Reflections from the Chief

The new academic year is upon us with nine new interns already well entrenched in this special year with the steepest learning curve of their lives. I’m happy to report they are living up to their “best of show” billing and doing a great job, as are all of our residents and fellows who stepped up a year with the passing of July 1.

The Department continues to thrive with a “few comings and very few goings.” This is reflected by the impressive list of those who will be recognized at this year’s Ether Day ceremony, including names like Paul Russell – 70 years, Bill Daggett – 60 years, Andy Warshaw – 55 years, and David Rattner – 40 years. It is little wonder, with such giants walking the halls, providing valuable institutional memory, that the MGH and the Department are so strong.

As we wrap up the Surgical Society Newsletter, now in its 19th year of existence, please note the final article recognizing a time of transition, as Bill Daggett steps down as co-editor after 10 years (2008 – 2018), serving with his good friend and colleague Les Ottinger. His retirement gave me the opportunity to reflect on the history of this newsletter, which was first published in the fall of 2000 with William Abbott as the first editor. Bill quickly passed the responsibilities on to Jack Burke and Rob Rutledge who served as co-editors until Les and subsequently Bill took over in 2007 and 2008. Bill’s devotion to the newsletter is very special and he leaves big shoes to fill. Although the newsletter has made great progress over the last decade, we need to revitalize and modernize the process including utilizing electronic distribution. Thus, we need your help! Please send me your email address (MGHSurgSoc@Partners.org) and also note if you’d be willing to try to help us update both the mail and electronic addresses of those we have lost track of over the years.

As we hope to see you in Boston this year for the Annual Alumni reception held at the Westin Waterfront Hotel during the ACS meeting. If you have not been in Boston for a few years, you will not believe the growth that has taken place in the beautiful Seaport District of the city. Also feel free to stop by the MGH when you’re in town. Just let us know when you’re coming. See you in Boston in October.

Keith D. Lillemoe, Surgeon-in-Chief
Chair, Department of Surgery, Massachusetts General Hospital
Articles

David and Goliath: Return of the Humble Tourniquet

By David R. King, MD FACS

In the early years of the Global War on Terror, U.S. military personnel were dying from limb exsanguination before they could reach medical care. Improvised tourniquets were universally failing, and, as science would later confirm, improvisation rarely results in arterial inflow occlusion to the limb. In short order, however, the acute need for prehospital limb hemorrhage control was answered by ubiquitous distribution and training in the use of the humble tourniquet, which had been newly re-engineered for the battlefield. After these measures were instituted, the number of soldiers dying from their wounds owing to extremity hemorrhage plummeted. I personally bore witness to this evolution in combat casualty care of limb hemorrhage during multiple deployments in the Global War on Terror, as a combat surgeon with the U.S. Army. After returning from a tour of duty in Iraq in 2008, I gave my first lecture to our emergency medicine colleagues at MGH, imploring them to understand the necessity of the purpose-made tourniquet, of knowing how to use one, and of the importance of stocking them in the Emergency Department. Fortunately, my efforts succeeded in convincing them, and commercial purpose-made tourniquets started appearing...
in our MGH Emergency Department, a decision that paid handsomely during the Boston Marathon bombing. After subsequent battlefield tours, I returned home with renewed enthusiasm for the widespread distribution of tourniquets and universal training. I undertook this as a true grass-roots movement. I had no grant support. No personnel. No money. It was just me. I simply started educating anyone who was willing to listen, including professional medical first responders, firefighters, nurses, even the non-medical lay public.

The Boston Marathon bombing in 2013 highlighted the need for professional emergency medical services (EMS) workers to have and to know how to use a commercial tourniquet. Sadly, of the 66 patients with severe limb injuries on Boylston Street that day, only one arrived at the ED with a purpose-made tourniquet in place: all others were improvised. I started a campaign with Boston EMS to encourage them to acquire purpose-made tourniquets and train their first responders in tourniquet technique. Although it took nearly two years, all Boston EMS responders now carry commercial tourniquets and know how to use them.

Later that year (2013), the Sandy Hook shooting rocked America. The senseless deaths caused by this tragedy resulted in the creation of the Hartford Consensus, a think-tank made up of medical professionals, law enforcement, emergency responders, and other interested parties. This group examined all mass shootings and mass casualty events over the past several decades with an eye toward identifying strategies to mitigate preventable deaths. One such outcome was the mandate that an aggressive limb hemorrhage control posture be adopted nationally, similar to the military’s approach.

Curious to know whether this was a widespread problem, I did some research, and later wrote a follow-up paper revealing an absolute lack of universal training and tourniquet availability for EMS agencies across the U.S. This helped spur awareness and change on a national level. Other surgeon-leaders across the nation also volunteered to support this effort in their respective states.

As a member of the Hartford Consensus in 2015, I felt passionately that I should lead by example, particularly as it related to school violence. Consequently, I educated, trained, and equipped with tourniquets every teacher, administrator, and aid at my children’s elementary school in the North End of Boston, creating the first Hartford Consensus compliant school in the country...and published my experience. This resulted in hundreds of requests for training from every region of Massachusetts and the country.

A combat surgeon in the U.S. Army, Dr. King served two tours of duty in Iraq and Afghanistan, and continues to serve in the U.S. Army Reserve.

In keeping with the need to lead by example, I approached the Ladies Visiting Committee at MGH for a grant to take my experience at my children’s elementary school and bring it to MGH. My grant request was approved and I began enlisting help from interested and invested parties, such as our Center for Disaster Management, to begin training the MGH Police and Security teams. We then offered training for all MGH employees at large. Finally, we equipped every automated external defibrillator location at MGH with a bleeding control kit that included a tourniquet.

To date, hundreds upon hundreds of MGH personnel have received bleeding control training. This has expanded to other MGH facilities, including the administrative offices at Assembly Square and others. The effort has culminated in MGH becoming the first Hartford Consensus compliant hospital in Massachusetts, a model I hope other hospitals will emulate throughout the state. Other states are already following this example.

The humble tourniquet...a device so simple and so inexpensive, battling its way through military, political, and civilian bureaucracy to create an environment where no one should die from a preventable cause of death: limb hemorrhage.

It was a true battle of David and Goliath...and David won.
References


Editor's note: David R. King is an Associate Professor of Surgery at Harvard and an attending surgeon in the Trauma Center at the MGH. He was born in Woonsocket, RI and graduated in 2000 from the University of Miami Miller School of Medicine. His training in general surgery was at the Beth Israel-Deaconess and University of Miami and in trauma care at the Jackson Memorial Hospital. He has had extensive experience as a Combat Surgeon with the U. S. Army.

MGH Lung Transplant Program

Mauricio Villavicencio-Theoduloz, MD MBA

Surgical Director of Lung Transplantation and ECMO

Being a lung transplant surgeon today is an exciting occupation. Once the poor relation of solid organ transplantation, lung transplantation has undergone an impressive turnaround in the past decade. In 2016, 2,345 transplants were performed in the U.S., the largest annual volume ever recorded. Over the past decade, the absolute number of transplants has increased continuously as well, from about 1,500 in 2006 to current values. This increase is mainly due to the rise in volume of double lung transplants, while single lung transplant volume has remained steady. The survival of double lung recipients now surpasses that of single recipients for all etiologies of advanced respiratory failure, including restrictive lung disease, leading to increased referrals. Listings for lung transplantation have soared from 1,500 in 2006, to 2,500 in 2016, greater than for all other organs.

The passion of the MGH Lung Transplant Team for the treatment of advanced lung disease mirrors this impressive progress. The team has grown to its present configuration of 5 dedicated pulmonologists, 3 cardiothoracic surgeons, 5 nurse practitioners, 4 nurse coordinators, social workers, physical therapists, nutritionists, and fellows/residents, all contributing to patient care. The volume of the program has tripled (Fig. 1) owing to important initiatives, such as ex vivo portable normothermic lung perfusion (EVLP), donation after circulatory death (DCD), aggressive donor management, extracorporeal membrane oxygenation (ECMO) bridge-to-transplant strategies, expansion of recipient indications, innovative surgical approaches, and more.
Ex Vivo Lung Preservation (EVLP)

For at least 2 decades, the cold storage method has been the standard of care for lung preservation in transplantation. In preparing donor organs for explantation, the lungs are flushed with low potassium dextran in an antegrade fashion via the pulmonary artery, and then in a retrograde manner via the pulmonary veins. The lungs are then surgically retrieved, placed in an ice cooler, transported to the recipient site, and subsequently transplanted. This is an inexpensive and highly effective way of preserving the lungs for transplantation, but is not without flaw. First, the risk of primary graft dysfunction (PGD), which occurs secondary to ischemia and other factors that result in pulmonary edema, low oxygenation, and diffuse infiltrates on chest X-ray after transplantation, remains high. PGD is clearly associated with both early and late deaths and is a major cause of morbidity. Second, it does not permit monitoring of lung function during preservation and transportation, rendering the outcome of transplantation uncertain, especially for long distance donors and DCDs.

To overcome these limitations, a portable ex vivo normothermic lung preservation (EVLP) system was introduced in the last decade to advance preservation. The Organ Care System (OCS™) we use at MGH allows lung perfusion with oxygenated blood and mechanical ventilation to continue within a sterile container that encases the lungs during transport from the donor to the recipient site (Fig. 2). More important, it allows continuous monitoring of lung oxygenation (PaO₂/FiO₂ ratio), compliance, airway pressure, vascular resistance, and macroscopic appearance.

The MGH lung transplant program participated in INSPIRE (ClinicalTrials.gov Identifier: NCT00075998), an international multicenter clinical trial designed to evaluate the feasibility of this system. This study compared cold storage preservation to OCS™ in standard criteria lung donors. The results, published in May 2018 in Respiratory Lancet, demonstrated a significant decrease in grade 3 PGD with the portable OCS™, suggesting better clinical lung preservation could be achieved using this system, with minimal lung ischemia.

In addition to improving clinical outcomes, the portable OCS™ is also intended to increase the donor pool. Currently, only 20% of donor organs are considered suitable for lung transplantation in the U.S., which means that 8,000 organs are disposed of every year for various medical or technical reasons. MGH was the second national enroller center for the EXPAND I trial, which evaluated the Transmedics OCS™ device in expanded criteria donors. In this trial, donor lungs with the following characteristics — donation after circulatory death (DCD), PaO₂/FiO₂ ratio ≤ 300 mmHg, expected ischemic time > 6 hours, long distance between donor and recipient, and donor age over 55 — were considered expanded criteria donors, as they normally
would not be utilized in the U.S. Using this approach, donor lungs that had been rejected for an average of 38 previous potential recipients were transplanted in 87% of cases (yield rate) with a 1-year survival of 91%. Furthermore, within the framework of this trial, our team developed a new surgical technique to reduce the ischemic time of the second implanted lung. Previously, the lungs were retrieved en bloc from the OCS™ device. This had the effect of prolonging the time the second implanted lung was exposed to cold ischemia. Since the second lung could not be implanted until the first lung implantation was complete and the contralateral pneumonectomy had been performed, the implantation was delayed by 2 hours. Now our practice is to take the lungs sequentially from the OCS™, continuing to perfuse the second lung until needed, to ensure that both lungs end up with identical cold ischemia times. This innovation in technique, along with the trial results, were presented at the International Society of Heart & Lung Transplantation (ISHLT) meeting in 2018.

Donors after Circulatory Death

Organs donated after circulatory death (DCD) are harvested from individuals with severe neurological injury who do not necessarily meet criteria for brain death, but from whom the family has decided to withdraw life support. When DCD organs are offered to the lung transplant center they come with limited information. Clinicians cannot request chest computed tomography, bronchoscopy, ventilator management, diuresis, or other common maneuvers in these donors because, legally, they have not passed away. Therefore, care is withdrawn, the donor is extubated, blood pressure and saturation drop gradually, and the heart stops after a variable amount of time. (Most lung transplant centers accept organs with up to 60 minutes between extubation and asystole.) Death is certified after 5 minutes. Then lung procurement proceeds as usual. This presents a logistical challenge because the multi-member team, led by a cardiothoracic surgeon, may have to travel long distances to reach the donor site, and donors may not expire within the 60-minute timeframe. Moreover, a mandatory period of warm ischemia must be observed between the time when the blood pressure drops below 70 and the cold flush preservation of the lung begins, rendering the outcome of the lung transplant unpredictable.

This is part of the reason DCD transplantations represent only 2%-4% of total lung transplant volume in the U.S., far behind Australia and the United Kingdom, where approximately 30% and 40%, respectively, of lung transplants from DCD donors are performed. However, with a nationwide policy that enhances DCD utilization, there is potential for greater increases in lung transplantation and minimization of waitlist mortality. In New England, for example, utilization of DCD donors was negligible for lung transplantation in 2015. At the request of our organ procurement organization, New England Donor Services, and for the benefit of our patients, the MGH has made every effort to improve the utilization of DCD donors. Currently, 15% for our lung transplant volume represents organs donated after death. Half of these have been done with EVLP and half with the cold storage method. Our data show that 10-year survival with DCD lung transplants is equivalent at our institution and nationally. While the degree of PGD at time 0 is higher in organs donated after death, they recover quickly by 24, 48 and 72 hours (with no difference in these time frames). Our results were presented at the 2018 meeting of the Society of Thoracic Surgeons and a paper is forthcoming in Annals of Thoracic Surgery.
Donor Management

EVLP and DCD organs are crucial to the effort to increase the donor pool and decrease waitlist mortality (currently 15% per 100 patient-years in the U.S.). However, conventional donor management is a very high yield strategy to keep in mind. A significant percentage of donor organs are rejected because of fluid overload due to the pathophysiological processes associated with resuscitation and brain death. These lungs have complete lower lobe atelectasis, leading to low $\text{PaO}_2/\text{FiO}_2$ ratio (<300 is the conventional threshold). Our policy at the MGH mandates a discussion between the pulmonologist and the surgeon for every single donor to ensure that every effort is made to maximize the utilization of donor organs. Diuresis is ensured with albumin/furosemide, and ventilation recruitment is performed. Open chest surgical recruitment maneuvers, focusing on the lower lobes, and on-site bronchoscopy by the recovery team are performed before rejecting a donor. This strategy has resulted in a dry run rate of 40%, but more importantly, it has decreased our waiting time from more than a year before 2015, to fewer than 60 days presently. According to the Scientific Registry of Transplant Recipients, the MGH transplant rate is 2.2 times higher than expected. Waitlist mortality is 30% lower than anticipated and 250% lower than regional and national rates. Moreover, our program accepts 250% more lung offers compared with the rest of the country. One-year survival is 31% better than the average, as well.

Bridge-to-Transplant

Compared to bridge-to-heart transplantation with ventricular assist devices, bridging strategies for lung transplantation are far less common and more controversial. Mechanical ventilation is the oldest bridging technique but has the problem of deconditioning the patient. In the current era of increased public scrutiny, many centers avoid transplanting sicker patients on mechanical ventilation. In this regard, ECMO has emerged as an alternative for highly selected patients. Via a single cannula right internal jugular approach, young patients can be connected to ECMO and exercise physical therapy while waiting for a transplant. The gas exchange can be so effective that essentially no lung function at all (tidal volumes < 50 mL) can be tolerated. The cystic fibrosis patient depicted in Fig. 3 was transplanted after 38 days on ECMO, the lungs flooded with pus and secretions and essentially no ventilation. The ECMO bridge-to-transplant cases account for 5% of all transplants at the MGH.

Expanded Indications

Approximately, 5%-10% of the recipients transplanted at the MGH have been rejected by other programs.
Our team strives to give patients of last resort a fighting chance to avoid death from respiratory failure. Coronary artery disease is aggressively treated with stenting and/or simultaneous CABG. Patients with previous CABG have received bilateral transplants through bilateral thoracotomies. Scleroderma recipients can be transplanted following a strict feeding protocol. Individuals with asymmetrical chest due to lung disease may undergo donor lung lobectomies.

Recipient Surgery

Ninety-eight percent of the lung transplants performed at the MGH are bilateral, surpassing the worldwide and national trend to perform more bilateral transplants. Furthermore, our data show that bilateral lung transplants demonstrate better survival in comparison with single for the most controversial of etiologies, e.g., interstitial pulmonary fibrosis (Annals of Thoracic Surgery, May 2018). In addition, our data indicate that patients with the severest pulmonary hypertension, highest allocation scores, and youngest age do better with bilateral transplants. Moreover, our team strives to perform many of these transplants off-bypass, as we believe this strategy results in less PGD and bleeding due to the extensive dissection, with severe pulmonary hypertension being the most common exception.

Our team is grateful for the opportunity we have had to support this beautiful endeavor — giving the gift of life to individuals with life-threatening advanced respiratory failure through lung transplantation. We welcome fellows, trainees, and all health care professionals to become part of our team and to learn our discipline with passion. Last but not least, we express our heartfelt thanks to the patients and families for the trust they have placed in our team over the years.

Editor’s note: Mauricio Villavicencio-Theoduloz is an Assistant Professor of Surgery at Harvard Medical School and Surgical Director of the Lung Transplantation and ECMO Program at MGH. Born and educated in Santiago, Chile, he graduated from the Pontificia Universidad Católica School of Medicine in 1997 and received his general surgery and cardiothoracic residency training at the Universidad de Chile. Subsequently, he completed advanced fellowships in Cardiovascular Surgery and Cardiopulmonary Transplantation at the Mayo Clinic; a fellowship in Cardiopulmonary Transplantation at the Freeman Hospital, Newcastle upon Tyne, UK; and a fellowship in Thoracic Transplantation and Assist Devices at Duke University Medical Center.
The Gundersen Clinic began around 1927 when my grandfather, Adolf, three of his surgeon sons, plus four other physicians, adopted the new formal name for their clinic. Several years later, they moved the clinic to a new building and a new location adjacent to the La Crosse Lutheran Hospital in order to achieve expansion and efficiencies. After that move, the Great Depression and WWII severely limited the growth of this institution until the 1950s, when a new generation of doctors, family and otherwise, began to return to the clinic after specialty training. Seven of these new doctors were MGH trained: four surgeons, two orthopedists, and one internist.

At this point, the clinic and adjacent Lutheran Hospital began to grow, the result of the arrival of a new wave of doctors with new training, new ideas, new energy, and an aggressive administration ready to accept new ideas. Advances in medicine and surgery were readily accepted such as open heart surgery, total joint replacements, X-ray, imaging techniques, laboratory improvements, and so on until the present.

Along with the new age came a significant change in institutional management. Increasing size, diversity, and energy gave rise in the 1970s to a change from a partnership to a non-profit service corporation with an elected Board of Directors and President. Of great importance, it was still a physician run organization.

Another significant change came in 1995 when the Gundersen Clinic and the La Crosse Lutheran Hospital merged, and the name changed to Gundersen Health System.

Of course, a number of factors have combined to make this system a growing, successful operation of 540 physicians and 1.2 million outpatient visits (2017). From a surgical point of view, there are two items of special interest: (1) The clinical practice of surgery. The system now (2018) has 17 general and subspecialty surgeons, excluding only organ transplants and severe burns. (2) A five-year surgical residency training program. The program began in the late 1890s with occasional one-at-a-time residents and has slowly expanded since. Currently (2018), there are 15 resident surgeons (three per year).
The surgical residents have requirements for research publications and presentations. They must also participate in formal Quality Improvement and Patient Safety projects to add to the academic nature of the program. It is a popular surgical residency with 487 applicants for the three 2017/2018 positions.

Other vital statistics for 2017-2018:

- 361 Gundersen Health System Associate Staff (Physician Assistants & Nurse Practitioners)
- 7,200 Gundersen Health System total employees (not including Medical and Associate Staff)
- 60 Regional Clinics (covering 21 counties in Wisconsin, Minnesota & Iowa)
- 89 Gundersen Health System peer reviewed publications in 2017

Perhaps the most significant feature of this Midwestern health system is the pride of all those who have contributed to its exponential growth, its quality, teaching, and research components. And, its long-standing dedication to community health continues.

Editor’s note: Erik Gundersen and I (wmd) worked together as surgical residents at both MGH and Boston Children’s Hospital. He was a superb surgeon, even in those early training years. Following his surgical training, he joined the surgical staff at the Gundersen Clinic, where he initiated a cardiac surgical program with excellent results. Now retired from clinical practice, Erik is the Vice President of the Gundersen Medical Foundation. Having been born at the La Crosse Lutheran Hospital, myself, in 1933, and having trained with Erik in Boston, I had a special interest in the growth and development of the Gundersen Health System, which has been substantially aided by the efforts of MGH trained surgeons, as well as other specialties.

Liliana G. Bordeianou MD MPH (General and GI Surgery) received a Partners in Excellence Award in the category of Leadership and Innovation for her role in implementing the Enhanced Recovery After Surgery (ERAS) Pathway in Colorectal Surgery, which has been adopted system-wide by Partners Healthcare.

Susan Miller Briggs MD MPH FACS, Director of the MGH International Trauma and Disaster Institute, has been appointed the inaugural incumbent of the Carmella R. and Steven C. Kletjian Endowed Chair in Global Surgery.

Patricia K. Donahoe MD, Director of the Pediatric Surgical Research Laboratories and Marshall K. Bartlett Distinguished Professor of Surgery at Harvard Medical School, has received the 2018 Gregory F. Pincus Medal from the University of Massachusetts Medical School (UMMS). Her talk on “Protection of Reproductive Function” was given at the annual Pincus Memorial Lecture in April. A year ago, she accepted an honorary degree from UMMS.

(l-r): Chancellor Michael F. Collins, Patricia K. Donahoe MD, and Thoru Pederson PhD.

Richard A. Hodin MD, Chief for Academic Affairs, and Keith D. Lillemoe MD, Chief of Surgery, have received the 2018 Program Award for Culture of Excellence in Mentoring from Harvard Medical School for their leadership of the MGH Department of Surgery Junior Faculty Mentorship Program.

Hiroko Kunitake MD (General and GI Surgery) received the Excellence in Clinical Surgery Award from the 2018 graduating class of Harvard Medical School.

Eric Liao MD PhD (Center for Regenerative Medicine) was one of five recipients selected for the 2018 MGH Research Scholar award. Dr. Liao will receive five years of research support through the Laurie and Mason Tenaglia Foundation.
Keith D. Lillemoe MD, Surgeon in Chief, was awarded the Joseph B. Martin Dean’s Leadership Award for the Advancement of Women Faculty at Harvard Medical School.

Honors and Awards — Residents

Daniel Hashimoto MD MS (research resident) was elected to a 2nd term on the American Association of Medical Colleges (AAMC) Executive Board.

Book Review

The Massachusetts General Hospital Surgical Residency

This carefully crafted little book by Fred Jarrett relates his experiences and explains the details of the MGH surgical training program for the six years beginning in 1967. It will be of great interest to persons who were in the residency during those years and also to members with an interest in the unique rectangular program itself. From the examination for intern applicants to the finishing stages of the senior years, it is rich in the details of resident life, their teachers, and the things that made it a special experience for them.


Also available through Amazon.com

In Memoriam

Janice Plunkett RN, teacher, supervisor, supporter, and friend to five decades of surgery residents, died on May 18, 2018. Born in Dublin, Ireland, she began her 48-year career at MGH in 1970. She worked in all the operating suites of her time; Phillips House, Baker Memorial, White, Gray, and Lunder. As a supervisor, she was especially associated with the East and West Services in the time when each was assigned its own operating rooms.
Janice had a tremendous impact on two generations of surgeons. She was a true advocate for the resident Services, coming to their support when controversies arose with the operating room administration. She worked to protect East and West OR time, making the chief resident’s life more manageable. Similarly, she was an invaluable resource to residents who couldn’t remember the exact details of an attending’s technique that they hoped to reproduce, or the name of some obscure instrument they wished to use. To an attending or program director she was invaluable in recognizing and communicating when a resident might need a little help but hadn’t recognized it him or herself. Most important, Janice was always interested in doing the best she possibly could in her roles as an operating room nurse, supervisor, and administrator. She knew her people well, their abilities, limitations, and proclivities and did her best to make things run as smoothly as possible. This same attention was equally focused on the entire OR staff and, particularly, every patient she encountered. Janice made the MGH OR a wonderful place to work and will surely be missed.

Furthermore, recognizing Ms. Plunkett’s important role in the education of surgery residents provides a chance to discuss the similar contribution of scores of her predecessors. For forty years after Edward D. Churchill returned from the war and until elements of social and regulatory change disrupted the Department educational system, the two Ward Services, the Emergency Ward, and their Clinics and operating spaces formed the core of the surgery residency program. As every intern or first year resident could attest, the head nurses of the wards along with those in the operating rooms assigned to them and the outpatient clinics had an extremely important role in their own education. Though many residents individually expressed their gratitude, the collective contribution of these nurses to meeting the education goals of the General Surgical Program was perhaps never recognized and acknowledged. Surely every former intern recalls vividly the contribution of a first Head Nurse to his or her education. I (L.O.) vividly recall Ms. C. saying, “You are my intern and I am your head nurse. Whatever you want me to do for you I will, and whatever I want you to do for me, you will.” And she did. And I did. And the legendary Mrs. Burns of the Surgical Clinic. She was able to teach us everything we needed to know about patient care, and did so. And Maureen McGrath, Head Nurse on the East Service when I was the Resident. Knowledgeable in nursing and surgical care. Efficiently and quietly organizing the floor and staff for excellence in every aspect of the care of the surgery patient. Calm in any crisis and patient in meeting any challenge. A wonderful teacher and support for patients, nurses, and residents.

Under the Churchill system, residents spent about half of their 60 months on one of these general surgical units or affiliated services. On them, teaching was a shared responsibility. It incorporated visiting surgeons, every resident, and many other staff members, but most especially the nurses who, like Janice Plunkett, led the surgery units.

Contributed by Charles Ferguson and Les Ottinger.

Comment: Janice Plunkett was a wonderful advocate of the ward service, always responsive to our needs and concerns, and as the article states, she “did her best to make things run as smoothly as possible.” A critical cog in the surgical service, she was an unsung hero and house staff savior — Tom Dodson.

With Appreciation

After more than a decade of yeoman’s service, Willard M. (Bill) Daggett has decided to step down as co-editor of the Surgical Society Newsletter, in this, his last issue. Throughout his tenure, he worked tirelessly to unearth many precious memories from the surgical alumni, while imparting his own wisdom, humor, and dedication to surgical education. A graduate of the MGH surgical residency, Bill was a force in cardiac surgery at the pinnacle of his career. A professor of surgery at HMS, his interest in cardiovascular physiology began in the Laboratory of Cardiovascular Physiology at the National Heart Institute in Bethesda. As founder of the MGH Laboratory of Surgical Cardiovascular Physiologic Research, he mentored literally hundreds of surgical trainees during his 50-year career, in addition to fostering innovative research in surgical techniques for heart transplantation and complex cardiac surgical repairs. We are indebted to him for his efforts.