



# The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY

## Newsletter

Spring 2007

Volume 8, Issue 1

### MGH SURGICAL SOCIETY

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**MGH  
Surgical Society  
Annual Reception**

**Monday  
October 8, 2007  
6:00 to 8:00 p.m.**

### A MESSAGE FROM THE PRESIDENT

The Visiting Surgeons in days past were an unusual group and Dr. Grantley Taylor was certainly one of the most colorful ever to be at the MGH. He received his MD degree from Harvard in 1922. During World War II, he served as a major with the Seventh Army in the Battle of the Bulge. The rest of his surgical career was in surgical oncology at the MGH or the Huntington and Pondville Tumor Clinics.

Dr. Taylor was left handed, and it was a joy for me, also left-handed, to operate with him. When we had a left-handed nurse, he called us his "Sinister Team."

Grantley Taylor died unexpectedly while on vacation on December 26, 1966. He was greatly missed at the hospital. Shortly after his death a committee of Marsh Bartlett, Lang Parsons, Bill Rogers, and Rich Warren was formed to evaluate and preserve Grantley's remarks and anecdotes in a small notebook entitled "Taylor's Tales."

Nathan Munro sent his copy to Seth Wolk who turned it over to the Newsletter. Where do we go from here???

### GRANTLEY-ISMS



When he asked for a six inch drain and was given one about two inches long, he stopped, looked at the scrub nurse and said, "if this is your idea of six inches, what are you doing tonight?"

Grantley was not very fond of Dr. X. One day someone meeting him in the Phillips House coatroom said, "Did you know Dr. X is sick? He is up on the fourth floor." "Oh" said Grantley, "Well, I hope it is nothing trivial."

He disliked the piecemeal excision of multiple metastatic nodules. He explained, "it is perfectly possible to get all the blueberries out of a blueberry muffin, but when you are through, you no longer have a muffin."

On a big case, he might start by saying, "we're not berry picking today, we're out for salmon."

When listening to an erudite discussion of cell biochemistry at a meeting of the New England Surgical, he said to the audience, "those last two papers went right over my head, and I did not even have to duck."

He described a difficult procedure as being "like trying to catheterize a wildcat with a piece of spaghetti."

On a panel session, a young surgeon asked, how long do you think one should take to examine a breast?" Dr. A answered, "A half an hour." The question was passed to Dr. Taylor, who replied, "If you take longer than five minutes, it's quit being scientific and becomes social."

Commenting on an older surgeon who was in a relationship with a not too young nurse, Dr. Taylor's comment, "They're both just a couple of dried sticks rubbing together trying to make a fire."

Robb Rutledge.♦

DO YOU HAVE ANY "ISMS" FROM YOUR FAVORITE MGH TEACHERS?  
Please send them along to the Editorial Office for publication in our next issue.

## That's All Right With Me by Jack Tetirick '56



Thoughts about what makes some hospitals differentiate themselves from all others requires specific examples – why, I am not certain, but somehow I believe it is important.

So I am going to recite the matter of – “that’s all right with me”.

First of all, disclaimers. I have always warned that my stories lose nothing in the telling. I am an old man and easily displace some facts with others, the very common human failing of all ages of believing what one wishes to believe, which must by good common sense make all such stories to be regarded as honest fiction as opposed to solid fact. *Nevertheless here we go!!!*

In 1951 I was a first year resident at the Massachusetts General Hospital, the finest hospital in the entire world and how I ever wound up there must remain one of the mysteries of the ages. A hayseed if there ever was one, from central Ohio with a beautiful wife, an enormous ego, and an abundant store of energy.

Every week on the surgical service (there were two – East and West) we had rounds where the “visits”, meaning the staff members would round on our patients for review and criticism – mostly the latter. *For* all of the patients admitted to the White Building of the MGH were the patients of the resident staff. They were ours. With all that implied. The patients came mostly from the North End of Boston, I think they had very great financial advantages in admitting themselves to that service, I know nothing about the details, what I do know is that they knew they were our patients and were proud of it. I must make a side note here – that particular

Boston population thought the MGH residents, mostly Harvard graduates, were all geniuses, they were used to us, they loved us in a very peculiar way, for instance they allowed us as students to have food fights in their restaurants without calling the cops and all that – but there was a *quid pro quo* – *when the rubber hit the road we were expected to deliver !!!* And believe me we did – with every ounce of energy we possessed.

The scene is now on one of those fateful Wednesday afternoon rounds. My memory is that the visit was Claude Welch – a very famous gastrointestinal surgeon – called to consult when the Pope was shot in the belly and all that – but what worries me is that Welch was East Service, and this happened on West – so be warned. A better likelihood was that it was Marshall Bartlett – the most kind and sage man I ever watched from across the operating table – when I went on his private service a year later he spent every surgery asking me at every step what I would do next, and, thinking the fellow needed my help, I offered my advice freely, only to realize at the end of four months that he went ahead and did what he always intended to do in the first place. I told you I was a hayseed – it took me a very long time to wake up.

It was late in the afternoon, either autumn or early winter, so I was at best 25 years old, and was in my most inferior position at the bottom of the patient’s bed while the visit questioned the patient, an old Italian lady, quite chubby and nervous, with a dark moustache on her upper lip which quivered a bit in front of this cluster of white coats and the presence of the man in the suit beside her. The chief resident, I think Bill Waddell, recited her history, which quite simply was a case of gallstones which had caused an acute flare-up of cholecystitis, now subsiding. Dr. Waddell’s recommendation was that she should have a cholecystectomy.

The visit leaned over her, casting, if not an actual, a huge dark psychic shadow, and said, “Your doctors think you should have your gallbladder removed.”

Her face twitched a bit before she replied. “I...I dun know,” with a thick accent.

“Well, what’s wrong then?”

“I...thinka I mus talk to mya doctor about that.”

The visit straightened beside the bed.

“Well, we can call Dr. Balboni, if you wish, but I am sure he knew this before he had you admitted here,” he replied, glancing at the rest of us for the implied recognition that one *never fails to praise the family doctor*. This was, after all, a teaching session.

“No,” she replied firmly. “My doctor down there.” Indicating me!

*I had admitted her, worked her up, and cared for her during all of the time she was there. I wanted to crawl under the bed.*

The visit turned and stared at me as my heart turned to stone. He turned back to the woman huddled in her bed.

“Well, Dr. Tetirick is a surgeon,” he pronounced, probably the greatest lie of his career. “Should he be your surgeon?”

I have never been sure if this was intended as a joke, or for that matter what was going on. All I know is that the old lady looked up at him, looked down at me, looked back up at him and said, “Thassa all right with me.”

We went on to other patients. We then had morbidity and mortality rounds until the sun had fallen and dinnertime long passed. As the meeting was breaking up, Dr. Welch said aside to me, “Tetirick, walk back over to the Baker with me.” That was usually the sign you were going to get chewed out in private. We had a very long walk back through the old dark brick-lined halls until we reached the final corner. “Jack,” he said to me as we parted, “the day patients stop feeling that way about you, the MGH will have lost its way.” The door closed and he was gone.

I did the cholecystectomy, I think my first. It was easy, particularly because there was a junior visit across the table watching every move. As you might imagine, I have always loved old Italian ladies.

*(Editor’s note: Jack Tetirick went through the MGH Surgical Residency Program from 1951 to 1956. In 1990 he retired after a long rewarding career in Columbus, Ohio, during which he rehabilitated an inner city hospital and was a clinical associate professor of surgery at Ohio State University, in addition to his large clinical practice. He and Helen have been married 58 years, have three children and seven grandchildren. They live in 100 acres of forest near Zanesfield, Ohio.)♦*

### **The Cost of Change by Grant Rodkey '50**

In April 1943, within two weeks of beginning my surgical internship at the MGH, I was summoned at 8 a.m. to the operating room in the Baker Memorial to assist Dr. Channing Simmons in the performance of a radical mastectomy, an operation which I had not previously seen. During our scrubbing, Dr. Simmons (who had begun his internship in 1904) was friendly, but quiet, and certainly spoke no word concerning the technical aspects of our planned operation.

With the patient prepared, Dr. Simmons outlined an oblique incision extending roughly from the xiphoid to the axilla with an island of skin left over the dome of the breast. Then began a furious, sustained onslaught of sharp dissection elevating skin flaps, excising the pectoralis muscles and dissecting the axilla - all without pause to tie a single bleeder! The failure of the patient to exsanguinate was purely due to my swiftness and dexterity (intern-type) in clamping all the bleeders! The breast was in the specimen pan 20 minutes from the beginning of the operation! At that point, Dr. Simmons turned, took off his gown and gloves and said, "You close up". It is my belief that Dr. Simmons was a role model for Dr. Grantley Taylor, twenty years his junior, also a staunch advocate of sharp dissection in mastectomy - as well as everything else - and left-handed at that!

Despite the fact that Dr. Ernest Daland in the mid 1920s had been able to collect and study a series of women with untreated breast cancer, the Halstedian radical mastectomy dominated surgical thinking. For the next 30 years following my introduction to mastectomy, the debates were centered around increasing radicalness of the dissection with thinner skin flaps, wider margins, excision of skin with grafting, and mediastinal node dissection (Urban). We all saw numbness of the underarm, lymphadema, and late lymphosarcoma, but we considered these to be a harsh but necessary price to pay for survival.

In the 1960s, I had three patients who seriously disturbed my thinking. Each of them was in her late 40s and intramenopausal. Two of the women had 1.5 cm ductal carcinomas in the upper outer quadrant and both were treated with radical mastectomy. There were no positive lymph nodes in either case. One was cured, the other was dead of brain metastasis in two years. The third, a patient of Dr. Gerald Foster, had a 2 cm ductal carcinoma in the upper out quadrant of the left breast with no palpable lymph node metastases. She adamantly refused mastectomy despite

predictions of serious consequences of this decision. I designed an operation for her which I conceived as a segmental mastectomy: a radial, elliptical incision leaving an island of skin over the tumor, elevating flaps on either side, and excising a wedge of breast parenchyma from the central pole to the periphery, full-thickness to pectoralis fascia, taking a margin of normal tissue 1.5 cm on either side of the tumor. This was reconstructed by three layers of interrupted sutures (at the deep margin, in the mid-portion and the superficial edge of the parenchyma) with linear closure of the subcutaneous fascia and subcuticular closure of the skin with absorbable sutures. There was no sampling of axillary lymph nodes. This patient has been cured of her cancer; and, to her great delight, she had a nice cosmetic result. Histological study of their tumors revealed no distinguishing features among the three cases. These results were inconsistent, unpredictable, and uncontrollable by current treatment.

During this same period, Dr. George Crile Jr., an iconoclastic surgeon at the Cleveland Clinic, was having similar misgivings. In 1964 he published "Results of Simplified Treatment of Breast Cancer" (*Surg Gynecol Obst* 1964;118:517-23). During the next three decades he published approximately 69 papers on this subject. Through some connection which I never learned, Drs. Oliver Cope and George Crile were good friends - and in some ways, kindred spirits. Whether it was through this connection, or upon his own motivation, Dr. Cope, at about the same time, took up at MGH the cause of limited surgery and x-ray therapy for breast carcinoma. In this he was joined by the Wang brothers - Dr. Chiu-an and Chiu-Chen - Drs. Milford Schultz, John Long (a psychiatrist), William Sohler (an oncologist) and Benjamin Castleman (*Am J Surg* 1976;131: 400-7). I did not join them because I was not willing to accept "lumpectomy" as a satisfactory primary excision of the tumor. I thought then - and still do - that segmental resection provides both more accurate dissection margins and better cosmetic outcome. I continued to do segmental resection plus/minus x-ray therapy throughout my career.

Those of you who were at the hospital during that period will remember vividly the tension that this occasioned. This directly challenged the Halstedian concept of cancer management now entrenched for three quarters of a century. Convictions were strong, reactions intemperate and division palpable. Dr. Cope, already some-

what isolated from his surgical colleagues by his rigid mannerisms and dogmatism as well as his meticulous and slow surgical dissection, was fair game. The old Aesculapian Club parody had just enough veritas to stick and revive:

**I'm Oliver Cope  
And I'm no dope,  
Despite persistent rumors.  
I spend my life  
In diligent search  
Of parathyroid tumors.**

To make matters worse, Dr. Cope - frustrated and angered by the rejection of his peers - advocated his ideas in the *Alumnae Journal of Radcliffe College*, a "lay publication"! In the eyes of many, this was an unforgivable professional breach.

Most fortunately, we are now able to look at the treatment of breast carcinoma more dispassionately and with much greater knowledge of its genetics, growth dynamics and effective treatment - which includes limited surgery. Undoubtedly, tremendous progress - but it comes at a cost in time, money, research and emotional pain.

*(Editor's note: Grant Rodkey is one of our few members who has received a 60 year MGH service pin and still is active both at the MGH and at the VA New England Health Care System. Grant was born in Simon, Colorado, received his B.S. at Whitworth College in Spokane in 1939, and received that colleges Distinguished Alumnus of the Year Award in 2002.*

*Grant received his M.D. at Harvard in 1943 and all of his residencies, surgical and orthopedic, at the MGH, finishing up in 1950.*

*He also has been active in the Boston Medical Library and was its president in 1997. He was president of the Massachusetts Medical Society in 1980-81, and has been active in the A.M.A.*

*Grant has been an early disciple of segmental resections as he points out in the article. A member of his family was one of Dr. Cope's early patients in 1957 and remains well.)♦*

**Fourth Reunion of the  
MGH Surgical Society  
June 2008**

**Please send us your  
ideas!**

### EVENTS OF NOTE

- ❖ Congratulations to *Hasan Alam, M.D.* on his recent Harvard Medical School promotion to Associate Professor of Surgery (Trauma, Emergency Surgery, and Surgical Critical Care).
- ❖ University Hospitals Case Medical Center's Rainbow Babies & Children's Hospital has appointed *Edward M. Barksdale, Jr., M.D. '91* as the new chief of pediatric general surgery. Dr. Barksdale will be the first holder of the Robert J. Izant, Jr., M.D. Chair in Pediatric Surgery.
- ❖ *Susan Briggs, M.D. '80* has been named Editor-in-Chief of the new American Journal of Disaster Medicine, the Official Journal of the American Society of Disaster Medicine.
- ❖ Congratulation to *Allan Goldstein, M.D. '00* on his recent Harvard Medical School Promotion to Assistant Professor of Surgery (Pediatric Surgery).
- ❖ At the invitation of *Eliot Chaikof, M.D. '85*, *Richard Cambria, M.D. '84* recently served as Distinguished Professor of Surgery at Emory University School of Medicine where he presented a lecture entitled "Stent Graft Repair in the Thoracic Aorta: Current Status".
- ❖ Congratulations to *Alan Hilgenberg, M.D. '75* on his recent Harvard Medical School promotion to Clinical Professor of Surgery (Cardiac Surgery).
- ❖ *Michael E. Jabaley, M.D. '66* was chosen by the Southeastern Society of Plastic and Reconstructive Surgeons as the 2006 recipient of the Pickrell Award at the Society's annual meeting. The Pickrell Award is presented to the person who most closely exemplifies, in his commitment to plastic surgery education, the characteristics of the late Dr. Kenneth L. Pickrell, a renowned surgeon and teacher who served for many years as chairman of the division of Plastic Surgery at Duke University.
- ❖ *Jeff Myers, M.D., Ph.D.* will be joining the MGH Department of Surgery and the Mass General Hospital for Children as the Chief of Pediatric Cardiac and Congenital Cardiac Surgery in July 2007. Dr. Myers is currently the Director of Pediatric Cardiothoracic Surgery at Le Bonheur Children's Medical Center in Memphis where he relocated with his family following the devastation of Katrina. Prior to that he was Chief of Pediatric and Congenital Cardiac Surgery at Tulane University Medical School in New Orleans. Dr. Myers will lead the efforts to develop the Pediatric Cardiac Program of the MGHfC as well as continue his existing clinical trial work developing a laboratory effort in basic and translational research.
- ❖ *Peter Rutledge, M.D. '89* presided as President of the 46<sup>th</sup> Annual Meeting of the North Texas Chapter of the American College of Surgeons in Dallas, Texas, on February 23-24, 2007. *David Rattner, M.D. '86* was guest speaker, and delivered the Robert Sparkman Memorial Lecture, "Natural Transluminal Surgery: Fantasy or the Future."
- ❖ Congratulations to *Thomas Vander Salm, M.D. '74* on his recent Harvard Medical School promotion to Clinical Professor of Surgery (Cardiac Surgery).
- ❖ Moving on: A Memoir by *George D. Zuidema, M.D. '59* was recently published by Milestone Publishing, 1327 Jones Drive, Suite 201, Ann Arbor, MI 48105 (734 998 6760).

### DEPARTURES

<b>Katherine Deans</b>	<b>Pediatric Surgery Fellowships, Children's Hospital of Philadelphia</b>
<b>Nathaniel Evans</b>	<b>Cardiothoracic Fellowship, Massachusetts General Hospital</b>
<b>Ara Feinstein</b>	<b>Trauma and Critical Care Fellowship, University of Miami</b>
<b>Dax Guenther</b>	<b>Plastic Surgery Fellowship, University of California, Los Angeles</b>
<b>Adrian Maung</b>	<b>Trauma and Critical Care Fellowship, University of Maryland</b>
<b>Peter Minneci</b>	<b>Instructor in Surgery, CHOP, University of Pennsylvania</b>
<b>Ashok Muniappan</b>	<b>Cardiothoracic Fellowship, Massachusetts General Hospital</b>
<b>Grace Wang</b>	<b>Vascular Fellowship, Hospital of the University of Pennsylvania</b>

**GOOD LUCK SENIORS!**

**A MESSAGE FROM THE CHAIRMAN**

**The Transplantation Center: Moving forward at the MGH**

Organ transplantation at the MGH began its distinguished history under the leadership of Paul Russell nearly half a century ago. In that time Dr. Russell and his successor, Ben Cosimi, have brought about many “firsts” in clinical transplantation, including New England’s first successful liver, pancreas, small bowel, liver-heart, and split-liver transplants. The basic science underpinning, bolstered in 1991 by creating the Transplantation Biology Research Center led by David Sachs, has fostered the first clinical use of monoclonal antibodies, the first successful clinical trial of tolerance induction for renal allografts in HLA-identical recipients, and in 2002 the first successful clinical trial of tolerance induction for non-identical recipients. The international visibility of the MGH program is exemplified by the prominence of our team leaders in transplant organizations: Ben Cosimi, President of the American Society of Transplant Surgeons; Jay Fishman, President of the American Society of Transplantation; Megan Sykes, President of the International Xenotransplantation Society; Frank Delmonico, President of the United Network for Organ Sharing, Director of the New England Organ Bank, and a top advisor to the World Health Organization; and David Sachs, Founding Editor of the journal Xenotransplantation.

In recent years the level of clinical activity has positioned the MGH as a medium-sized program, with about 90-100 kidneys, 40-50 livers, 15 hearts, and a dozen lungs transplanted every year. The volume of transplants has been hobbled by the shortage of potential donor organs, both as a national phenomenon and locally because of the plethora of competing transplant programs in our organ distribution area. Living donors have sustained modest growth but involve intrinsic and ethical limitations. Innovation, such as the successful tolerance initiative, will help us to grow, but truly significant expansion will probably depend on basics (like increasing the inflow pipeline of candidates via new transplant physicians) and breakthroughs – especially the opening of an unlimited new supply of organs by xenotransplantation. The genetic engineering by David Sachs of a herd of mini-pigs, a 35-year effort, now puts xenotransplantation on the threshold of reality. With the combination of induced tolerance and Dr. Sachs’ pigs, which have organs of the right size to fit humans but do not have the natural cell-surface antigens which cause hyper-acute rejection, successful xenotransplantation may be here in as little as five years.

Last year an institutional task force led by David Torchiana, CEO of the MGH Physicians’ Organization, set the vision of “a multidisciplinary center for transplantation that will advance the integration of basic and translational research, education and patient care.” The Center is charged with fostering “communication and multidisciplinary collaboration between clinicians concerned with different organs and tissues and between basic scientists and clinicians so that knowledge gained in one area will be applied in others.” It will develop: a comprehensive database to facilitate clinical care, research, finance, and the interface with transplant organizations; new educational and career pathways; a tissue bank with the capability of expanding into transplant genetics; core laboratories; and a foundation to coordinate philanthropic efforts. An over-arching goal will be to coordinate and optimize the somewhat silo’d organ programs for purposes of efficiency, economy and a united front for contracting with transplant payors.

Joren Madsen, M.D., D.Phil., has been named the Director of the MGH Transplant Center. Joren, who has been head of the heart transplant program, has passed that position to Bruce Rosengard, M.D., formerly the British Heart Association Professor and Chief of Heart Surgery at the University of Cambridge (England) who came to us in 2006. Jeffrey Myers, M.D., Ph.D., a congenital heart surgeon, will join the team in July to add expertise in pediatric heart transplantation.

Jay A. Fishman, M.D., Chief of the MGH Transplant Infectious Disease Program, has been appointed Associate Director of the Center. Megan Sykes, M.D., Associate Chief of the MGH Transplantation Biology Research Center, will lead the research arm of the new center with a particular focus on translation between the basic science and clinical efforts.

James Markmann, M.D., Ph.D. (*left*) will be coming to the MGH from the University of Pennsylvania as Clinical Director of the Division of Transplant Surgery. Dr. Markmann’s arrival will bolster our existing strength in transplant surgery by adding broad surgical expertise in adult and pediatric liver, kidney, and pancreas transplantation. Dr. Markmann also brings an active basic research program studying immunologic tolerance mediated by regulatory T cells. He has had a long-standing interest in pancreatic islet transplantation and will initiate a clinical isolated islet transplant program centered at the MGH and serving the Boston area. The team joining him from Penn includes a talented young transplant surgeon, Dr. Heidi Yeh (*center*), and an expert human islet-isolation team headed by Dr. Shaoping Deng (*right*).



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**IN MEMORIAM**  
**WILCOX KIRKLAND RUFFIN, M.D.**

**WELCOME INTERNS**

***(Top l to r) Elizabeth Blazick, University of South Florida College of Medicine; Michael Kurtz, Brown Medical School; Michael Kwon, University of Maryland School of Medicine; Melissa Levack, Emory University School of Medicine;***



***(Bottom l to r) Deepika Nehra, Stanford University School of Medicine; Vanessa Olbrecht, Johns Hopkins University School of Medicine; Smita Sihag, Washington University in St. Louis School of Medicine; Karen Walp, Tufts University School of Medicine***



*(above) Drs. Hendren, Donahoe and Vacanti*

*(right) A postcard sent by Dr. Hendren to Dr. Warshaw which uniquely captures the usually busy surgeon sitting on his ass.*



On March 8, 2007 we celebrated the dedication of the W. Hardy Hendren Conference room in appreciation of his 55 years of service to the MGH both as a world-renowned pediatric surgeon and his first Chief of pediatric surgery. His accomplishments are legendary, but he is extraordinarily well remembered for being the father of pediatric surgical urology and for innovative major reconstructive procedures on the esophagus, for cloacal malformations and other especially complex problems in the infant pelvis. Dr. Hendren has been extremely influential in directing many of the MGH general surgical residents toward careers in pediatric surgery, many of whom are now Chiefs of pediatric surgery around the country. Comments were made by Drs. Patricia Donahoe and Jay Vacanti (the second and third Chiefs) and by Dr. David Torchiana and Dr. Warshaw. Dr. Warshaw noted, among the lessons learned from Dr. Hendren, his meticulous attention to surgical technique and equally meticulous attention to building relations with referring physicians by detailed, timely follow-up communication. He also noted that all of Hendren's pupils have personal anecdotes to relate, some of which rival the Grantley Taylor stories (see page 1). A Bachrach photo of the three chiefs of pediatric surgery will hang in the conference room.

## “SIMIE” by Bob Hopkins ‘54

Dr. Nathaniel Faxon’s history of The Massachusetts General Hospital, 1935-1955, describes the birth of the George Robert White Memorial Building, the result of a bequest made in 1930 by Mrs. Harriet J. Bradbury to honor her brother. Although delayed by the Great Depression, during the spring of 1937, a group of elderly buildings of the MGH, including the Gay Ward (1884, the original OPD); the Bigelow Surgical Amphitheatre (1867), the old Accident Room and Recovery Room, (1878, including the X-ray Department and House Officers’ Flat), and the Surgical Building (1901) were demolished in anticipation of the construction of the White Building in the middle of the hospital grounds. In the winter of 1937-38, operations on the White Building were suspended.

Dr. Faxon goes on to relate: “A sizable pond collected in the excavation, leaving only a few iron rods projecting from the caissons showing. One morning a wooden fisherman complete with pole and line appeared on one of the caissons. The next morning he was joined by a rainbow collection of live ducks: purple, green, red, blue, brown, and white. What breed could these be? Speculation ran rife, and it was anybody’s guess. The ducks paddled contentedly in their pond for about two weeks, then disappeared as suddenly as they had appeared.

“Cautious detective work finally solved the mystery, by working backwards. The night of the disappearance coincided with the “Change Day” of a certain surgical service. The piece de resistance of the Change Day dinner was roast duck. Ergo, the ducks belonged to that service. The varied colors – oh, those were stains from the Pathological Laboratory, methylene blue, carbol fuchsin, and the other dyes, liberally applied before release in the pond.”

Who were the perpetrators of this unusual gourmet event? They all remain anonymous – but rumor has it that the group included some of the greats among MGH surgical alumni – Ed Hamlin, Butch Donaldson, Otto Aufranc, and the principal object of this essay, Fiorindo A. Simeone – known as Simie to all of his contemporaries (photo center →).

In the same general era, an urgent call was received in the emergency room from a hospital in New Hampshire (or was it Maine?) indicating that they were referring to the Emergency Room a Mr. Moosehead, who had apparently been injured so severely that his condition, although stable, could not be adequately handled in their community facilities. The medical record was started, the ER was prepared, the operating room alerted, and the staff, especially the surgical residents, were ready and waiting when the patient arrived about 90 minutes later (traffic was somewhat less in those days). With deliberate speed, the stretcher was wheeled into the ER, where all appropriate resuscitative measures and studies were undertaken – alas, to no avail. Mr. Moosehead was then discharged to Allen Street – and the remains were subsequently returned to the Moseley Rotunda, which thanks to a currently unknown benefactor had been his dwelling for many years after his original hunting accident at the hands of said unknown benefactor. Was this the origin (or continuation) of an MGH tradition by kindred spirits?

Born in 1908 in St. Ambrose, Italy, Simie decided at the age of two to move to Providence, Rhode Island, (with his family)

in order to obtain the great educational advantages of that city, especially Classical High School and Brown University. At Brown, he developed a keen interest in physiology, working with Professor W. C. Young. He deferred his entrance to Harvard Medical School because his research work on reproductive physiology with Dr. Young was at a point too interesting to leave. Simie received a MS degree from Brown and entered HMS in 1930. Dr. Walter B. Cannon was well aware of this interest before he arrived at Harvard, and it was not long before he was an active member of Dr. Cannon’s laboratory group. Graduating from HMS in 1934, Simie began his surgical training at MGH. He maintained close ties with Dr. Cannon’s laboratory, including two years as a research fellow (1936 to 1938). During this time, his work significantly expanded knowledge of the effects of the sympathetic nervous system, an area in which he maintained a lifelong interest. He completed his residency in surgery under Dr. Churchill in 1940 and began a fellowship in urology with Dr. William Quinby Sr., at the Peter Bent Brigham Hospital. Dr. Churchill had nourished the idea that progress in surgical specialties would be made by surgeons with a broad general surgical background and an interest in physiology and research in addition to training to achieve the necessary tools to work in the specialty. His hope, apparently, was that Simie would be in line to become the next MGH chief of urology.



Events were to undermine Simie’s anticipated career in urology, however, to the good fortune of many of us in the field of vascular surgery. Simie entered the Army in January 1942, with the Fifth General Hospital. The research unit to which he was attached made lasting contributions to the knowledge of the effects of war wounds and management of traumatic shock. His description with Dr. Michael DeBakey of the effects of arterial ligation following arterial injury remains a classic in the field. The volume of medical history of World War II on “Cold Injury”, based in large part on his reports, may still be the most definitive discussion of the different types of cold injury, including frostbite, trench

foot and high altitude cold injury.

After being discharged from the Army with the rank of Colonel, Simie returned to the MGH in 1946, just in time for celebration of the 100<sup>th</sup> anniversary of “the First Public Demonstration of Surgical Anesthesia by Williams T. G. Morton, a Dentist of Boston.” Coincidentally, a daguerreotype (see center photo page 8) was uncovered of those participating in the original event, and this has been hanging in the Operating Suite or, later the Sweet Room, ever since. It is quite remarkable that the pioneers of 1846 so closely resemble members of the junior MGH attending staff at the time of the centennial.

During the war, the position as chief of urology had been filled. With his interest in the sympathetic nervous system and the circulation, he inaugurated with Dr. Bob Linton one of the earliest vascular fellowships and one of the first vascular laboratories, using volumetric and thermometric techniques for the study of the circulation and responses to changes in sympathetic stimuli. During this time, he co-authored with Dr. James White and Reginald Smithwick of the MGH the third edition of the definitive treatise: “The Autonomic Nervous System.”

*(Hopkins continued on page 8)*

(Hopkins continued from page 7)

He was soon (1950) invited by Dr. Joseph Wearn to participate in the new experiment in medical education at Western Reserve University (now Case Western Reserve [CWRU] as Professor of Surgery and Chief of Surgery at the Cleveland City Hospital (later Cleveland Metropolitan General Hospital [CMGH – emphasis added]). Simie was always an ardent integrationist in education methodology, and he was a staunch supporter of Dr. Wearn’s efforts to have members of multiple disciplines coordinate activities in teaching of basic and clinical medical sciences. Many of the techniques adopted by Dr. Wearn, Dr. Simeone and the new young faculty at WRU5 have stood the test of time and have been adopted in large measure by schools throughout the country. Dr. Simeone’s interest in research flourished at WRU and CMGH, both in his own laboratories and those of his associates. He continued his interest in circulatory physiology and oligemic shock with many junior colleagues, including the author. It was also in his laboratories that the initial membrane oxygenator was developed by Dr. George H. A. Clowes Jr. (MGH ’48).

In 1967 Dr. Simeone was called to his alma mater, Brown University, which had recognized him with an honorary degree and by election to its Board of Trustees. Here he became the first Chair of the Section of Surgery (as it was called at the time) and provided strong direction and support for the development of the school. Of the more than two decades back at Brown, the first half was devoted largely to the development of the medical school and surgery in Rhode Island and the second half to service to the University and the community. During the first decade, he worked to promote the

concepts of small group and integrated teaching and was never happier than when discussing clinical or research problems with small groups of students and research fellows. Research activities consisted primarily of investigation of hemodynamic and metabolic aspects of circulatory shock. After his “retirement” he served as a senior advisor to the University, to the Health Department of Rhode Island and to the community at large. In my opinion, things flourished when his advice was heeded and fared much less well when it was not.

Dr. Simeone received many national and international honors during his career, including election to most prestigious surgical societies. He was president of the Society for Vascular Surgery and several other surgical societies. He served as Surgeon-in-Chief pro tempore in many institutions here and abroad, including Peter Bent Brigham Hospital in Boston, St. Bartholomew’s and St. Thomas’s Hospitals in London, and the American University of Beirut in Lebanon. He was designated a Perpetual Student, St. Bartholomew’s Hospital Medical School. For his work in Beirut in 1960, especially for the development of cardiac surgery in the University Hospital he was made Commander, Order of the Cedars by the President of the Republic of Lebanon.

For those who knew him well, he is best remembered as a kind, thoughtful, imaginative and compassionate friend and physician. He was extraordinarily dedicated to his patients, students, and junior colleagues. He was a brilliant and perpetual scholar, and many of his close colleagues and collaborators relied heavily on his analytic mind and encyclopedic knowledge. He died at home on June 13, 1990, at the age of 82.



G. A. Donaldson; F.D. Moore; J. B. McKittrick;  
C. E. Welch; F. A. Simeone (center); H. Ulfelder;  
L. Souttar; C.C. Miller

*(Editor’s note: Robert Hopkins attended Harvard College from 1941 to 1943 and graduated from HMS in 1947. His residency was at the MGH until 1954 except for military service in Korea. He went to the University of Pennsylvania (Pennsylvania Hospital) surgical service with the late John Raker, and then joined Dr. Fiorindo A. Simeone at CWRU in 1959. Dr. Simeone was called to the Chief’s position at Brown University in 1970. Dr. Hopkins joined him there and remained at Brown until he retired in 1997. He still goes to the Vascular Laboratory which bears his name. His research projects require one or two days a week. He was president of the New England Society of Vascular Surgery in 1989 and 1990.*

*Bob and his wife Ann are very proud of their two daughters – Mary Ann, a surgeon trained at New York Hospital and HMS ’92 graduate and Liz, the younger daughter who has been a school teacher and editor, and is the mother of Bob and Ann’s two grandchildren.)*

*Bob is grateful to many for useful discussions about Simeone. These include Hermes Grillo, Brad Millet, Nathan Munro, Grant Rodkey, Len Roseman, Ben Roe, and Bob Tracy. ♦*



**LETTERS TO THE EDITORS**

Dear Editors:

I am aware of the great contributions of Judson Randolph, but I wish to take issue with his comment about somebody on the MGH staff for whom he had little regard. The patient had an abdominal-perineal resection, and the surgeon elected to leave the perineum open, and to pack it. Dr. Randolph calls this "a unique way to completing the perineal resection."

Dr. Randolph ought to know that at Memorial Hospital for Cancer and Allied Diseases, as it was called at that time, it was customary to treat the perineal defect in that manner. The feeling was that the perineal resection was more generous than that which allowed for a primary closure, and thus that perineal recurrence would be decreased. They may have been correct, but I don't have figures to support this allegation.

Perhaps primary closure has led to "Mesorectal excision", which may not be necessary.

Joe Barrie '65

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Dear Editors:

Dr. Barrie is correct: most surgeons performing the Miles Abdomino-perineal resection for carcinoma of the rectum have done so with some form of packing of the perineal wound. This approach was prevalent in my time at the MGH, 1954-1958. However, the surgeon I described was, according to my contemporaries with whom I have checked, known to be inept. He was an anomaly among the glittering roster of surgeons on the staff of the General: Allen, Welch, Donaldson, Rodkey, Bartlett, Sweet, Taylor, and to be sure, McKittrick. In any of their hands, reconstruction of the pelvic floor and its peritoneum was always an exercise in accuracy and precision. I had not wanted to attribute such a picture of slipshod surgical technique to a bona fide member of the surgical staff. However, I find that most of the Staff and house Staff recognized this gentleman's inadequacies. It was this, I believe, that led Dr. McKittrick to his quiet observation, "I believe I would have fixed it so

that it never would have happened in the first place".

If I had wanted to carry forth an argument with Dr. Barrie, which I do not, for he has made his point quite clearly, I might have quoted Sir Ernest Miles on his method of closure of the perineal wound; "The skin margins are brought together with sutures and a large drainage tube is inserted in the anterior and posterior extremities of the median incision." A final irony is to be found in Sir Ernest's paragraph about cause of death in his carefully studied series of patients, to wit: "one was caused from a strangulation of a knuckle of small intestine which had become herniated through a rent in the pelvic floor." How I wish that I could have shared that pearl with Big Mac!!

Judson Randolph '58

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Dear Editors:

I always enjoy reading the newsletter from the MGH Surgical Society. It has been a wonderful way to keep up with people and events. I also appreciated Clem Hiebert's little volume, "Seldom Come By, A Surgeon's Stories." It was a joy to read and it brought me back to my first days as an intern at the MGH, starting out in the Emergency Ward and Overnight Ward, with Clem as my Assistant Resident. Some of my MGH memories inspired me to commit my own memories to paper [Editor's note: see the *Events of Note* section for the particulars on George's book]. It was an enjoyable experience and I recommend the idea to my MGH colleagues.

George Zuidema '59

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Dear Editors:

Five of the six 1950 MGH freshman surgical house pupils were from the post WWII medical school graduates. There was Dick Austin, a Marine fighter pilot who survived the Battle of Coral Sea. He also flew several missions in torpedo planes and was grateful to be alive. Bob Coe was executive officer of a sub chaser commissioned at Fal-

mouth Foreside, Maine and during the shakedown cruise, destroyed three enemy submarines. Frank Garran was a whimsical engineer on a WWI class destroyer that ranged the north Atlantic. Dave Sheldon was an ATC pilot flying the Atlantic combat areas. He survived a respiratory illness that left him with a tracheostomy scar. I was the low man on the totem pole, a rifleman in a regimental infantry combat team. I survived with bilateral tinnitus from a near enough mortar round - no one believed me. John Head, Harvard College 1946, was the only non-veteran but the most talented - he played the cello. I am still a full time surgeon.

Eji Suyama '55

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Dear Editors:

The latest issue of the MGHSS Newsletter arrived this morning and I have enjoyed it tremendously, having digested every sentence and word.

May I comment on several items. First, the *In Memoriam* list is not only staggering (I had a special relationship with each) but frightening when I think of their ages. You know the warning *there but for the grace* etc. I was reminded that at age 8 I heard a radio report *The Lone Eagle has landed*. The earlier French failure/disaster was publicized years later. I would add an historical bit to Ed Dunn's *Memories of Kansas*; Peter Brooks was the first MGH resident to go to the Snyder-Jones Clinic, Hank Moorman the second, and Suki and I were the third. I thought my term was profitable: educational and fun. Hermes thought it was dreadful. (I'm sure he was the reason it was ultimately dropped.) Finally, the Bruins beat the St. Louis Blues for the Cup in 1970 and the New York Rangers in 1972. (I don't know which Dick Myers was referring to - I'd guess 1970.)

Beyond that, what goes on presently at the hospital just dramatizes the enormous, yes monumental changes from our day. We still had it pretty good; some say the golden years.

Earle Wilkins '51

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