

The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY Newsletter

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Message from the President Jo Buyske '93 What the MGH Surgical Society Means to Me

My first job as an attending surgeon was at the Lahey Clinic. It was at the Lahey that I was first fully responsible for my own patients, which was, as everyone told me it would be, uniquely different from being a resident. I grew a lot as a surgeon there, in a strong, clinical, mentored environment. I then spent 12 years as a surgeon at the University of Pennsylvania. My residency at MGH was only 5 years, and it was a long time ago; and yet I think of myself as "an MGH-trained surgeon." I don't think of myself as an ex-Lahey surgeon, or a Penn surgeon. I define my professional self by those 5 years spent at the General.

This is true of many of the members of our society. Those of you who made your careers at MGH, who stayed on as visits, or who were "4H", might be surprised by that. Surely YOU are the MGH surgeons, and those of us who just passed through as residents have moved on. The MGH Surgical Society is a testimonial to the lasting effect of training at the MGH. Conceived of by Drs. Austen, Ottinger, and Warshaw, the Society has been in existence now for 13 years. We have 572 members, and last year's meeting was attended by 92 surgeons. For those of us who have left, the MGH Surgical Society has provided a welcome link to those important days of residency, to the training that so profoundly shaped each of us. We look forward to coming back, seeing the old and new buildings, the familiar and new faces, and hearing the updates. We appreciate that those of you who are still there come out to the meeting and the social events in force, thereby acknowledging and strengthening that bond. Not many training programs could support such an effort—the loyalty of alumni, the gift of time of the staff surgeons, the commitment of the chair, the interest of the residents all combine to make this society vital.

These are trying times. Organized medicine is pressurized to the bursting point. The economy is challenging, and we are all getting older. Times like these bring focus to the things of real value. Shared experiences, commitment to excellence, and leading by example come to mind. Old friends and time together with like-minded people are welcome respites.

The value of the society lies in its members. Please continue to send us your news, to read this newsletter, to come to the meetings. If names and faces from your days at the General are missing, let us know, or, better yet, contact them and tell them about the society. Our next meeting will be in September 2011, the bicentennial of the MGH. There will be much to celebrate—come join us. ♦

Message from the Chairman

My newsletter column has always been about us – what is going on in the MGH Department of Surgery. This one is a departure: it is about you and the world of surgery. Unless you have been working yourself into a tunnel-visioned stupor, you know that big changes are in store for healthcare, health systems, and compensation for doctors. The Obama administration has healthcare reform near the top of its priorities; the economy can't afford the steady climb of healthcare costs; the uninsured are a growing problem; and primary care physicians want both greater control of the patient and a bigger share of the healthcare dollar – at the expense of surgical specialists. What it comes down to is that you can be either a player or a victim. With regard to coming changes, you can make it happen, watch it happen, or ask "what happened?" There are lots of new systems under consideration – the medical home, bundling, episodes of care, accountable care organizations, among others – and surgeons are at risk of being at the tail end of control in these systems. At this point we can only be sure that the near future will be different, perhaps within months.

In addition to fee schedules, surgeons have critically important concerns about a growing surgical workforce shortage and patients' access to surgical care. We worry – or should worry – about the challenges to choosing a career in surgery: lifestyle, debt, increasing subspecialization, and the cost of graduate surgical education. While surgeons are retiring earlier, it takes up to 8 years after medical school to train a new surgeon for replacement.

Our message must get to our legislators: surgeons want to be part of devising the formulas for restructuring the healthcare system. We want to be at the table with primary care physicians, business leaders, and insurers. We all have a dog in this hunt.

(Warshaw continued on page 9)

An Alternative History of Surgery at the MGH

By Michael N. Margolies '64

I am delighted to be given the privilege of recounting a history of this department that is not reflected in the department archives, nor in the constant stream of self-aggrandizing bulletins emanating from this hub of the surgical universe. I will speak mainly about the lives of house officers past and present, and little about the personalities and mores, if any, of those who lead and have led the Department. The reason for this choice lies in the text of the following documents, which were served to me yesterday. The first is from the Suffolk Superior Court, and appears to be a civil injunction. It reads in part as follows: "You are hereby enjoined from casting aspersions upon, slandering, causing vexation to, denigrating, demeaning, and otherwise maligning with scurrilous intent the person, reputation, and office of Dr. W. Gerald Austen, his forebears, successors, and issue." It then goes on to enumerate the usual civil penalties, etc. Attached to this is a personal letter dated June 17: "Dear Mike: Patty and I really look forward to your comments tomorrow about the history of the Surgical Service at the MGH, and in particular my stewardship over nearly 30 years. Please do remember that fortunately, as Chief Executive of the Massachusetts General Physicians' Organization, I am responsible for your salary, fringe benefits, and loans, as well as your hospital privileges and office space, which I have always made an effort to ensure. Say "hi" to Carol. Best wishes, Jerry."

I must say that when I entered this vineyard of surgery, I did not foresee that our vines would bear such tender grapes. Appended to this letter is a tender note from Dr. A.L. Warshaw in the form of an epistolary memo:

TO: M.N. Margolies
 FROM: A.L. Warshaw, M.D.
 W. Gerald Austen Professor of Surgery
 The Danser Professor of Surgery
 The Chief of the General Surgical Services
 The Lord of the Horizons
 and an endless sequence of titles.

The text is striking in its directness and economy: "If I were you, I would pay close attention to the above."

The Surgical Service is not the same as when you were tempered in the inferno of surgical residency. Economic realities have dealt harshly with us (Fig 1), and cloud the future. You could not learn this from the administration of the Department or the Hospital, whose view of the future is similar to the one shown here (Fig. 2).

Fig. 1

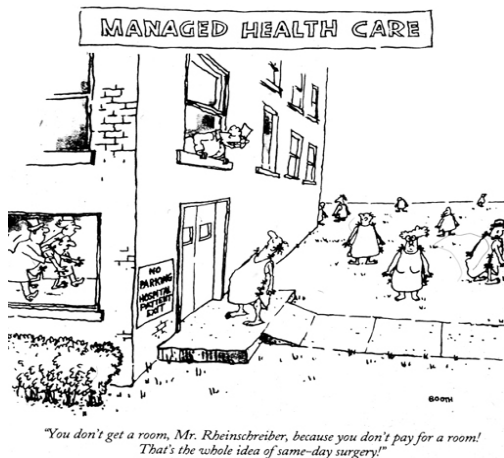
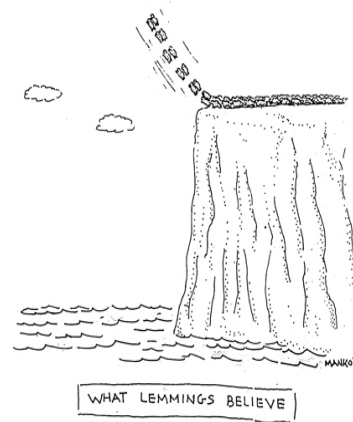


Fig. 2



Many of the changes I will describe are certainly not unique to this department, and are part of the common experiences of the alumni and other survivors in the audience. For this I apologize.

And now for some history. In the olden days the house officers lived in the hospital in the Parkman building as interns, or in the elegance of the Moseley building as residents. The administrator in charge of the house staff quarters, Mr K., was a menacing homunculus who also managed the "dispatch service", whose deliveries were never marred by dispatch. Mr K., was equally adept at handling the intellectually challenged, as he was the humility-challenged of the surgical house staff. In one encounter with him I became aware that he labored under the unswerving conviction that there were regularly scheduled orgies involving the house staff in the Moseley building – no doubt in this rotunda (Fig. 3). As a second-year house officer I was astonished by these stories, and in the interests of furthering my scholarly career, spent the better part of the next three years searching for an opportunity to witness such events.

Fig. 3



It was Mr K.'s conviction that the surgical house officers were parasites who preyed upon the living body of the Hospital, and therefore should be given as little opportunity as possible to utilize the Hospital's resources. In keeping with his dictum, and with the aid of a willing administration, the number of rooms assigned to the house staff as on-call rooms gradually diminished as the rooms assigned to new administrative personnel increased. Some of the rooms assigned previously to single persons contained two, or three. As a cost-saving measure, it became possible to remove the furniture – other than the bed, which consisted of a straw pallet obtained at a reduced rate from the dungeons of the Mahdi at Omdurman.

(Margolies continued on page 3)

(Margolies continued from page 2)

A house officer taking a mid-afternoon nap after a long night of arduous duties was awakened to find his bureau being removed, along with his uniforms. Mr K. announced that since we were not actually living there, we would not therefore need the furniture. Although at times I agreed with the first part of his statement, we suggested to him that at least some of the surgical house staff changed their clothing, but he refused to believe this.

The building designated for the interns, the Parkman building, did not appear on plans or dioramas (Fig. 4) of the Hospital at this time – despite the fact that it existed – because it had been condemned in the 1940s by the Building Department of the City of Boston, as a firetrap. It was an honor for interns to be confined to this building, as it was so close to the site of the murder of Professor George Parkman of the Harvard Medical School by Dr. John Webster in the 19th century. These events set the tone for fratricidal behavior among Boston medical academics for the rest of the millennium. As Mr K. was often heard to remark, one reason medical politics is so vicious is because the stakes are so small.

As an intern, these were commodious accommodations, sufficient in the summer for both the house officers and the hordes of pestilential mosquitoes which lived in the alluvial delta upon which the Hospital was constructed. The cases of blackwater fever that cropped up among the house officers in this era were not publicized by the Hospital. The original Hospital could, of course, be easily reached by small craft. The George Robert White building opened in 1938 and became the jewel in the diadem of the Surgical Service (Fig. 5). In the next slide (Fig. 6) is the building site of the White building in the 1930s, which was constantly flooded while the pilings were being placed. These (Fig. 7) have been identified by Dr. John Constable as blue-winged teal.

Fig. 4



Fig. 5



Fig. 6



Fig. 7



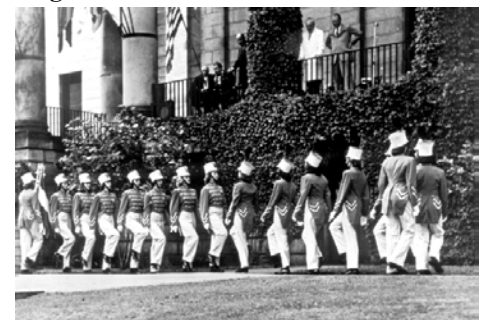
In retrospect, the pay of house officers was astonishingly low, being in 1962, \$64 a month; but then again, they had no material needs. In that era, a house officer in a Philadelphia teaching hospital applied for, and was granted, welfare benefits by that city because his pay was adjudged insufficient to breach the poverty level. He was, as a matter of course, fired by the hospital. The house staff, after all, had not traditionally been regarded as professionals to be afforded the same privileges provided to workers at the Triangle Shirtwaist Factory in New York at the turn of the century*, the site of a destructive fire within locked doors; but we never expected anything else.

The plight of the Philadelphia house officer prompted house officers at institutions in Boston in the early 1960s to seek higher wages. For reasons of equity and with generous good will, the MGH administration also raised the pay, but simultaneously made it no longer possible to live in the hospital, and instituted charges for food and other services. The increase in pay exactly matched the increase in expenses, and similar accounting models have been used ever since to calculate salaries – although on the whole they have improved, despite efforts during the administration of Dr. Buchanan to decrease the house staff pay when Medicare first threatened to withdraw support from teaching hospitals. This was also an era in which house staff hours were reduced by fiat, and some of the labor laws that had been extant even in the time of Dickens were instituted for the benefit of the house staff, who were otherwise exempt from the usual regulations governing indentured servants and convicts deported to Australia.

This is an interesting photograph (Fig. 8), found in the archives taken from the Bulfinch building, allegedly on the day that Dr. Buchanan the Truculent announced the end of his reign.

Fig. 8

The Hospital gradually entered the 18th century during the 1970s. The most singular change to occur was the change in composition of the house staff. In the early years, surgical house officers combined the worst excesses of English public schools with the best behavior obtainable after five to ten in San Quentin or Attica. The attitude of some of the administration, on the other hand, was that boys will be boys. During a resident change party, held in the White Building penthouse, the bacchanal ended by systematically removing the furniture and depositing these over the parapet, and by defenestration, as party favors for those below. A high percentage of the applicants to this surgical program, and of those accepted, were from the Harvard Medical School, which at one time actually provided coursework involving clinical teaching. As time went on, the percentage of house officers from Harvard declined as the students stumbled along their “New Pathway”. The Harvard medical students were too highly chosen to take part in competitive uniform examinations such as the National Boards. The relationship between the Surgical Service and the Medical School became strained as a



(Margolies continued on page 10)

Hermes Grillo by John Wain '85

Hermes C. Grillo, MD, world renowned thoracic surgeon at the Massachusetts General Hospital and Professor of Surgery, Emeritus, at Harvard Medical School, died on October 14, 2006 near Ravenna, Italy in an automobile accident. He had been traveling with his wife, Sue, in their beloved Italy visiting family and planning to attend the Italian Association for Thoracic Surgery.

Born in Boston in 1923, Dr. Grillo was widely recognized as the father of modern-day tracheal surgery. He published over 350 scientific articles on a wide array of topics in thoracic surgery, but the majority advanced the practice of surgery of the tracheobronchial tree. He is credited with developing several original operations to address disorders which were considered to be uncorrectable prior to his pioneering efforts in this field. His text book, "Surgery of the Trachea and Bronchi", published in 2004, is viewed worldwide as the definitive text on airway surgery.

Raised in Providence, Rhode Island, Dr. Grillo attended Providence Classical High School and was justifiably proud of his "classical" education and especially of his four years of Latin education. Graduating from Brown University in 1943 and Harvard Medical School in 1947, Dr. Grillo joined the surgical house staff at Massachusetts General Hospital in 1947. He completed his Chief Residency in Surgery in 1955 and joined the staff at the MGH. He retired from active clinical practice in 2000, but remained active in teaching and writing until the time of his death. I had the opportunity and privilege to train in thoracic surgery under Dr. Grillo from 1986 to 1988 and subsequently to join him as a member of his Division of General Thoracic Surgery at the MGH.

Dr. Grillo was the epitome of a true Professor. He embodied excellence in teaching, research and surgical technique. His gifts in these areas were an example to all and an inspiration to many. As a young student, Dr. Grillo had considered a career as an architect, but ultimately chose surgery. The artistic and creative aspects that drew him to consider architecture were equally applied to surgery. He combined creativity and technical skill with a persistence and uncompromising approach to each patient's problem. Throughout his career, he challenged the assumptions of the day about what was feasible, asked the proper questions, designed and executed the necessary experiments and eventually brought these lessons and techniques to clinical culmina-

tion. His official portrait (Fig 1) conveys a professorial bearing, with a composed and erudite countenance, gazing into the distance, perhaps contemplating the next "impossible" surgical problem to be solved.



Fig. 1

My personal recollections of Dr. Grillo, however, are better represented by the image of him in scrub attire, reading the newspaper, awaiting the beginning of the next surgical adventure. (Fig 2) He seems at ease and has his wonderful infectious smile, reflecting his joyous passion for the craft of surgery. He is wearing his distinctive glasses, underscoring his inquisitive and sagacious nature. Dr. Grillo always had time for questions and for students. When you approached him for counsel on clinical or other matters, he would frequently remove those glasses, set them carefully aside and then listen so intensely, that the impression was that at that moment you and question were the only things that mattered to him in the world. He spent countless hours, ever the gentleman, listening in that fashion, critically appraising the issue at hand, and then dispensing well-considered advice or suggestions.



Fig 2

Dr. Grillo was always reading, continually looking for new knowledge and information, not just about science and surgery, but about the world at large. I recall his passionate sense of progressive social justice, in the best of terms, underscored by his choice of the New York Times as his favorite reading material in the surgeon's lounge. That passion for fairness and *egalité* shone through in his thoughtfulness and concern for any patient who presented to him for care.

He was also a man of action, and the image of him in his scrubs, "ready for action" underscores that sense. He was extremely proud of his service to his country as a combat surgeon in Korea in 1951-52. Perhaps because of this experience, with all of the unknowns of patient arrivals and time commitment, it was not uncommon to find Dr. Grillo taking short naps in the surgeons lounge between cases, much like his countryman and forebear, Leonardo Da Vinci. Similar to the reputed effect they had for Leonardo, these naps seemed to rejuvenate Dr. Grillo and maintain his seemingly limitless energy. I recall a complex reoperative procedure that Dr. Grillo undertook at the age of 72, lasting 20 hours and requiring 2 additional staff thoracic surgeons, not to mention several anesthesiologists. Dr. Grillo was present throughout the entire procedure and at its conclusion seemed as fresh and energetic as anyone in the room.

Like many of us, Dr. Grillo didn't like to be wrong. But unlike many of us, he was always ready to critically re-appraise a negative outcome. He was always honest about his results and freely shared his experiences, good and bad, with his colleagues and residents. While he was at times demanding of others in his quest for perfection, I believe he demanded the most from himself, always trying to improve that which, prior to his efforts, frequently wasn't even attempted. Those lessons, of honest reporting, continuous critical re-evaluation and sharing of results were imprinted on generations of residents who both worked with him in the operating room and had the benefit of his example at weekly clinical rounds even after he had retired from clinical practice.

In our modern era, there is a lot of discussion about mentoring, without really recalling who Mentor was – the person a father, Odysseus, would entrust his son, Telemachus, to when he was absent and unsure of his eventual return. Mentor was to guide the growth of Telemachus into adulthood. I believe that Dr. Grillo's legacy (Wain continued on page 12)

Inheriting the Values of a Profession

by Jason H. Wasfy, MD, MPhil

“So what else causes dysphagia?” my surgery clerkship director, Dr. Charlie McCabe, asked me one afternoon when I was a third-year medical student at Harvard Medical School. A few of the other students sitting around the large, brown conference room table already had called out the most common causes - strokes, for example, motility disorders, cancers of the gastrointestinal tract. At that moment, I could only remember one more.

“Multiple sclerosis,” I replied, with hesitation.

Dr. McCabe, who had suffered from multiple sclerosis for many years, said: “That’s right – and don’t be afraid to talk about MS. I’m not scared of talking about it, and you shouldn’t be either.”

A relentless drive

That response crystallized his outlook: although he could not control multiple sclerosis, he would prevent multiple sclerosis from controlling him. He received the diagnosis just before the end of his long training in cardiac surgery. Few diagnoses threaten a career in surgery more than a progressive neurological disease. But as a physician, he considered his calling to help others vital. In that spirit, as multiple sclerosis gradually robbed him of his ability to walk, he transformed his career to focus on surgical education.

Much has been made of Dr. McCabe’s ability to overcome multiple sclerosis and become a national leader in academic surgery – and rightly so. But those of us whom Dr. McCabe mentored understood that multiple sclerosis was just one of many obstacles that he had overcome. As a fourth-year medical student, he had been told that he would have to sign up for repeated, grueling visiting electives to win a spot in Mass General’s surgical residency. As a resident in surgery and later a fellow in cardiac surgery, he was known to arrive at 3 am to prepare for his clinical responsibilities. Even decades later, his contemporaries – many of them now senior surgical staff at Mass General – still spoke of how he always prioritized the care of the patient, and how he never left work unfinished for his colleagues.

As students, we came to learn that no obstacle, medical or personal, ever drove Dr. McCabe to feel sorry for himself. Feeling sorry was not an option, because feeling sorry would not help any patients, and feeling sorry would not make his multiple sclerosis fade. Thus, he possessed a quintessential doctor’s skill: the ability to look reality straight in the eye, and then confront that reality with decisiveness.

His humility meant that he never underestimated the difficulties in confronting the realities of medical training and clinical care. He told us a story about trying to spend time with his daughter and wife at the beach during a precious day off in surgical residency. Exhausted and sleep-deprived, he fell asleep behind a sand dune, and his wife could not find him for hours, ruining the family outing. While reiterating the significance of doctors’ obligations to patients, he acknowledged that the personal challenges in fulfilling those obligations would be tremendous. He was able to express both the absolute importance of confronting challenges while never minimizing the difficulties those tasks entailed.

“Letting us watch”

He conveyed the exigency of perseverance in medicine the way that the best medical educators do – by example. Medical students observe and listen constantly. Students detect and internalize their teachers’ values and motivations. Dr. McCabe inculcated the basic values of medicine by setting the standard -- and letting us watch.

I was mesmerized when I saw him race around in his wheelchair checking on patients faster than many able-bodied, younger doctors. I was inspired to perform better myself when I could detect from the inflection of his voice how much he cared about providing excellent care.

Simply by letting us watch, he allowed us to not only understand, but also internalize fundamentally that taking care of patients is hard and requires tenacity. Challenges come up, whether a technically difficult surgery or a long list of patients to examine the morning after a tough night on call. Seeing him



rush in his wheelchair to the emergency department to supervise surgical residents during a trauma revealed a fiery intensity for patient care. That enthusiasm infused his students, and taught us to celebrate the responsibilities of patient care.

Sustaining his legacy

Dr. McCabe died this past July, when I was beginning the second year of my residency. In July, I was in my first large supervisory role, with a team of four new medical interns and three medical students. The day of his funeral, I led my team in a discussion about the causes of large bowel obstruction. Teaching them a topic that he had taught me, I thought, would honor his memory.

But his death also led me to reflect on the more elusive, more precious lessons he had taught me – the values that transformed me from a medical student into a doctor. On a day to remember the gifts that Dr. McCabe had given to generations of Harvard medical students, I realized that new students were watching me now. At the same time that I lost the chance to watch one of my mentors, I had become the one being watched. The gifts that he had given me had become debts that I owed my medical students.

As my career progresses, I cannot ever imagine that I will ever live up to the legacy of mentors like Dr. McCabe. But the weightiness of my evolving role and the legacy of his life have taught me about the indispensability of mentorship in medicine. By never allowing any obstacle from hindering his ability to help others, Dr. McCabe led me to appreciate the fundamental value of patient care.

I hope that Dr. McCabe understood his gift to so many physicians and the patients they now serve. Furthermore, I hope that clinical educators everywhere recognize how much medical students learn from merely observing their example. Their example sustains the core values of a profession that demands selflessness and sacrifice.

Dr. Wasfy is a resident physician at the Massachusetts General Hospital and a clinical fellow in medicine at Harvard Medical School. ♦

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From Boston to Bethesda and Back by David Sachs '70

Having spent a year in Paris studying organic chemistry on a Fulbright fellowship, I entered Harvard Medical School in 1964, but kept my laboratory in the Converse Building at Harvard College, where I spent my spare time working on a research project in organic chemistry with Professor Louis F. Fieser. Fieser was an inspiring teacher and a wonderful friend, but he and I both knew that it was only a matter of time until I would find an area in medicine which would take me from his laboratory to one more closely related to my chosen career.

That moment came during a lecture by Hugh McDevitt in the second year Microbiology and Immunology course at HMS. Dr. McDevitt, then an Instructor, introduced the topic of transplantation by describing an experiment of nature reported almost two decades earlier by Ray Owen. Owen had reported that Freemartin cattle, which are fraternal cattle twins born from a common placenta, showed a mixture of blood types from both animals later in life. The immunological implications of this finding were profound, as they indicated that the immune system would accept foreign tissues long-term if exposed early in life. These implications were explored further by Sir Peter Medawar, who demonstrated that injection of bone marrow cells into neonatal mice led to tolerance to skin grafts from the donor strain later in life. Thus, nature had provided an experiment demonstrating that acceptance of allogeneic tissues, and potentially of organs, might be possible without immunosuppressive drugs if we could figure out how to induce such tolerance in adults.

McDevitt's lecture led me to seek someone in the Boston area who was doing research in this new field of transplantation. I was directed to Dr. Paul Russell, who directed a program in renal transplantation at the MGH, and who had recently recruited Dr. Henry Winn from the Jackson Laboratories to start a basic science laboratory in his department. Within a few days, I had met Dr. Winn, whose new laboratories were located in a temporary building that looked much like an airplane hanger, located where the Thier Building stands today. Dr. Winn took me on as a student research fellow for part-time and summer work and I joined the growing laboratory efforts of Dr. Paul Russell in transplantation at the MGH. That was in 1965, and I have maintained a close relationship with Drs. Russell and Winn ever since.

Undoubtedly because of my interest in transplantation, I gravitated toward surgery and entered the MGH surgical residency in 1968. During my second year, I was awarded a surgical scientist training grant, allowing me to work with Drs. Russell and Winn in the laboratory while serving as a clinical fellow on the transplant service (Fig. 1). At the end of that year, I interrupted my surgical



Figure 1 Russell Laboratory 1969

residency to accept a two-year research fellowship as a Clinical Associate at the National Institutes of Health (NIH) – which was an opportune way to satisfy my military obligation while carrying out basic research. Two years later, I requested another year's leave of absence from the residency to accept the offer of my own laboratory at the NIH. During that year, my lab made a discovery that made it even harder to leave. Another year's leave of absence ensued, and then another, and before I knew it, I had become the Chief of the Immunology Branch of the NCI. It wasn't until 21 years later, in 1991, that I finally returned to the MGH.

During those years at the NIH, I continued my interest in transplantation and in the induction of tolerance. My laboratory explored two main avenues to tolerance induction, anti-idiotypic and mixed chimerism. Anti-idiotypes are antibodies directed to the binding sites of other antibodies, forming a network that is thought to be able to modify immune responses. This approach led to many interesting experiments on antibody networks and on manipulating immune responses, but never produced tolerance. On the other hand, mixed chimerism, a state in which the hematopoietic system contains a mixture of cells derived from both the host and the donor after a bone marrow transplant, was extremely successful in achieving long-term tolerance in experimental animals.

By 1988, it was clear to me that our experiments on tolerance were ready for potential clinical applications. Since there was no clinical transplantation program at the NIH, I decided to look elsewhere for an environment where I could combine transplantation research with an active clinical transplant program. Although Dr. Russell and I had discussed the possibility of my return to the MGH on several occasions during those twenty years, appropriate laboratory space had never been available. Fortunately, at just about this time, the MGH acquired Building 149 in the Charlestown Navy Yard, effectively doubling its total research space.

Another issue of importance to me relative to the possibility of returning to Boston was the fact that the MGH had no clinical bone marrow transplant unit. Since I thought it likely that the induction of clinical transplantation tolerance would require both bone marrow and organ transplantation, I saw this as a major potential problem. However, I was assured that the MGH was "just waiting for a reason" to start a bone marrow transplant program, and that if I were to return I'd be asked to participate in a search committee to find a leader for that program. I suggested Dr. Thomas Spitzer, from Georgetown, with whom I had collaborated previously in Washington. The search committee, of course, wanted to interview a large number of candidates before making a decision, so it took over a year before Dr. Spitzer was offered and accepted the job. This has proven to have been an outstanding appointment, as Dr. Spitzer has subsequently developed a leading bone marrow transplant unit at the MGH.

I was also offered positions at two other excellent transplant centers, but it was clear to me that MGH was where I wanted to go. After about a year of visits and discussions, I accepted Dr. Austen's offer to return to the MGH. I recall with great fondness the words of his assistant, Connie Martino, the next time I called Dr. Austen: "Hello Dr. Sachs, Welcome home!". Among the main reasons for my choice of MGH, was the outstanding organ transplant team that had been put together, originally by Dr. Russell, and now led by Dr. Ben Cosimi, with whom I had been a resident many years earlier, and in whose clinical skills and judgment I had complete confidence. Ben and I have remained close colleagues and close personal friends ever since. Shortly after my

(Sachs continued on page 7)

(Sachs continued from page 6)

return, Dr. Tatsuo Kawai, who was then a research fellow in Dr. Cosimi's laboratory, took on a project attempting to translate our mixed chimerism tolerance results from mice to the cynomolgous monkey model. By 1995, Dr. Kawai was able to publish a landmark paper demonstrating that mixed chimerism induced tolerance to kidney allografts across major histocompatibility barriers in monkeys. Importantly, his studies showed that the mixed chimerism did not have to be permanent in order to induce tolerance, as long as the kidney was in place by the time the transient chimerism had disappeared. Furthermore, under these conditions, the animals showed no evidence of graft vs. host disease (GvHD), a potential complication of bone marrow transplants in which the grafted immune cells attack host tissues. The next step was to take these results to the clinic.

Fortunately, shortly after the publication of our paper on the induction of tolerance in monkeys, the NIAID established a new initiative called the Immune Tolerance Network (ITN), with the goal of bringing immunologic tolerance to the clinic in the fields of allergy, autoimmunity and transplantation. We applied for two grants from the ITN to attempt to induce tolerance in patients requiring kidney transplants. In the first grant, led by Drs. Sykes, Cosimi and Spitzer, we attempted the procedure in patients with end-stage multiple myeloma, a frequent complication of which is renal failure. These patients are generally unable to receive a kidney transplant because of their refractory malignant disease and are unable to be treated further for myeloma because of their renal failure. They therefore represented a patient population that might especially benefit from this procedure. Six patients with refractory myeloma and end-stage renal disease, who had HLA-identical siblings willing to provide both a kidney and bone marrow, were recruited. The trial was highly successful, with all six patients becoming tolerant to their renal transplants, although, as expected, not all were cured of their myeloma. The first patient enrolled in the protocol is now over ten years since her transplant, has normal renal function and no evidence of myeloma.

The second grant from the ITN, led by Dr. Cosimi and myself, was directed toward treatment of patients who had neither an HLA-identical sibling nor a malignant disease. The preparative regimen chosen for this study was one of several regimens that had been tested by Sykes and Spitzer for the treatment of lymphoma by mixed bone marrow transplantation. This particular protocol had been found never to cause GvHD, but not to be effective for the treatment of lymphoma because it led only to transient mixed chimerism. However, these were exactly the characteristics that we sought, since they had led to tolerance without GvHD in our monkey experiments. The results of the second trial have just recently been published in the *New England Journal of Medicine*, and have demonstrated the induction of tolerance in four of the first five patients enrolled in the study, confirming the clinical utility of this approach. The first patient (Fig. 2) is now five years since her transplant and enjoys normal renal function as well as a life free of immunosuppressive drugs and their complications.

What will come next? Clearly these are early results, and we need to treat more patients to assure that the results are reproducible. We have applied for another grant from the ITN to treat fifteen more patients in a trial that we hope to begin very soon. All of the transplants we have performed so far on these protocols have involved donations of kidneys from living donors. We are also anxious to extend the results to transplants of other

organs, such as the liver and the heart, as well as to the use of organs from deceased donors. However, as excited as we are about the possibility that this tolerance approach will improve the quality of life for patients receiving allogeneic transplants, it will unfortunately do nothing to increase the availability of organs, a problem that is increasingly becoming the most critical limitation to the field of transplantation. The use of donors of another species, so called "xenotransplantation," could provide a solution to this problem, making organs available to the thousands of patients who die while on waiting lists for organ transplants each year. Since the amount of immunosuppression required to prevent rejection of a xenograft would be considerably higher than that required for an allograft, a tolerance approach could be particularly important. To this end, our laboratory is devoting considerable effort to the study of xenograft tolerance in a pig-to-primate model, using special inbred, genetically modified miniature swine, which are exactly the right size to provide organs to human beings. Success in this endeavor could eliminate waiting lists and bring the field of transplantation to its full potential.

In closing, I would like to emphasize the importance of a team approach to the success of this kind of clinical research. Among the team of highly motivated and committed scientists and clinicians without whom these studies would not have been possible, I would particularly like to mention: Dr. Tatsuo Kawai, who has tirelessly piloted this approach to tolerance through mixed chimerism, from the first monkeys through the latest clinical trials; Dr. Ben Cosimi, who has led the surgical effort for both tolerance trials and serves as co-Principal Investigator on our ITN-sponsored study; Dr. Thomas Spitzer, whose expertise in bone marrow transplantation has been critical to this approach; Dr. Nina Rubin, Medical Director of the MGH Renal Transplant Program, on whose medical competence and guidance we have always relied; and Dr. Megan Sykes, whose laboratory efforts have been key to the design and interpretation of our tolerance protocols. In addition, each of these individuals represents a team of junior staff and fellows, without all of whose contributions the studies could not have been successful.



Figure 2 Patient (center) with Transplant Team 2006

(Editor's Note: David graduated summa cum laude from Harvard College in 1963 then traveled to France where he studied organic chemistry, receiving a D.E.S. (M.S. equivalent) from the University of Paris before entering Harvard Medical School. He graduated from HMS in 1968 magna cum laude and began his internship in general surgery at MGH the same year.

(Sachs continued on page 12)

WELCOME
INTERN CLASS OF 2010



Joseph Bornstein
 Tufts University
 School of Medicine



Tiffany Chao
 Mount Sinai
 School of Medicine



Danielle DePeralta
 Tufts University
 School of Medicine



Amy Fiedler
 George Washington
 University
 School of Medicine



Maria Lucia
 Madariaga
 Harvard Medical
 School



Madhury Ray
 Drexel University
 College of Medicine



Laura Rosenberg
 Jefferson Medical
 College



Harry Salinas
 Mount Sinai
 School of Medicine

EVENTS OF NOTE

★**Carlos Fernandez del Castillo, MD** was awarded the 2008-2009 "A. Clifford Barger Excellence in Mentoring Award" by the Harvard Medical School.

★**Richard S Myers '72**, Chief East Surgical Service 1972, recently finished his term on the Board of Trustees at Rex Hospital in Raleigh, NC. He served 14 years on the board, the last 6 as Chairman of it. To honor his service a continuing medical education scholarship was established in his name at the hospital. In addition the Governor on North Carolina awarded him the "Order of the Long Leaf Pine"(This is similar to the Kentucky Colonel award and is the highest civilian honor that can be presented by the Governor.)

★**David Rattner '86** was named president-elect of the Society for Surgery of the Alimentary Tract for 2010.

★**Scott Regenbogen '10** was recently awarded 1st prize in the resident competition at the Annual Meeting of the New England Surgical Society of Colon and Rectal Surgeons for his abstract "The intraoperative surgical APGAR Score predicts post-discharge complications after color and rectal resection".

★**Elizabeth Sailhamer '10** won the American College of Surgeons-Committee on Trauma resident paper competition on March 20th, 2009. This competition starts at the state level and progresses through the regional stage to the finals where winners from the seventeen different regions (12 US regions, Canada, military, and 3 international) compete for the award.

★**Patricia Sylla** is the recipient of the 2009 MGH Physician-Scientist Development Award for her application entitled, "NOTES transanal rectosigmoid resection using TEM: Study of feasibility and safety in human subjects received an award from the MGH Multicultural Affairs Office for the project entitled "NOTES Transanal Rectosigmoid Resection using TEM: Study of Feasibility and Safety in Human Subjects". The project period is for one year. She also was awarded the 2010 Fellowship Grant by the Association of Women Surgeons Foundation for the project "NOTES Transanal Rectosigmoid Resection using Transanal Endoscopic Microsurgery (TEM): Study of Feasibility in a Human Cadaver Model."

★**Parsia Vagefi '09** was chosen by the Foundation of the American Society of Transplant Surgeons to receive the 2009 ASTS Fellowship in Transplantation Award for the award period covering July 1, 2009 June 30, 2011.



The MGH Trauma and Emergency Surgery Team celebrated the new helicopter of Boston Medflight. The team rely on BMF's expertise and commitment for a large number of severely injured patients transferred directly from the scene as well as complex surgical patients transferred from other hospitals. "I truly believe that Boston Medflight has raised the bar of prehospital trauma care to a level that very few heli-transfer agencies can reach around the country. To have them in Massachusetts is a true privilege", remarked Dr. Velmahos.

Warshaw continued from page 1)

We get access to the process as individuals and through our organizations by developing active relationships with our elected representatives. Sending an e-mail or a letter is worth something, but meaningful recognition by the representative takes face time, and face time is earned by helping them. The first order of business for an elected official is to get re-elected, not to pass legislation. They face an overwhelming number of issues (bills), and the ones most likely to get attention are those affecting their friends (read “supporters”), those who contribute time and money to their re-election.

Many medical and surgical organizations have political action committees (PACs), which contribute funds to legislators. These political contributions should not be construed as buying specific votes, but rather as helping to build a positive relationship by keeping a friend in office. When the American College of Surgeons was considering forming a PAC, some of its leaders were resistant to the idea of “paying to be heard.” Now the ACSPA SurgeonsPAC has raised more than a million dollars in its third election cycle (2006-2008), greatly increased the access of ACS lobbyists to Capitol Hill offices, and attracted many members of Congress to speak at our meetings. Our concerns are being heard. Nonetheless, only 4% of the eligible ACS Fellows contributed during the last cycle. Think of what power we have left untapped thus far.

There are many PACs that include surgeons, whether attached to a surgical subspecialty (neurosurgery, orthopedics, etc.) or a state or regional PAC. Each of these has its agenda, and a surgeon may be conflicted as to which should receive his/her contribution. Remember that the specialty PACs usually have a focus on the special issues of that constituency. The SurgeonsPAC of the ACS is the big umbrella which carries the power of the 75,000 ACS Fellows and lobbies for the issues which are common to all surgeons, skirting those which divide us. We may not agree on abortion, gun control or same-sex marriage, but we are united on the desired role of surgeons in a new healthcare system, the need to be fairly compensated, support for GME and research, and medical liability reform.

The ACS has also taken the lead in forming a coalition of surgeons and surgical PACs. In March the Joint Surgical Advocacy Committee (JSAC) brought 450 surgeons of all stripes together in Washington for training in methods of political advocacy and for visits to their Congressional Representatives and Senators. In May the ACSPA SurgeonsPAC hosted a conference of surgical PACs in Louisville.

The College has coalesced its advocacy think-tank into a new Health Policy and Advocacy Group (which I chair) to prioritize and develop positions on issues important to the Fellows, including healthcare reform, Medicare and other compensation issues, quality and safety, workforce and access to surgical care. The Committee works with the ACS Institute for Health Policy Research and reports directly to the ACS Regents. Its home base will be in the new ACS building currently under construction on Capitol Hill.

My message is simple: know the issues and get involved. One five-minute call each week to deliver a message to one of your Senators or your Representative, added up over, let’s say, 50,000 surgeons, will generate 2,500,000 calls to Congress per year – don’t you think that will be heard? Get to know your legislators; attend their fundraising events. Become a face they recognize.

Michael Dunn, a Washington political involvement consultant in Washington, cites what he purports to be an old Chinese proverb: “A man can sit for a very long time with his mouth open waiting for a roast duck to fly in.” ♦

CONGRATULATIONS CLASS OF 2009



Back row (left to right) Michael Giuffrida, Peter Fagenholz, Liam Ryan, Anthony McCluney. Front row (left to right) Jason Wertheim, Parsia Vagefi, Emily Christison-Lagay, Ahmed Sheikh

DESTINATIONS

- EMILY CHRISTISON-LAGAY**
Clinical Fellow in Pediatric Surgery
The Hospital for Sick Children, Toronto
- PETER FAGENHOLZ**
Clinical Fellow in Thoracic Surgery
Edinburgh Royal Infirmary
- MICHAEL GIUFFRIDA**
General Surgery/Advanced GI
Minimally Invasive Fellowship 2010
- ANTHONY MCCLUNEY**
Minimally Invasive Surgery Fellow
Brigham and Women’s Hospital
- LIAM RYAN**
Cardiovascular Surgery Fellowship
University of Pennsylvania
- AHMED SHEIKH**
Cardiothoracic Surgery Fellowship
Stanford University School of Medicine
- PARSIA VAGEFI**
Fellowship in Abdominal Transplant
Surgery
University of California, San Francisco
- JASON WERTHEIM**
Clinical Instructor, Liver and Pancreas
Transplantation
University of California, Los Angeles

(Margolies continued from page 3)

large proportion of surgical applicants originated elsewhere. However, even those from Harvard Medical School were able to flourish in this environment.

Ann Brace (later Barnes) (Fig. 9) was the first female surgical intern at the Massachusetts General Hospital in 1962. You must recall that at this time women were not granted admittance to the downstairs grill at Locke-Ober, and were allowed to enter the Harvard Club only through a separately designated entrance. It was also a time when the surgical staff was comfortable choosing candidates who appeared to fulfill their image of themselves. By now the proportion of women among house officers has increased to about one-third*, and it is this which resulted in major changes in the atmosphere of the program. The house officers are now less agitated, and in most cases nearly normal. The result is a welcome civility that was not always present many years ago. The evolution of the annual resident change party is a case in point. In earlier years these parties were held in the penthouse in Stygian darkness, unencumbered by matrimonial ties, which were then few, were paid for by the chief resident, and occurred every six months. The change parties now* include dinner catered by the Hospital, families are present, the satirical skits are generally subdued, and the whole affair is G-rated and decorous to the point of torpor.

During the earlier period, the entire legal apparatus and “dean” of house officers was the Assistant Director, Charles Clay, shown in (Fig. 10), in which the Hospital administration totaled seven members. Dr. Clay came by his position honestly, inasmuch as he had been previously the superintendent of a regional lunatic asylum. His experience allowed him to be particularly successful with house staff. His discussions of the legal implications of record-keeping were brief and practical. He was a relatively benign administrator, and was certainly preferable to the now legions of lawyers, managers and other suits employed by the Hospital.

During earlier administrations (Fig. 11) the Hospital directors were friendly, had an open-door policy in their office, and they actually knew some of the staff (Fig. 12). Thus, a small parochial hospital with few administrators evolved into a corporate conglomerate where the administration is anonymous. I am at the moment not quite certain of the identity of the Director of the Hospital; as soon as I become settled on one name, the Hospital changes all the titles and reorganizes itself, much as the influenzal viral coat protein mutates. A photograph of some of the current administration is shown here (Fig. 13).

Fig. 11

Fig. 12



Fig. 9



Fig. 10



Fig. 13



I am happy to say that the quality of the training has been constantly renewed by the higher quality of the applicants to the program, despite the fact that it is the only program in which there is some kind of examination that includes questions actually related to the profession to which the candidates aspire. The examination has metamorphosed from the barbarism of a simple keel-hauling or bastinado to only occasional gratuitous cruelty. The oral examination has been retained, but the candidates are seduced by the provision of informational sessions at dinner, luncheons, and pleasant conversations with the current house staff.

The pernicious effect of grade inflation occurring in universities throughout this nation have also become apparent here. The term “intern” is no longer used. The chief resident is now a staff member. While there were once a few senior surgeons meriting the title “Visiting Surgeon” (Fig. 14), surgeons no longer constitute a departmental oligarchy. There are now more Visiting Surgeons (Fig. 15) than any other rank, and more professors than instructors. The era of surgical apprenticeship (Fig. 16) has also ended; the surgeons now spring full-blown from the program, like Minerva from the head of Zeus.

Ten years ago I discussed some dominant themes concerning the habits and idiosyncrasies of a now retired Chief of Surgery; I now will briefly refer to him, within the constraints of the injunction. The influence of harsh economic times in medicine has had its impact, here as well, to which none of you are strangers. The alluring portrait of Dr. Austen revealed to the multitudes at last night’s

(Margolies continued on page 11)

(Margolies continued from page 10)

Fig. 14



Fig. 15



Fig. 16



celebration was not, as in previous eras, paid for by the Trustees and executed by a Boston Brahmin portraitist, but rather, was created first electronically, and then by a method known as “painting by numbers”. The frame was either purloined from a Gilbert Stuart in the Trustees’ Room, or shoplifted at K-Mart.

My analysis of the current administration of the Surgical Service is incomplete, as Dr. Warshaw’s tenure has just begun* in times which are far more challenging than those of his predecessor. Here (Fig. 17) is the young Lochinvar enthusiastically attending a surgical procedure in the Ether Dome in 1900. The only clue I can offer you about the direction the department may take in the future is his taste in art. In the place of honor in his office, which was recently renovated in Las Vegas style to resemble the Topkapi Palace in Istanbul, is this calendar (Fig. 18). The outer offices contain several stylish paintings and photographs of *other* outhouses. My interpretation of this penchant for the coprological is as yet tentative, although I have had some guidance from reading Krafft-Ebbing. Does it symbolize humble beginnings, or does it signify the eventual fate of American surgery? I suppose it presages what will become known in the history of this department as a kind of “cloacal period”. Dr. Warshaw faces much greater challenges than past surgical chiefs -- after all, the average surgical Chief Executive Officer is either incarcerated or incinerated within four years.

Fig. 17



The house staff constitutes the promise of this surgical service. They should be credited for their enthusiasm and optimism necessary to sustain service in surgery. They believe, at least, that surgery can continue to offer the fulfillment promised in the past.

How the tension between the enormous changes in the environment of medicine and the deleterious effects of drive-through medical treatment on teaching and the financial health of institutions such as this one will play out in the future, is the unwritten part of this history of this surgical service, at this institution and others.

**reproduced from a presentation by Dr. Margolies at the MGH Surgical Society Reunion in 1999*

(Editor’s note: Mike Margolies was born in New York City, graduated from Harvard College summa cum laude and Columbia University College of Physicians and Surgeons, and came to the MGH as an intern in surgery in 1962. He finished his residency training in 1969, having spent two years in the Laboratory of Chemical Biology at the NIH. Since then he has followed a joint career in clinical Surgery and in biology research even until the present time. His research has led to over 100 published articles with an interest centering on structural immunology and antibody engineering. He became a Visiting Surgeon in 1989 and a Professor at HMS in 1997. The most recent of his numerous society memberships is to the Gustav Mahler Society of New York. Many efforts to suppress this article by persons not to be here named have been reported, and its inclusion in the newsletter must be directly attributed to the courage and persistence of one of the editors (WD). Les Ottinger) ♦

Fig. 18

OUTHOUSES

Photography by Londie G. Padelsky



**MGH SURGICAL SOCIETY RECEPTION
MONDAY, OCTOBER 12, 2009
6:00 TO 8:00 P.M.
HILTON CHICAGO**

(Wain continued from page 4)

is not just being the “father” of tracheal surgery, but being a true mentor to many of us during our residency, guiding us to surgical “adulthood” by teaching, counsel and example. He taught us to observe, ask questions and be creative in our answers. All of us who had the opportunity and advantage of his guidance, as well as our patients, are the beneficiaries of his efforts.◆

(Editor’s note: John C. Wain, Jr. was born in Pittsburgh, and attended Pennsylvania State University, graduating with Highest Distinction in 1978. He subsequently graduated in an accelerated program from Jefferson Medical College, Magna Cum Laude. He was accepted as an intern in surgery at the MGH in 1980, and did all of his clinical training in surgery at the MGH, completing his Chief Residency in Cardiac and Thoracic surgery in 1988. During his residency years, he served as Senior Registrar in CT surgery at Southampton Hospital, UK in 1983.

He completed additional research fellowship years at the MGH, and at City of Hope Medical Center in California, as a Traveling Research Fellow in Surgery. John is currently Visiting Surgeon at the MGH and Assistant Professor of Surgery at HMS. His research has largely been in the areas of lung transplantation, pulmonary physiology and lung cancer. Since 1990, John has been Surgical Director of the Lung Transplant Program at the MGH. He initiated living donor lung transplantation in New England after careful preliminary laboratory studies. He pioneered the use of cytolytic induction immunosuppression for both living donor and cadaver lung transplantation, an approach which has become the standard for lung transplant immunosuppression worldwide.

He has received numerous honors throughout his career and has been elected to many important clinical societies in thoracic surgery, as well as serving on national and international committees governing policy in lung transplantation. An author of almost 200 scientific and clinical articles, John is also a much sought after teacher of both medical students and thoracic surgical residents at the MGH.)◆

(Sachs continued from page 7)

David likes to joke that he is the oldest MGH surgical resident around because he never officially resigned when he left the program for the NIH 40 years ago. Actually, David’s early surgical experience has had a profound impact on his research and the way he runs his laboratory. From the animal rounds twice a week, to the exceptional care his “patients” receive, to the thorough workup of each complication, when you are in the Transplantation Biology Research Center, you feel like you are on a surgical floor.

David returned to the MGH in part because he had first hand knowledge about the quality of the surgery and patient care being practiced here. David knew that to achieve his dream of bringing transplant tolerance to the human transplant recipients, the patients would require the best doctors and care available.

David and the MGH team have gone on to achieve the Holy Grail of transplantation— taking an organ from one human being and grafting it into another without the need for long term immunosuppression. What is sometimes overlooked is that it took David over 30 years of intensive, dedicated research, first in mice, then pigs, then monkeys to achieve this dream. His perseverance and unwavering faith in the concept of tolerance through mixed chimerism compares to that of Judah Folkman and angiogenesis. Both MGHers are exemplary reminders of how important and rewarding translational research can be and what it takes to achieve one’s dream.

David’s achievements have been well recognized by all of the world’s major transplant societies. In 1996, he was elected to the Institute of Medicine of the National Academy of Sciences and in 2001, he received the Medical Foundation Award for Distinguished Contributions to Health Care. When David is not making dreams come true, he is usually spending time with his family in Newton or at his summer lakehouse.)◆

Letter to the Editor

The article by Dr. Hendren reminded me of a day in the summer of 1967 that you may find amusing.

Dr. Hendren was doing a ureteral reimplantation on a small child. Assisting were Peter Mansfield, and me, a newly arrived Surgical Intern. Dr. Hendren did a very slick move to make a tunnel for the ureter to follow by passing his scissors obliquely through the bladder wall then grasping a heavy silk between the blades of the scissors and oh so gently pulling the suture back through the newly created tunnel. "What do you think about that, California?" he addressed me with a twinkle in his eye. "Not much, Kansas City!" was my (impolitic) answer. Peter laughed so hard he doubled up and contaminated his gloves. The anesthesiologist actually fell off his stool and was holding his sides on the floor. The surgical nurse, Dorothy, I believe, had tears running from her eyes. When order was restored Hardy's eyes flashed just a bit and said, "Interns shouldn't oughta talk to professors of surgery that way." "Oh, c'mon Hardy, why not?" said Peter.

"Because on the Phylogenetic Scale, interns rank just below the flatworm." answered Dr. Hendren. This comparison between the intern and the flatworm gained quite a bit of currency that year.

In all seriousness, the excellence of Dr. Hendren's pure surgical technique was an inspiration

to all that had the honor of training with him. He presented a film of hypospadias repair to the Plastic Surgery Service years later when I was the resident. Dr. Bradford Cannon broke in at one point and asked that the film be stopped and rerun at one particular move that Hardy had made. "Do you see how he gently pulls the curved scissors back toward himself while cutting forward on the tissue? That's how he gets such smooth edges." Dr. Hendren acknowledged that this move was intuitive and not deliberate. This small instance illustrates what it is that makes a master a master.

Thank you Dr. Hendren

Josh Tofield '74

Addendum to Pediatric Surgery at the Massachusetts General Hospital: Looking Back Half a Century and Further by Dr. Hendren.: Inadvertently omitted from the list of MGH residents entering pediatric surgery were David Gibbs, Vin Lam and Sharon Muenchow. The author and editors apologize for this oversight.

In Memoriam

**G. E. Erikson
Clement A. Hiebert
Alan Hilgenberg
W. Reid Pitts**



**PHOTOS FROM THE
MGH SURGICAL SOCIETY RECEPTION
ACS SAN FRANCISCO
OCTOBER 2008**

**PLEASE BE SURE TO JOIN US THIS YEAR IN CHICAGO
MONDAY, OCTOBER 12TH, 6 TO 8 P.M. AT THE CHICAGO HILTON**

