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Newsletter

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Message from the President Jo Buyske '93

For many years the MGH offered residents an international clinical year as an alternative to a research year. Residents who had finished at least three years of training could choose to go to either England or Australia and have a supervised year of high volume surgery. Invariably those residents came back changed. They were better surgeons—more mature, calmer, surer. They also seemed, for at least a period of time, to be better people—more mature, calmer, more balanced, perhaps even happier. It was a striking and predictable change.

Interest in international rotations has skyrocketed. Medical students at their residency interviews now routinely ask if there is an opportunity to do international rotations. Residency programs have responded by first allowing then creating opportunities for their residents to do just that. What drives this interest? Is it the spirit of volunteerism? Adventurousness? Commitment to service? Curiosity? Restlessness? A desire to escape the routine of residency and home? Is it just tourism?

There is some concern that these rotations are little more than incompletely trained doctors practicing on unfortunate people with few resources in an unsupervised setting; that these trips allow for a certain cowboy or girlish bravado, allowing residents to jump into cases better not done. This is clearly not acceptable, and must be controlled. There is also some pushback against the cloak of self-less volunteerism. Many if not most of these trips are financially supported by the home institution, so the “volunteer” gets a free trip, continued salary and benefits, and a job to which he or she can return—not exactly the situation most of think of when we think of self-less giving. There is some concern about the educational value. These trips are being taken during residency (or sometimes during lab or research years). This is a time reserved for training and education. Surely operating in the dark both literally (many third world operating rooms lack lighting) and figuratively (with poor quality or no supervision) would not move the goals of surgical training forward. Such trips might be better reserved for a fully trained, experienced surgeon equipped with a battery powered headlight. Last, if residents are to continue to receive their salaries while travelling strict attention must be paid to the source of those salaries. Government reimbursement for the direct and indirect costs of graduate medical education is intended for the care of American citizens, not for care given abroad.

Why then would the house of surgery have any interest in international experience? I offer that the advantages are myriad, and vastly outweigh the negatives. From a practical point of view, these rotations offer the surgeon in training an opportunity for clinical decision making that rarely if ever exists in the United States anymore. Decisions must be made without CT scans or MRIs, complications must be managed without an angiography suite, invasive radiology, or an infectious disease consultant, fluids must be managed without the safety nets of either assisted ventilation or dialysis. Clinical acumen is paramount. This in and of itself might be a strong enough argument to encourage if not actually require such a rotation.

The travelling surgical resident is exposed to the new world of limited resources as well. Blood transfusion may not be an option. It may be necessary to wash and reuse surgical gloves. Sponges may be limited to two or three per case, and energy sources for coagulation may not be available for every case.

That same resident will also come face to face with startling disparities that exist in global health. People who have illnesses that could have been treated and overcome in the United States will have to go untreated. Disease presents in an advanced state. Sometimes hospitals don't provide food to patients, requiring instead that families provide sustenance. Families may also provide physical therapy, chest percussion, and dressing changes. For sure there will be no visiting nurses to take vitals and change dressings when the patients go home. The travelling resident will meet surgeons who have trained under less than ideal circumstances, nurses and other healthcare providers who are committed to care despite poor living conditions themselves. The eye-opening nature of living and working in an underdeveloped or developing country cannot be underestimated.

What about supervision? The surgery Residency Review Committee and the American Board of Surgery, as well as the Association of Program Directors in Surgery have been actively engaged in setting out parameters for acceptable rotations. These include supervision by ABS certified surgeons, safe housing, health insurance, and other details. By meeting these requirements many of the objections to international rotations can be addressed. (*Buyske continued on page 9*)



Mortimer Joseph Buckley was born July 1, 1932 in Worcester, Massachusetts to an Irish immigrant family from near Killarney. Raised in a good Irish Catholic family, Mort attended the College of the Holy Cross and then Boston University Medical School, later being named a distinguished alumnus of both schools.

Dr. Buckley did all of his surgical training at the Massachusetts General Hospital. In the middle of his general surgical training, he spent two years participating in a clinical and research fellowship in the Clinic of Heart Surgery at the

National Institutes of Health, where he worked with Dr. Andrew Glenn Morrow. Dr. Buckley returned to the MGH to complete his surgical training, finishing in 1966. He immediately joined the faculty at the MGH and remained with that institution for the rest of his professional career until his retirement in 1998. During that career, he also helped to initiate or expand cardiac surgical programs at the Beth Israel Hospital, Mount Auburn Hospital, University of Massachusetts in Worcester, and University of Athens, Greece.

Dr. Mortimer J. Buckley, MJB to those of us on the cardiac surgical service at the Massachusetts General Hospital, and Mort to his friends, was a cardiac surgical legend and a very complex person. Until his final illness, he was physically imposing, could be intellectually and professionally intimidating, and socially charming. The timing of Mortimer Buckley's life, what he inherited from his parents and the skills he developed placed him in the enviable position of having the privilege and the capacity to be one of the true pioneers who helped to guide the rapid growth of cardiac surgery as a specialty.

Professionally Mortimer Buckley combined raw intelligence, a prodigious memory, great technical facility, tenacity in the care of patients, an unbelievable work ethic, and absolute dedication to teaching with an inability to accept anything less than the complete commitment of his residents to learning and the total dedication of the staff to the welfare of the patients. For over thirty years he was relentless in his devotion to teaching residents to become cardiac surgeons and equally demanding in what he expected in return. While Mort could make accommodations for lesser degrees of intelligence or native surgical skills, he accepted nothing less than a resident's absolute best efforts to try to be perfect – no cutting corners, no half-hearted attempts, only total involvement. Mort abhorred wasted talent.

As a teacher, Mort Buckley was in part a product of his times, and, therefore, a demanding taskmaster. I think he would have been comfortable with Vince Lombardi, legendary coach of the Green Bay Packers, who said, "Success demands singleness of purpose." Mort would also have understood Coach Paul 'Bear' Bryant of the Alabama, who said, "I make my practices real hard because if a player is a quitter, I want him to quit in practice." As his residents quickly learned, Dr. Buckley was an intense competitor. In cardiac surgery he had to be; his opponent was death. In the care of patients Mortimer Buckley only played to win.

While the operating room could be a tough learning ground, the rewards were invaluable. Residents learned a consistent, reliable, tested and safe approach to even the most complex cardiac surgical pathologies, and were assisted in doing a lot of operations, as long as you did

them his way. While some observers described the atmosphere in Mort's operating room as at times intense, to most of his chief residents, including me, he became a mentor, occasionally to some who did not get the message, a tormentor. When patients did well and his residents worked hard, life on the cardiac surgical service was good. When patients did not do well and Mort perceived that his residents had not done their best, life got complicated. The standard of personal accountability was both implicit and explicit across the entire cardiac surgical service. Despite the intensity of training, during Dr. Buckley's over twenty-five years as Chief of the Cardiac Surgical Unit, the residency was always oversubscribed.

As Chief of our Cardiac Surgical Unit, Dr. Buckley was a leader who had a vision for MGH cardiac surgery. God help the person who stood in his way! He would confront cardiology, nursing, anesthesia, the department of surgery, the hospital administration, the state government or anyone else if he felt that it would benefit the MGH cardiac surgical program. In that process MJB earned the loyalty of operating room nurses, perfusionists and cardiac intensive care and floor nurses, scores of who remained on the service for decades to work alongside Dr. Buckley and the rest of the team.

The intensity of life on the cardiac surgical service in the 70's, 80's and 90's was frequently broken with humor and good times. When I was Dr. Buckley's chief resident in 1975, my father, a general practitioner from a small town in Minnesota and my hero, one day came to watch me perform an aortic valve replacement with Dr. Buckley in Room 25. The operation seemed to be progressing smoothly and expeditiously, when Dr. Buckley chose a quiet moment to turn to my father, who was standing at the head of the table, and say, "Dr. Akins, I hope that at the conclusion of this operation you will have a few minutes to spend with me in my office. There are some aspects of your son's behavior that we need to discuss." Even behind his mask, you could see my father's jaw drop. Mort waited a few tantalizing seconds and then burst out laughing and kept laughing until my father smiled...and I resumed breathing. He looked at me and said, "Gotcha!" People worked hard and played hard. A defined mission and shared sense of purpose bred camaraderie.

As a colleague, Mort set a high standard of performance and expectation. His work ethic, excellent results and commitment to teaching set a valuable example for the rest of the staff. In my own case Mort realized that I did not need, nor desire, a lot of handholding. He allowed me relatively free rein to succeed or fail on my own. Although as two cardiac surgeons not lacking in ego we had our professional differences of opinion, we shared true respect and what became an evolving affection for each other. Although like all surgeons in high-pressure specialties, Mort could be on occasion difficult in day-to-day interactions, when a major problem developed, particularly for a colleague, no one was more effective than Mort at facing complex situations and resolving problems. In his final years we shared many special conversations when he would at times unburden himself to me and in turn become my confidant.

As a surgeon, MJB was unflappable in the face of any cardiac surgical problem. He was equally comfortable managing

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ing the most difficult valvular, coronary, aortic or even congenital cases. Although he was an early leader in the field of myocardial revascularization, coronary artery bypass grafting was not Mort's favorite operation. He was much happier with complex valvular or aortic cases, although he felt that his greatest reward lay in helping an infant achieve a chance at longer life. He was an excellent technician, a master at managing cardiac physiology and a genius at getting out of trouble.

As a scientist, Dr. Buckley was an early innovator in the application of mechanical circulatory support, contributing to the development of the intra-aortic balloon pump and its clinical application to treat acutely ischemic and failing hearts. Along with his colleagues of that time, particularly Eldie Mundth and Bill Daggett, under the guidance of Jerry Austen, he pioneered the surgical treatment of cardiogenic shock and the mechanical complications of acute myocardial infarction. Working with colleagues in cardiac anesthesia, he helped to establish the technique of deep hypothermia and hemodilution for the correction of congenital anomalies in infants. His bibliography of over 200 published articles spans the entire gamut of adult and congenital heart disease.

As a young surgeon, Mort Buckley made important contributions to the cardiac surgical literature, but in his later years unfortunately he could not motivate himself to write about the lessons learned from thirty years of practice. Today his wisdom resides in the minds and hearts of the residents that he trained and continues to be passed to succeeding generations of residents taught by his pupils.

Dr. Buckley served as Chief of the Cardiac Surgery Unit at MGH from 1970 through 1998, during which he enjoyed a distinguished career as Professor of Surgery at Harvard Medical School and was a recipient of the American Heart Association's prestigious Paul Dudley White Award and of the Abraham Colles Medal from the Royal College of Surgeons in Ireland. In 1995 Dr. Buckley was elected president of the prestigious American Association for Thoracic Surgery for his contributions to the specialty.

Numerous cardiac surgeons around the globe invited Dr. Buckley to visit their programs to impart his knowledge and expand their understanding. Not only did he mentor surgeons in operating rooms from China to Venezuela, but his international residents from Greece to Korea brought

their surgical skills, honed under his tutelage, back to their own countries to improve cardiac care.

Outside of medicine one could see a different personal side to Mort Buckley, including his ability to be the world's most charming raconteur. Mort had a well-honed Irish sense of humor and loved to tell stories, many of which I am sure were true. When not in the operating room, Mort Buckley enjoyed tennis and golf, but he was his happiest out at sea, sailing with his family. As a host, he was kind, generous and deferential.

Mort Buckley was totally devoted to his family. He adored Marilyn, his wife of forty-five years, who unfailingly supported him throughout the countless long days and late nights that were required to build and sustain a premier cardiac surgical program in Boston. Mort took immense pride in the success of his children - Kathleen, Deirdre, Kara and Tim. For all of the joy he gained from their accomplishments, he was even more proud of the people they had become. In later years Mort equally loved his ten grandchildren and their diverse personalities.

Several years after retiring Mort acquired multiple myeloma. That terrible disease cut short a well-earned retirement, made his last years difficult and his last months painful. His courage in the face of those trials provided further inspiration and life lessons to his friends and pupils.

Dr. Buckley died on November 24, 2007 at the age of 75 in his home in Osterville on Cape Cod. His funeral service was celebrated at Christ the King Church, a large Catholic church on Cape Cod before a filled sanctuary. It was right and proper, no matter what their individual religious preference, that hundreds of Dr. Buckley's friends gathered in a Catholic Church to celebrate the life of Mortimer J. Buckley. Throughout his life, Mort's religion was very important to him; he was a Knight of Malta, a Knight of the Holy Sepulchre and a lifelong supporter of the Church. Mort once told one of his daughters that if he had not instilled in her the importance of her religious faith, then he had failed as a parent.

During the height of Dr. Buckley's career he was often described as being "larger than life." Considering the success of his family, the scores of cardiac surgeons he trained who have gone on to great accomplishment and their continued dissemination of his teachings; we might argue that Dr. Mortimer J. Buckley's legacy is even larger than death.

At his funeral mass his daughter Kara recounted her father's love of the sea. "In the sea my father found adventure, time with his family, and closeness to God. The day Dad looked out to sea for the last time couldn't have been a better one for sailing. It was a windy morning after a storm. The sun's rays were dancing across the white-capped sea and reflecting in Dad's eyes. Looking out to the horizon, to the sailboats



racing off Hyannis, with the wind and sun in his face, Dad recited by heart an old favorite of his, John Masefield's "Sea Fever."

I must go down to the seas again, to the lonely sea and the sky,
And all I ask is a tall ship and a star to steer her by,
And the wheel's kick and the wind's song
and the white sail's shaking,
And a gray mist on the sea's face, and a gray dawn breaking.
I must go down to the seas again, for the call of the running tide
Is a wild call and a clear call that may not be denied;
And all I ask is a windy day with the white clouds flying,
And the flung spray and the blown spume,
and the sea-gulls crying.
I must go down to the seas again, to the vagrant gypsy life,
To the gull's way and the whale's way,
where the wind's like a whetted knife;
And all I ask is a merry yarn from a laughing fellow-rover,
And quiet sleep and a sweet dream when the long trick's over.

I am honored to say that Mortimer Buckley was my teacher, my boss, my colleague and my friend. On all four accounts I consider myself fortunate.

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Teaching the MGH Way in a Faraway Land

by Chad Wilson '08

Being an alumnus of the Massachusetts General Hospital Surgical Residency means something special. This meaning is not easy to articulate, but there is something that we all share and can see in one another. Whether it's our shared memories of our panel interview before we arrived, or the sense of accomplishment when we finished. Perhaps it's the MGHisms like "the way it's been done since 1811" or the GI stress test that is also known as the 9 o'clock meal. But we all share a culture that includes fierce dedication to patient care, clinical excellence, and achievement (that is seasoned with a healthy dose of surgical sarcasm and wit).

Of course, after graduation from the MGH, we all go in many different directions, but I believe we take a little bit of the MGH with us wherever we go, even if it is to the other side of the world.

I graduated from the residency this past year in the summer of 2008, and took a rather unusual professional step after passing my written and oral boards a few months later. Last September, I moved to a small rural town called Kijabe in Kenya, East Africa to be a missionary doctor for my first year out of residency. Many of my MGH colleagues raised eyebrows at this career move, but most people encouraged me, and some even said they were envious. I was doubtful myself at times about whether I would accomplish anything, but in my heart, I felt a calling to this work, and I have learned to trust the "still small voice".

Kijabe is a town of about 15,000 along the edge of the Upper Rift Valley. Kijabe means "place of the wind", and at 7000 ft elevation, this location is surprisingly cool for its equatorial location. The hospital there is nearly 100 years old. Teddy Roosevelt actually laid a cornerstone in the first building of the neighboring Rift Valley Academy school. As of 2009, Kijabe Hospital is a relatively modern institution for a rural area in a developing country. It is a 200+ bed hospital with 5 operating rooms, an intensive care unit with ventilators, a laboratory/blood bank, and radiology department complete with ultrasound and good plain film capacities. The hospital is blessed to have a very strong surgical department with surgical specialists including orthopedic surgeons, gynecologists, pediatric surgeons, and during some parts of the year even has visiting otolaryngologists, plastic surgeons, and neurosurgeons.

I joined two other general surgeons to make up the department of "general surgery". Of course, general surgery at Kijabe often goes beyond the usual dimensions of general surgery and includes, vascular surgery, plastic surgery, urology, neurosurgery, surgical oncology, endocrine surgery, thoracic surgery, head and neck surgery, and of course gastrointestinal surgery. I was assigned 3 days of block time in the operating room, 1 day for the surgical clinic, and an "administrative day", which was usually the day I begged for OR time to do the cases I couldn't complete in my elective block time. There are 8 interns in the hospital (two of which are usually rotating in surgery) and even a couple of surgical registrars (2nd and 3rd year surgical residents). As the most junior general surgeon, I usually had an intern and occasionally a medical student on my team. I took call every 3rd night (or more often as the other two surgeons used my time there to take some much needed vacation). While that sounds grueling, one must remember that it is very difficult to travel at night in rural Africa, so patients rarely show up after 8pm, and by midnight most surgical patients have been sorted out, and I only operated after midnight a half dozen times or so during my 8 months in Kijabe.

I have to say that it was an amazingly productive "fellowship in



Dr. Chad Wilson on a hike in surrounding countryside

general surgery in the developing world". I did over 600 cases, took care of over 300 inpatients on my service, and I attended over 1500 clinic visits during the 8 months I worked there. The most common procedures were minor ones like: EGDs, dressing changes, breast lumpectomies, and of course ano-rectal cases like hemorrhoidectomy/fistulotomy/sphincterotomy. However, approximately 230 of these cases were major cases: the most common procedures being: hernia repairs, thyroidectomy, cholecystectomy, exploratory laparotomy, prostatectomy, and C-section. Most of the surgery was elective scheduled surgery, but approximately 16% of the cases were urgent. Also 15% of the cases were trauma related, but only 20% of the trauma cases were acute/urgent trauma operations like ex-lap or craniotomy (burr holes). The lack of emergency medical services and infrastructure (good roads, communications systems) prevents the most severe traumatic injuries from reaching the hospital during the "golden hour".

There were a fair number of complex problems and difficult operations as well.

Fournier's Gangrene, esophagectomies, whipples, CBD explorations, pyelolithotomies, craniectomies, pulmonary decortications, APRs, contracture release, and various other plastic/reconstructive operations. Of course operating in rural Africa requires some creativity, especially when the instruments and supplies are limited. What I learned though was that most general surgery can be improvised even with limited instruments, but it was the post-operative care that cannot be easily replaced or duplicated. In fact, if I was to name the single biggest limitation to my ability to care for my patients, it would be the quality of surgical nursing in the general wards of the hospital. The factors that cause the nursing to be so poor are multifactorial including some cultural issues, hospital administrative problems, and educational deficits, but I eventually learned that my patients needed constant attention by me in the post-operative period if they were to do well..."trust no one." Overall, though I was amazed at the breath of problems we were able to treat in spite of our limitations.

Perhaps what made my time at Kijabe most rewarding was not the interesting case mix, but it was the dire needs of the patients, and their incredible appreciation for my efforts. I have never had patients so thankful (even when the outcome was poor) for what I did. Even after amputating limbs, patients would demand to have their picture taken with their doctor. What really touched me was that the families of patients that I lost never once blamed me. In fact, many times, they comforted me as I expressed my own sorrow for not being able to help their loved ones.

(Wilson continued on next page)

(Wilson Continued from previous page) The burden of surgical disease in a developing country with too few surgeons is overwhelming. Every week, my surgical clinic was overflowing with people who needed help, and my OR schedule was always overbooked. Unfortunately, the patients often presented late, because they had no way to get to a hospital or at least a good hospital. On many occasions, I had patients leave other hospitals to come to Kijabe, after their problems had been largely ignored at the local district hospital, provincial hospital, and sometimes even the national hospital in Nairobi.

Sometimes the opportunity to save the patient had been missed like a 19 year old man who sat at a district hospital for 4 days with a clear clinical picture of a perforated viscus (even an x-ray showing free air). By the time he came to us, and I was able to explore him, it was too late. He had profound sepsis, renal failure and without ionotropic agents or any type of renal replacement, he died the next day in the ICU. His death angered me so much. I asked one of the Kenyan interns why these other hospitals exist if they cannot even recognize the most obvious surgical emergency. She explained to me how the district hospitals were often staffed by doctors who are not committed to patient care, because of the lack of reimbursement for their efforts. It surprised me to learn this, because my assumption was that all Kenyan doctors are

committed to saving lives regardless of pay, because the need is so great and obvious, but actually there is a terrible culture of professional arrogance among doctors there. I am told that they work from 9am to 3pm, and sometimes not that much, and the only hard working physicians are the ones who see private patients. That is why Kijabe Hospital and the other mission hospitals in Kenya have such a good reputation among the people, because people know that they will get hard working doctors regardless of their financial status. In hindsight, I see that while I was able to treat hundreds of patients while in Kenya, the most important thing I provided was education...and not just education about how to do a procedure. The most important education I was teaching the interns, residents, and nurses was a cultural one. A culture of professionalism, dedication, commitment, and teamwork, no matter who is watching or who is reimbursing. I learned this work ethic at the MGH. More than what I was teaching with my words, I was teaching and leading by example, and what I was teaching was the "MGH way". And I know when those 8 interns at Kijabe hospital complete their internships, and are dispatched to the surrounding district and provincial hospitals by the national health ministry, they are going to take a bit of the "MGH way" all over Kenya. And maybe, that is what will ultimately save the next 19 year-old with a perforated viscus.



Top row(l) to(r): Chad with OR staff, open in-patient ward, the Casualty (Emergency) Department. Bottom row (l) to (r): Chad operating, surgical clinic waiting room, Chad with his patient who survived ruptured AAA repair – all at Kijabe Hospital

Editor's note: Chad T. Wilson, M.D. MPH graduated from the University of Texas in Chemical Engineering in 1997, then received his M.D. from Johns Hopkins University School of Medicine in 2001. He worked summers in college as a field engineer for an East Texas Oil Field. He received his MPH degree from Dartmouth Medical School Center for Evaluative Clinical Sciences, where he did outcomes research in coronary bypass surgery patients, as well as those with abdominal aortic aneurysms with an emphasis on racial disparities. He has participated and published on basic, translational and clinical research subjects, and received numerous awards for teaching throughout his college and medical school education. Chad came to the MGH as a surgical intern in 2001, completing his general surgical residency training in 2008. He has served as vice President of the National Society of Black Engineers, and has been a member of the Johns Hopkins University School of Medicine Admissions Committee. Following completion of his general surgical training here at the MGH, Dr. Wilson was awarded a Durant Fellowship in Refugee Medicine, which he elected to serve for 8 months at Kijabe Hospital in rural Kenya, Africa, operating and caring for patients there, as well as teaching the staff the principles of modern surgical care. This experience was the subject of a recent presentation by Dr. Wilson at Surgical Grand Rounds. As of July, Chad has returned to the MGH to serve a two year fellowship in Acute Care Surgery.) ♦

Anecdotes from Gil Hermann '61



Residency Research Memory

Doing research as a surgical resident can provide rich memories not necessarily related to the scientific aspect of the work being done, but rather to unexpected events which are peripheral to the science.

The dog in the cage was large, dull brown in color, with short hair, a big head and a menacing mouth marked by large incisor teeth and long dagger-like canines. He may have been part Doberman, but I'm not sure. For all that, he appeared to be a gentle animal.

This dog and I came into contact late one fall afternoon in the Warren Building of the MGH during my fourth year of residency. A fellow resident, Art Baue and I, under the auspices of Bob Shaw, were doing a research project studying cardiac function related to the potential toxicity of banked blood. The protocol required anesthetizing a dog for about two hours with an IV-administered anesthetic while we measured various cardiac parameters with different storage times of banked blood.

That memorable afternoon, I was holding the dog's leg as usual while Art began injecting the IV anesthetic. Suddenly, the dog jerked his leg when only about half the dose had been administered causing the animal to go into the excitement stage of anesthesia rather than the desired soporific state. This previously gentle dog now became a completely berserk beast, running madly around the lab, barking wildly, jaws snapping, frothy mouth agape. Art and I wisely decided to escape to an adjacent room, shut the adjoining door, and planned to wait until the drug wore off and the dog returned to his usual placid state. The situation now unexpectedly began to unravel. This temporarily insane animal decided to take up his post on the landing where the elevator door opened onto our floor. From our refuge, we were able to see the dog, as well as the elevator door and the light which indicated the elevator's location. To our dismay, the elevator now left the first floor. We watched with mounting alarm as it ascended past the second floor and then stopped on the third, our floor. The elevator door slowly opened, revealing two research fellows in long white lab coats who had not the faintest idea of what they were about to encounter. Not two feet away they were suddenly confronted by a large crazed animal with fangs bared, barking wildly. While my partner and I were responsible for this unfolding catastrophe, we were frozen in place. The people in the elevator were momentarily also paralyzed, probably with fear. Fortunately, the dog did not move either. One of the passengers regained some control of his body and convulsively pressed the button to return to the safety of the ground floor. Shortly after the elevator departed, the dog began to calm down and we quickly returned him to his cage.

Needless to say, we did no more research that day and in fact left the building as quickly as possible. We never found out who the potential victims were, but truthfully we didn't try too hard. Despite this rather troublesome event, the work was eventually presented and published. ♦

An Act of Kindness

This act of kindness took place at the end of June 1950. I had graduated from medical school and was about to start my surgical internship at the MGH. The salary was miniscule, but the hospital provided room and board for those of us who were single. The

house staff living quarters were in one wing of the hospital, then called the Moseley Flats. The rooms seemed to me probably not to have changed since the hospital was built in 1821. Each room was small with barely room for a cot, a desk, a chair, and a washbasin. Showers and toilet facilities were communal and located down the hall.

I had arrived on a Saturday, two days before my internship was to start. I knew no one, as all of my seven fellow surgical interns were graduates of Harvard Medical School. I was the outsider, having received my MD from Washington University in St. Louis. While lying on my bed early that evening, feeling very lonely and also quite apprehensive as to whether I could measure up to the challenge posed by becoming a part of this prestigious medical institution, there was a sudden knock on my door, and it swung open to reveal one of the older surgical residents, although in retrospect he was probably only two or three years my senior. He curtly, but kindly inquired if I was a new intern. When I acknowledged that fact, he introduced himself and asked if I wished to join him and several other residents for some fishing off of Cape Cod the following morning. I promptly answered in the affirmative, my spirits lifted by this act of kindness to a stranger.

At 3 a.m. the following morning, I joined my companions in the predawn darkness outside the hospital. We were to be at the Cape and on board our rented fishing boat by 7 a.m.

At the dock I was duly informed that we would be returning about noon and that the boat would not turn back any earlier if anyone got seasick. Having been brought up in a totally urban environment, I had never been fishing anywhere before, let alone the open sea. I looked forward to a great adventure and novel learning experience.

The boat was about 25 feet long. It had a wheelhouse enclosed on three sides for the captain and a large open space behind for the fishermen. As we headed out to sea, we encountered large swells and the boat, as is the way of small boats, began to rock in rhythm with the unceasing waves. I shortly began to feel the first twinges of nausea and by the time we reached the fishing grounds, I was violently seasick.

The only way I could gain some relief was to lay on my back in the bottom of the boat. This was not too bad until my new friends, who were somewhat less than sympathetic, began to catch fish. Unfortunately for me, the fishing was excellent. As the fish were hooked, they were thrown into the bottom of the board where I lay in the throes of my seasickness. These dead and dying finned creatures flopping around and over me plumbed the depths of my misery. I could do nothing, but lie there in an abject state of unhappiness. After what seemed like a never-ending morning, we headed back to shore around 11 a.m. I was thankfully on dry land by noon. A tiny bite of lunch and a lot of fluids later, I somewhat recovered my spirits. I took the good-natured ribbing on the way back to Boston as a sign of acceptance by my new colleagues, some of whom became my lifelong friends.

I remain extremely grateful for their kindness to a stranger, but I did learn two things. First, that I was very susceptible to motion sickness and second, that even acts of kindness can have unpleasant and unexpected consequences. ♦

In Memoriam

Rudolfo Herrera-Llerandi

Isaac V. Manly

RESIDENT WORK-HOURS: GETTING IT RIGHT -- A Message from the Chair by Andy Warshaw

All of us know that in 2003 the ACGME ruled that the time that residents work must be limited to 80 hours per week (averaged over 4 weeks), with additional requirements for at least 10 hours between shifts and one full (24-hour) day off per month. This mandate was the downstream effect of public and congressional concern arising from the death of Libby Zion at New York Hospital 1984, erroneously attributed to the sleep-deprivation and fatigue of the intern involved in her care. Incidentally, no-one has ever been able to tell me where “80 hours” comes from – certainly not from the comparisons to long-distance truck drivers and airplane pilots that are so commonly cited in the resident work-hours debates.

Research conducted on our MGH experience before and after the 2003 regulations (Hutter et al, Ann Surg 2006;243:864-871) found that the residents indeed felt better rested and had an improved quality of life (based on more free and family time), but there was no evidence of improved test scores on the ABSITE (in-training exam of the American Board of Surgery). In addition, concerns were raised over diminished resident/faculty interaction and shifting of workload to faculty.

In response to the 2003 mandates the MGH surgical residency program, under the leadership of Program Director Charles Ferguson, made concerted and continuing efforts to stay within the guidelines — with partial but not complete success. Despite regular reminders to the faculty and residents, backed with monthly data reporting, violations of one or another component of the limitations continued to occur as frequently as 30%. How many of the apparent infractions were real and how many were a function of the failure to sign out or the failure of retrospective record keeping is speculative. Some infractions were trivial – i.e. 23 instead of 24 hours off, 9½ hours instead of 10 between shifts, but, truth be told, some residents probably reported compliance despite staying late to do the right thing with patients for whom they felt commitment.

In April, 2009, we received a notice from the ACGME and RRC for Surgery of a proposed probation of our surgery residency. This decision was based upon a recent site visit and was heavily influenced by the 2007 (anonymous, self-reported) ACGME survey of our surgical residents, in which 20.9% reported that duty hours exceeded 88 hours/week (surgery is allowed 10% more than the 80 hours); 39.6% reported that they were not provided a full day in seven free from responsibility; and 18.6% noted failure to have a full 10 hours between shifts. As the site visit report noted, we had continued to make progress toward compliance between 2007 and 2009, but the program was still demonstrably short of the mark.

The April ACGME letter was a loud and clear wake-up call. We responded accordingly, not only by requiring absolute adherence to the rules through unequivocal communications to faculty and residents, but by constituting task forces of residents and faculty to redesign the residency program and its daily operations.

The June work hours report showed remarkable improvement even without the structural changes to be put in place June 27.

TABLE 1

-----# of violations-----

PGY	Avg. Hrs.	>80	No Day Off	<10	>30
1	43.51	0	2	2	2
2	50.10	0	0	0	1
3	50.73	0	0	0	0
4	44.96	0	1	2	0
5	55.61	0	0	0	0

The structural changes emanating from the task forces included:

- Elimination of non-required rotations of marginal educational value to our program (urology, neurosurgery, orthopedics, anesthesia, cardiac surgery, and a pediatric surgery rotation at Children’s Hospital Boston).
- Reassignment of residents from eliminated rotations to bolster general surgical services and to increase the number of “night-floats”, making true and consistent surgical teams.
- Requirement that all interns must leave the OR by 4:30 p.m. and all other residents by 5:30 p.m. in order to assure timely completion of duties and hand-offs to the night teams
- Elimination of 5 PM didactic sessions (GI surgery rounds, etc).
- Condensation of many didactic teaching sessions into a weekly half-day of education, encompassing M and M rounds, Grand Rounds, core curriculum conference, skills labs and a rotating series comprising GI surgery conference, ethics rounds, endocrine rounds, etc. During this 5-hour period residents are free from all clinical duties, which must therefore be the responsibility of attendings, physician extenders, and fellows.

The July work-hour statistics, incorporating the new program, have achieved 100% compliance:

TABLE 2

-----# of violations-----

PGY	Avg. Hrs.	>80	No Day Off	<10	>30
1	74.68	0	0	0	0
2	65.91	0	0	0	0
3	69.80	0	0	0	0
4	69.44	0	0	0	0
5	60.85	0	0	0	0

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The August and September performance has continued to be near-perfect. We are proud of this accomplishment, but our success must be maintained, of course. It will take vigilance and diligence, as well as extra effort by the faculty and certainly extra investment by the hospital and practices to bring on physician extenders to make up the hours of patient care previously provided by residents. Prior to this year 18 nurse practitioners and physician assistants were added since 2003. If it is judged that patients were getting the “right” amount of care up until now, it may take 20 or more additional NP/PA’s to provide safe patient coverage.

Questions and uncertainties remain. Will resident education suffer from the curriculum changes or the reduction in operative experience? Will the ACGME adopt any or all of the further work-hour restrictions advocated by the Institute of Medicine (such as an additional 25% reduction of work hours and a requirement for a 5-hour sleep period if a shift exceeds 16 hours!)? And if it does, how will we be able to educate surgical residents adequately without extending the duration of residency? Will the future product of residency be up to the standard we now have? How can the faculty accommodate to the absence of residents as assistants in surgery (after 4:30 p.m., Thursday mornings, etc)? What is the future role of NP/PA’s; are there enough being trained; and who will pay for them?

And incidentally, when will some well-meaning but misguided body (legislature, attorneys, media) decide that work-hour limitations should not apply only to residents? How about practicing surgeons and physicians? Who wants a tired doctor, some ask – unless that doctor is your doctor, the one who is committed to knowing you and the details important to your case. We need to be aware that just those circumstances are already unhappily the law in Europe.

(Note: At the time of this writing, we have been notified that the MGH Surgical Residency has in fact been placed on probation, a decision based on prior years’ infractions – despite our present remarkable improvement. Lifting the judgment must await a return site visit by the RRC.)♦

Events of Note

- **Susan Briggs** was awarded the 2009 Nina Starr Braunwald Award by the Association of Women Surgeons. The Association’s highest honor is presented annually to a member or non-member surgeon in recognition of a lifetime of contributions to the advancement of women in surgery. Dr. Braunwald was the first woman cardio-thoracic surgeon in the country and the award was established with an endowment from her family. Susie was specifically recognized for her professional and personal accomplishments as a surgeon, researcher, mentor and role model for women.
- **Eugene Fukudome PGY4** was awarded an American Association for the Surgery of Trauma resident scholarship entitling him to attend their annual meeting in Pittsburgh in October 2009
- **Richard Hodin** and Madhu S. Malo have been awarded a Grand Challenges Exploration Grant from the Bill and Melinda Gates Foundation (\$100,000 for one year) for a proposal entitled, "Intestinal alkaline phosphatase to treat and prevent diarrheal disease".
- **Eric Chien-Wei Liao, MGH Plastic Surgery Division** has been awarded with an American Surgical Association Fellowship Award (\$75,000 per year for 2 years) for his proposal entitled “Application of Zebrafish Models of Cleft Lip and Palate as Whole-organism Substrate for Drug Discovery”.
- **Richard Pierson** was appointed Director of Surgical Services at the VA Maryland Health Care System in 2008. He served as President of the International Xenotransplantation Association 2007-2009 and is a member of the TTT Study Section.
- **Elizabeth Sailhamer PGY4** was awarded First Place (\$1500), Basic Laboratory Research from the Committee on Trauma’s Residents Trauma Papers Competition for her work entitled “Histone Deacetylase Inhibition: A Novel Treatment for Lethal Septic Shock”.

The MGH Surgical Society is missing contact information for the following alumni. If you have any contact information for these alumni, please send it along to the address on the front of this newsletter. Thank you.

**John Adams
Alfred DeFalco
Larisse Lee
Ronald R. Magee
John A. Moody
Benny Tan
Dennis Whitlow**

**John Ambrosino
John Hallett
John L. Lewis, Jr.
Michael Meistrell
Robert O. Powell
Steven Untracht
Leroy S. Wirthlin**

**David Collins
Elizabeth Hingston
Howard Lipton
John D. Mitchell
James J. Ryan
Lynn Weston**

Letters

Oh My

The last edition of the Surgical Society newsletter contained a most regrettable error. W. Reid Pitts is not deceased, as was reported, but is very much among the ranks of our living alumni. He has an active practice of Urology and is intensely involved in research related to his unified theory of prostate cancer. His present address is 115 East 61st Street, 14th Floor, New York, NY 10021.

All this I have personally verified and can report that he has definitely retained an acute sense of humor and great enthusiasm for his present activities.

Les Ottinger and Bill Daggett

“The reports of my death are greatly exaggerated” (Mark Twain). I am not “as

dead as a coffin nail” (Dickens – A Christmas Carol). “It ain’t what we don’t “I shall return” General Douglas MacArthur on leaving the Phillippines during WWII. N.B. He did return and defeated the Japanese decisively.

See BJU International 2007;100:254. “Validation of the Pitts Unified Theory of Prostate Cancer, Late Onset Hypogonadism and Carcinoma”.

W. Reid Pitts

Dear Les and Bill:

Congratulations on a wonderful newsletter. I enjoyed the alternative history of surgery at the MGH, appreciated the tributes on Hermes Grillo and Charlie McCabe, and was motivated to give again to the ACS PAC after reading the message from our Chairman.

Great idea to put the pictures of the incoming class, although it made me nervous (again) to see such gender disproportion.

Carlos Fernández del-Castillo

Personal note to Fellow Alumni:

I have “failed” retirement. Walked away from medicine and surgery at age of 65. Moved to a ranch in southern Arizona. First six months was great. Doubt then set in. Started giving lectures at the University of Arizona, Arizona Cancer Center in Tucson. I accepted my Error in Judgment, and my wife and I bought a home in Tucson with enough property for my 3 horses and 4 dogs, and have returned to work. I have negotiated a 4-day-a-week clinical and administrative position – a great compromise.

Alfred Cohen

Announcement from our Chair

I have been the head of this department and MGH Surgeon-in-Chief for 12 years now. Most of my original goals, as well as a procession of new challenges, have been met. The department and its activities, including the faculty, clinical work, research funding, and outreach have grown enormously, in many cases more than doubled. This is a department of which I am very proud. Nonetheless, the administration and I have recognized that the time has come to hand over the reins to a successor who will carry us upward to the next level.

A search committee will soon be constituted by Harvard Medical School. The search process normally takes a year or more, so I will continue to lead the MGH Department perhaps until late 2010. I will continue to build our programs, advocate for our faculty, strengthen the training programs, and participate in new directions at the MGH and Partners levels (I serve on the Board of Directors of the MG Physicians Organization, Partners Healthcare, and the Martha’s Vineyard Hospital).

I will not be retiring, instead taking on new administrative roles for the MGH while continuing to lead the health policy initiatives of the American College of Surgeons and to edit the journal SURGERY. Andy Warshaw

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Our own program director, Charles Ferguson, has petitioned the MGH Surgical Society for funds to support two residents in their lab years to do international rotations. As president of the society, I strongly support this goal. With your continued generosity we can help our soon-to-be colleagues have these enriching experiences, which we hope will make them better surgeons—calmer, surer, citizens of the world. Maybe we can even buy them battery-powered headlights. ♦

(Akins continued from page 3)

(Editor’s note: Cary W. Akins was born in Eveleth, Minnesota and grew up in Red Wing, Minnesota, the son of a physician. He attended Harvard College and Harvard Medical School graduating from both cum laude. He received his training in general and cardiac surgery at the MGH, including six months as Senior Surgical Registrar at Southampton Western Hospital, England as part of his residency, which he finished at the MGH in 1975. He then entered the US Air Force and served two years as a staff cardiac surgeon at Wilford Hall USAF Medical Center in San Antonio, Texas. Cary joined the staff of the MGH Cardiac Surgical Unit and the faculty of HMS in 1977, and has remained at these institutions for his entire career. He is currently Clinical Professor of Surgery at HMS and Visiting Surgeon at MGH. Cary is known internationally as a consummate technical surgeon and as an expert in valvular, coronary and aortic surgery. His clinical outcomes are such that Cary has become a true “surgeon’s surgeon,” and he is frequently sought out by patients who are themselves discerning leaders in our society. A member of all the most prestigious surgical societies, Cary has served in leadership positions on many aspects of cardiac surgical practice, particularly in the area heart valve function. He has received many honors for his work, and has served frequently as an invited visiting professor worldwide, most recently being invited to give the upcoming John Kirklin Lecture at the Mayo Clinic. Not as widely known as his surgical accomplishments are his talents as an artist specializing in oil painting of sunsets and seascapes.) ♦

