was born at dawn, to the victim of the auto accident, the sudden fire. All year, no matter how hard he works, there will always be one more patient than he can possibly see, one more report than he can write, one more book than he can read. And for this he will get his room and board, and a few dollars a month.

Sometimes, getting up while you sleep, he thinks how other men of his age are moving on in the world — buying homes, raising families, even finding time to play with their kids. How long will it be before he can support a family? How long before he gets a full night's sleep?

Then he puts on his white coat. In the ward he finds that the baby for whom he ordered an emergency operation a few hours before is going to live; that the old man who had a temperature of 104 yesterday is now sitting up and asking for ice cream; that the mother of the little girl who swallowed a pin wants to shake his hand. Suddenly he feels sorry for the young men who waste eight hours a night in sleep, who've never heard a mother say: "I don't know how to thank you, Doctor."

In time he will forget the harshness of that year, the weariness and the strain. He will remember it as the year he learned what all good men must: that it is a great thing to be needed and, when you are needed, to be there.

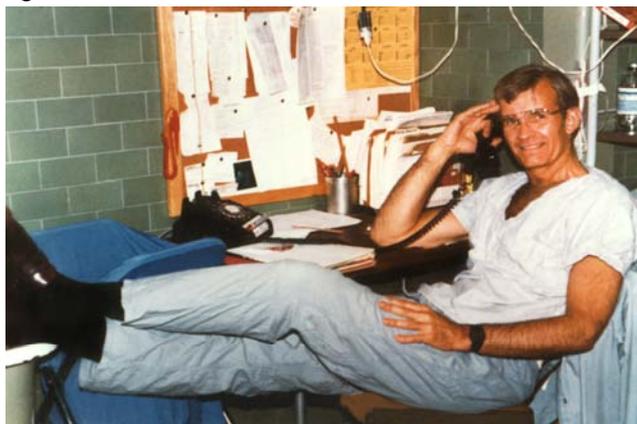
(Hedberg continued from page 4) time placed the MGH surgery department ahead of its medical colleagues. By the middle 1970s the department had a surgical resident slot devoted to endoscopy and Steve created an endoscopy fellowship. This was a wonderful experience consisting of scoping patients all morning and assisting this gifted surgeon in his afternoon cases where Steve was an early employer of stapling and mechanical ligating devices. My predecessor as fellow, Dr. Dennis L. Fowler and Dr. Hedberg tackled the difficult problem of esophageal variceal bleeding advancing techniques for endoscopic sclerotherapy. Steve was essentially self-taught in ERCP and developed innovative ways to relieve esophageal obstruction using stents made of chest tubes. He was gifted in identifying a problem and formulating its solution as in his use of a suction cup device attached to a sump suction to aid in the healing of fistulas and difficult wounds. Today we enjoy the use of VAC sponges to tackle similar problems.

In 1980 Dr. Hedberg met in Chicago with like-minded surgeons to form the Society of American Gastrointestinal and Endoscopic Surgeons, SAGES, projecting they would need 400 members to make the organization viable. Steve was on the original board and vice president in 1984. This organization is now 6,000 members strong. SAGES' first named lecture was given in Steve's honor.

While endoscopic techniques prompted the growth of a large clinical practice, Steve took care of the basics by being ever available, mostly affable, and highly skilled in the care of his and Dr. Welch's patients. Dr. Hedberg's many letters welcome new physicians to the community and give careful follow up of patients to referring physicians. He lectured and consulted in hospitals from Worcester to the Cape and the Islands. At the time I worked most closely with him in 1981, I could not imagine a busier practice.

A man of tremendous energy and author of many papers and book chapters, Steve was interested and involved in the affairs of MGH, the political world around him, and even some less consequential matters. His correspondence offers constructive comments on the MGH phone service, the difficulties of the parking system, and the matter of a found turquoise ring he entrusted to MGH Security. When its owner could not be found, Steve doggedly reasoned that the ring should be his. He petitioned the makers of Drano to urge that they make the product's taste less appealing to children. He wrote to Governor Volpe about the state licensing of chiropractors and to Senator Brooke commenting on the controversial Supreme Court Justice Abe Fortas. He was deeply involved in matters before the county and state medical societies. A detailed letter to Dr. George Nardi passionately supports fee for service private practice as being the best system for delivering optimal patient care. He challenged the movement at MGH to narrow one's practice into sub specialized fields arguing that a single doctor caring for his single patient was best. Long before they were used clinically and before the days of desktops, he championed the use of computers to organize patient information and to avoid medication interactions and errors. His arguments were always clear, forceful and usually dispassionate. But few issues interested him more than the relationship between physician, patient and insurance company.

By the middle 1970s Blue Cross and Blue Shield of Massachusetts was the predominant insurance company in the Commonwealth. Its payment policies had evolved over forty years into a system where each physician had to sign an individual contract accepting a "usual and customary" fee schedule with terms dictated largely by the company. There was no indemnification of the patient whereby the patient would pay a physician's bill for a service rendered and then seek reimbursement from his insurance company. Physicians not participating in the contracts were paid only in emergency situations. Dr. Marshall Bartlett had assigned to Steve Hedberg the task of developing a list of fees for endoscopic services. BC/BS payments for these services were so low as to make purchasing equipment and providing the service fiscally challenging. Steve argued with BC/BS President John Larkin Thompson that this "lock in" of fees and participation stifled innovation favoring open colectomies for polypectomies that could easily be done with a colonoscope. Would not the colonoscopic approach be cheaper for the system and better for the patient? His arguments were rebuffed and when in 1976 BC/BS "froze" physician fee increases, Steve as a participating physician brought suit against the company and was joined by non-participating Dr. James Kartell. Complicating the issue was the fact that some of Steve's colleagues at MGH and at the Massachusetts Medical Society were board members of Blue Shield or involved in the company in other ways. Proceedings dragged on for seven years; Steve's name was ultimately dropped as a plaintiff, and the Mass Medical Society finally joined Dr. Kartell as a litigant. Steve, however, was the star witness at a forty-day trial before Judge Andrew Caffrey. Persuading the judge that BC/BS was limiting innovation, the case was won. But the victory was temporary and functionally void when soon thereafter Governor Michael Dukakis pushed through the legislature a bill banning the practice of balanced billing. BC/BS fearing monetary damages appealed the case to the US First Circuit Court of Appeals. In 1984 Judge Stephen G. Breyer, now a member of the Supreme Court, reversed the verdict. Not until the formation of Partners Health Care in the 1990s would the imbalance between physician and insurance company power begin to be corrected.



Steve Hedberg would not live to see these changes as he died in October of 1984 at age 54. As a young athlete Steve suffered a football injury necessitating a splenectomy. According to his brother David at a date not known, Steve sustained during an operation a laceration from the fractured rib of a motor vehicle accident patient. He contracted hepatitis B which by 1982 progressed to the point where his work was affected and he self treated himself with steroids, azathioprine and eventually cyclosporine. Consultations ensued with the English hepatologist Sheila Sherlock and noted transplant surgeon Thomas Starzl, but to no avail. In October of 1984 Steve's health suddenly declined and he died at the MGH of multisystem failure caused by E. coli sepsis. The details of the autopsy were presented to Steve's widow Betsy in a sensitive letter penned by Dr. Daniel S. Ellis.

Steve was a tall, lanky, good-looking guy with an easy smile. His office workers and fellows will remember his generously hosting lunches at the Ritz Hotel. He was the ultimate individualistic surgeon, unwilling to share in the care of his patients because he believed he could treat them best. (Hedberg continued on page 10)



Soldiers involved in combat in Iraq and Afghanistan (countries referred to collectively as “downrange”) sustain extreme polytrauma characterized by massive soft tissue destruction secondary to high velocity missiles, rocket propelled grenades, and improvised explosive devices (IED’s). The resulting injuries involve complex combinations of blast and burn wounds, mangled extremities, penetrating abdominal and thoracic trauma, open and closed pelvic fractures, as well severe, multilevel spinal column fractures. As an MGH trainee from the mid 1980’s, these are injuries that I had cared for in isolation and in a relatively small number of individuals. I wish to discuss my role as volunteer, consultant vascular surgeon for the US Military where I saw the magnitude and multitude of these injuries on a scale that I had not previously imagined. Perhaps, for those MGH graduates who have served in previous armed conflicts, this author’s report will break no new ground. However, for the author, who had heretofore treated exclusively civilian trauma, witnessing and caring for this increased level of destructive effects was simultaneously both exhilarating and horrifying. Initial care for wounded combatants downrange, including both resuscitation and operative intervention, is performed by a Forward Surgical Team (FST’s). These teams usually are approximately 20 in number and include 2 general surgeons, 2 orthopedic surgeons, nurse anesthetists, and other medical support personnel. A wounded soldier is routinely evaluated by a surgeon within 30 minutes of sustaining an injury. Following resuscitation, evaluation, and intervention, wounded soldiers are air evacuated to a Combat Support Hospital (CSH) for more definitive care. Transfer to a CSH usually occurs within 12 to 24 hours. There are three CSH’s located in Afghanistan and two in Iraq. In addition to general surgeons, these facilities have multiple surgical specialists including vascular surgery, neurosurgery, and ophthalmology. Additional surgical interventions are performed at these facilities. Within the next 24 hours, all wounded soldiers are then flown approximately 3,200 miles to Ramstein Air Force Base located in southeast Germany. Landstuhl Regional Medical Center (LRMC) is located near the base. On average, 3 to 4 critically injured soldiers (along with 20 to 40 less severely injured) are air evacuated from the war theaters to LRMC each day. At LRMC, a wounded soldier typically undergoes one to three subsequent operations (e.g. removal of pelvic and abdominal packs with abdominal washout and closure, debridement and washout of open traumatic amputations with application of wound vac dressings, definitive spine stabilization procedures). Within the subsequent 24 to 72 hours, wounded soldiers will be flown 40,000 miles from Ramstein to Andrews Air Force Base (Maryland) and then brought to either Walter Reed Army Medical Center or Bethesda National Naval Center depending on their service designation. If a significant burn injury has been sustained, the soldier will be flown to Brook Army Burn Center in San Antonio. The average time from injury to arrival in the US is 4 days compared to 48 days in the Vietnam War. At the same time advanced surgical care has been pushed greatly closer to the battlefield. Although LRMC is an Army hospital, the physician staff comes from all service branches, is comprised of both active duty and reservists, and treats all US wounded combatants. LRMC also cares for all wounded Coalition soldiers as well civilian contractors involved in supporting the war effort. Additionally, LRMC provides care for active duty US soldiers stationed in Europe, military retirees, and their dependents. Presently, there exists a relative shortage of military vascular surgeons in both the active duty and reserve sectors. The ongoing conflicts in Iraq and Afghanistan have exacerbated this problem. The need for on-site vascular expertise at LRMC was identified in 2006. Members of the Society of Vascular Surgery (SVS) proposed a solution of volunteer civilian vascular surgeons from the US come to LRMC for 2 week rotations with the support of the US Army and American Red Cross (ARC). The US Army provides transportation and housing while the ARC assumes the volunteer’s malpractice insurance coverage. The ARC certifies each vascular surgeon as an ARC volunteer. Surgical credentialing is done by routine application complete with references and is approved by the chief of surgery and the LRMC Commander. Since 2007, SVS volunteers have provided year round coverage and acted as vascular consultants at LRMC. My rotation at LRMC was in April, 2010. The most common mechanisms of injury include blast wounds from improvised explosive devices and rocket propelled grenades. As mentioned above, the extreme degree of resulting polytrauma is staggering. The following description of injuries is representative: “Patient is 22 y/o active duty US Marine involved in an IED on foot sustaining bilateral LE amputations. Arrived at FST w/ CPR in progress. Procedures performed included resuscitative left thoracotomy, exploratory laparotomy with repair and division of rectum, placement of suprapubic tube, placement of external pelvic fixator, repair penis degloving, bilateral orchiectomy, right above knee amputation, left through the knee amputation, left hand 4 and 5th digit amputations. Right chest tube placed for treatment of right side pneumothorax. CT scans show evidence of T3 and T7 compression fractures and right orbital floor fracture. Patient received 14 units PRBC’s, 14 units FFP, 5 units cryoprecipitate, and 3 units platelets. Patient presently ventilated and sedated.” This is a minimally edited portion of an actual report the physicians at Landstuhl received as this patient was being flown from Afghanistan to Germany. The logistics and medical expertise to safely transfer these types of patients over large distances is beyond impressive. The extent of trauma described above was typically not survivable in previous conflicts. Each morning I would round with the ICU team. Afterwards, I would assist and advise as needed. Typically, I would be asked to evaluate extremity bypasses that had been performed downrange. It was not uncommon that a bypass had thrombosed and required thrombectomy and revision. Placement of IVC filters was frequently performed, but many wounded had already had filters placed prior to their arrival at LRMC. I also had the opportunity to assist orthopedic surgeons with wound debridements and fixation of complex fractures, as well assist the urologists and neurosurgeons with various procedures. I also volunteered to assist the general surgeons with their elective cases such as hernia repairs and breast cases. These were all areas that I don’t get a chance to participate in back home in the “states”. Another difference was the organizational culture present at LRMC versus that found at most civilian hospitals. At all levels at LRMC, everyone that I encountered shared a sense of common purpose. Perhaps, having such a common tangible goal makes it easier to build an organizational culture. Among the physician staff, I did not observe the common problem of loyalties divided between one’s institution and one’s specialty. I am sure I was naïve as resident, but this sense of common purpose reminded of my training at MGH (at least among the house staff!). Remarkably, many of these severely wounded young men will recover. However, their lives and those (*Wolk continued on page 10*)

ANECDOTES from Bruce Zawacki '67

Bruce E. Zawacki entered the MGH surgical training program immediately after graduating from Harvard Medical School in June 1961. He finished the program in 1967 having spent 1966 on a Burn Surgery Fellowship (arranged for by Paul S. Russell) at the Birmingham Accident Hospital in Birmingham England. "Forever grateful for, and forever nostalgic about "the MGH experience, he shares below three of his more memorable MGH recollections. First is a very short story about "an initial physician-patient encounter" he witnessed on the Urology Service.

While rotating through the MGH Urology Service and during early-morning rounds, I and another surgical intern (I believe his last name was Rodman) were presenting to the Urology Chief Resident the patients admitted the night before from the Emergency Room. The Urology Chief Resident (I shall call him Dr. Prostaticus) on this occasion seemed to be very much in a hurry to finish rounds and get to the operating room. His manner was rushed, curt and blunt, and he gave the impression that he wanted to hear only the most salient pathophysiological details about each case, and nothing else. Dr. Rodman, on the other hand, was from "main-line" Philadelphia. Whenever his sense of etiquette required, he would speak slowly, unperturbedly, and in an exceedingly polite manner with an impeccably calm voice.

Mr. Albert Clark (I shall call the patient) was the second patient presented on our rounds. He was a tired but distinguished looking 70 year old man with close-cropped "salt-and-pepper" hair, a narrow and carefully tended mustache, and a one-day growth of beard. He was seated comfortably upright in his bed covered from waist to toes by a single white sheet. A clear plastic tube filled with purplish urine and blood clots exited from under the sheet and ran into a half-filled clear plastic bag hanging from the bedside near Mr. Clark.

As the small group of rounding physicians approached, Mr. Clark, sensing who was in charge, mustered a welcoming smile and turned to greet Dr Prostaticus as Dr. Rodman said in his slow, resonant baritone and very, very polite and ceremonious way: Dr. Prostaticus. At this time it is my very great pleasure to introduce to you Mr. Albert Edward Clark, a 70 year old gentleman from Brookline who, for the past 3 days has been troubled by increasing urinary retention, frequency, dysuria and midline lower abdominal pain. Foley catheterization relieved his retention and distress but was accompanied by the transient bleeding visible in Mr. Clark's urinary drainage bag..." Dr. Prostaticus ignored both the patient and his smile. Without closing the bedside curtain or saying a word, he strode quickly to the bedside and abruptly pulled down the bed sheet exposing his patient as naked from the waist down. Then, grasping the Foley catheter and drainage tube with his bare right hand, he shook them to enhance flow into the drainage bag. Initially shocked by this experience, Mr. Clark quickly calmed himself. Then, with an even broader smile, he said in a very clear and calm voice: "It is of course a pleasure to meet you Dr. Prostaticus. But usually when I am introduced to persons, they shake my hand."

Next is a story about a memorable event that occurred in the Baker Building.

Henry K. Beecher was Chief of Anesthesiology at MGH when I was a junior surgical resident. Referred to as "Harry" by many of the senior surgeons, Dr. Beecher was well known and greatly respected for his work in Anesthesia and medical ethics. But it was also widely rumored among the surgical faculty that Dr. Beecher was superior to all the other faculty members in regard to one particular professional skill: he delivered his "bill for professional services" faster than any one else. In fact, he was said to have regularly placed his bill for intraoperative anesthesia on the bedside table of each of his patients even before they had awoken from anesthesia.

One day I was scheduled to assist J. Gordon Scannell with an operation which was to begin in one of the Baker Building operating rooms shortly after the first case of the day. As we scrubbed next to each other at the same sink, Dr. Scannell and I were conversing about something of mutual interest, perhaps Latin grammar (Dr. Scannell at times taught Latin at Boston Latin School and we both shared an interest in that language.) Suddenly, and without warning, we both heard a familiar but unusually loud sound coming from a nearby operating room or recovery room, we couldn't tell which. It was the sound that characteristically comes from a patient's mouth after an anesthesiologist bagging the patient forces an especially deep inspiration of oxygen into the lungs and then quickly removes the endotracheal tube. The sound was that of a loud and extremely forced expiratory gasp and sounded like "Haahuuh!" Immediately, and without missing a beat, Dr. Scannell said calmly: "It sounds like that patient just got a look at Harry's bill!"

Bruce's final story is in the form of a "prose poem" and concerns an event that also occurred on the Operating Room Floor of the Baker Building.

...so be back home in bed by then" Mom warned whenever I left to go on a high-school date. One midnight, years later, her words returned. As a junior surgical resident I had been on my feet for 18 hours with no rest and only a pint of oil-topped peanut-butter on Saltine crackers to keep me going. Shuffling up painted steel steps to the top-floor Baker Building operating rooms, I was a sleepless automaton in rumpled white pajamas, lifting then scuffing-forward one blood-speckled shoe after the other. At the top, urgent chatter erased the muffled comfort of the stairwell. The words "Here's your patient" felt like a sucker-punch from behind. Born prematurely with a defect in his chest, he was breathing saliva and swallowing air. Grey in color and "circling the drain," for him "nothing good" was already happening. Pacing like racehorses in their paddock were the peds surgery team and its skilled, sovereign leader Hardy Hendren. Behind his back we called him "Hardly Human."

By 1 AM we had opened Grey-boy's fragile-bird chest and exposed his tiny but terrible defect. "Much worse than I thought" grumbled Hardy behind his cloth mask. No one but me seemed upset. My right knee buckled. It felt like a portion of the peanut-butter-energy holding me up had drained through my right foot and into the floor.

By 2 AM the defect was corrected, but the repaired tissue was blue from lack of circulation. If it didn't heal Grey-boy would die. "IT'S NO GOODAH" declared Hardy.

By 3 AM, after some changes, the repair looked less blue. Hardly stepped back. With omniscience dripping from every word, he announced "IT'S STILL NO GOODAH!" By 4 AM, after still more changes, the repair looked ok to me. With less than his usual certitude, Hardly growled softly: "It's still no good."

By 5AM, a new approach was tried and completed. I was fully alert, but afraid to look. After a 30-second delay, the whispered verdict was "It's still no damn good." I thought I might fall face-forward-asleep into the wound if we con- (*Zawacki continued on page 10*)

WELCOME INTERN CLASS OF 2012



Geoffrey Anderson
Emory University



Jordan Bloom
Jefferson Medical College



Jordan Bohnen
Harvard Medical
School



Christy Cauley
Indiana University



Robert Goldstone
Mount Sinai School
of Medicine



Andrea Merrill
Tufts University



George Molina
Harvard Medical
School



Philip Spencer
Harvard Medical
School

EVENTS OF NOTE

- *Richard Cambria* was elected 2011-2012 President of the Society for Vascular Surgery on June 17, 2011 during the Vascular Annual Meeting in Chicago, Illinois
- *Amy Colwell* received the 2011 Leonard R. Rubin American Association of Plastic Surgeons Best Paper Award for “Three Hundred Thirty-one Consecutive Immediate Single Stage Breast Implant Reconstructions with Acellular Dermal Matrix in 211 Patients: Indications, Complications, Trends, and Patient Satisfaction.
- *Patricia Donahoe*, Marshall K. Bartlett Professor of Surgery (Department Pediatric Surgery), has been selected to receive the 2012 Society of University Surgeons Lifetime Achievement Award at the Academic Surgical Congress meeting February 7-9, 2012 in Las Vegas, Nevada.
- *Carlos Fernandez del-Castillo*, Professor of Surgery (Division of General and GI Surgery), received the 2011 Harvard Medical School Charles McCabe, MD Faculty Prize for Excellence in Clinical.
- *Dicken Ko* has been elected the 28th President of the Urologic Society for Transplantation and Renal Surgery (2012)

MGH SURGICAL SOCIETY RECEPTION

MONDAY, OCTOBER 24, 2011.

HILTON SAN FRANCISCO – CONTINENTAL BALLROOM 5

ACS RECEPTION 2010



In Memoriam

George S. Richardson '54

We hope you enjoyed this issue of the MGH Surgical Society Newsletter.

Your comments, suggestions, letters to the editor, photos and news are welcome.

Hope to see you at the reunion,

Les and Bill

(Hedberg continued from page 5) Realizing that in early middle age he had fallen out of shape, he abruptly quit cigarettes and took up running participating in several Boston Marathons and the American Heart Association Doctor's Run. He was known for never giving up on a patient or on an issue in which he believed. At his funeral service Claude Welch remarked, "... when his principles were threatened he became a formidable opponent in debate," and further stated, "(he was) a man of enormous energy..." Both his endoscopy nurse Linda Lauratano and his scrub nurse Judy Perley volunteered that working with him marked the height of their careers. Dennis Fowler in comments shared by all of his fellows with whom I spoke said, "He meant everything to my practice." Colleague Dr. Fred Ackroyd called him a "maverick and out of the box thinker and completely honest." His good friend Dr. Alfred Cohen at his service used the words of Kahlil Gibran to describe his character as being filled with "Love, Rebellion and Freedom." It occurs to me that Steve Hedberg would have embraced the laparoscopic revolution of the late 1980s and quickly made the MGH a leader in that field. I will never forget his advice, "Never decide not to learn something." He was as skilled a surgeon as I have seen, and for the development of surgical endoscopy, any surgeon who handles a scope is deeply in his debt. I know that I am. *(Editor's note: Russell Ryan writes with the authority of his own personal experience when he describes Steve Hedberg and his career at the MGH. After graduating from Cornell Medical College and completing the internship and residency in general surgery at the MGH, Russell became Hedberg's endoscopy fellow in 1981. Since then he has practiced general and endoscopic surgery at the North Shore Medical Center and remained active at Harvard and the MGH as a Clinical Instructor in Surgery.)* ♦

(Zawacki continued from page 7)

tinued any longer.

By 6 AM another approach was completed. Afraid to look I closed my eyes, slept for an instant, then jerked back in alarm as I felt myself falling forward. "NOW THAT'S REALLY GOODAH!" bellowed Hardly. "LETS CLOSE UP AND ALL GO OVER TO THE UNION OYSTER HOUSE FOR LOBSTER."

I stayed in the hospital to look after Now-pink-boy, and smiled as I imagined Hardly and his team trying at 7 AM to open the restaurant with a demand for lobster. Then I recalled Mom's "Nothing good happens after midnight" and similar warnings from advocates for reduced resident-work-hours. Yes the exhaustion, no sleep and no lobster were not good, but two things were: 1) the child did well, and 2) when I least expected it, and in the toughest of circumstances, I had seen in real-life action, the do-whatever-it-takes-hero-surgeon I always wanted to be. *(Editor's note: Bruce Zawacki graduated from HMS and was a resident in surgery at the MGH between 1961 and 1967. He had a Burn Fellowship at the Birmingham Accident Hospital and was also awarded a MA from the USC School of Religion and Social Ethics. Before he retired, he was the director of the Burn Center at LAC+USC Medical Center, associate professor of surgery, USC School of Medicine, and associate professor of religion, USC School of Religion)* ♦

(Wolk continued from page 6) of families will never be the same. The permanent physical and psychological effects will always serve to remind all of the incalculable suffering that war leaves behind. I hope that we as society will continue to care for these wounded individuals 10 or 20 years from now, when their physical and psychological disabilities will have made it hard for them to be employed or be part of a family. I am neither pacifist nor warrior, but after my rotation at LRMC, I would urge policy makers (and those who vote for them) to think carefully of the consequences before placing young men in harm's way. *(Editor's note: Seth Wolk is presently the Chief, Section of Vascular Surgery and Endovascular Therapy, Veterans Health Administration, Albuquerque, New Mexico. He graduated from HMS in 1983, completed the residency in surgery at the MGH in 1988, and, a year later, a Vascular Surgery Fellowship at the Mayo Clinic. He then practiced general and vascular surgery at the St. Joseph Mercy Hospital, Ann Arbor, MI, for 20 years, serving for seven of these as the Program Director in General Surgery. In 2010 he completed a MHSA in Health Management and Policy at the University of Michigan School of Public Health and then joined the Veterans Health Administration with a focus on patient safety. He deserves to be especially recognized for his key role in the founding of the MGH Surgical Society and was the Secretary-Treasurer for our first six years.)* ♦