EDITORS' COLUMN

We are pleased to have the opportunity to be co-editors of The Massachusetts General Hospital Surgical Society Newsletter. All of us share a rich heritage because we have been molded by the traditions and unique personality of the Massachusetts General Hospital. Our time at the MGH, whether it was five years or fifty, has been the dominant factor shaping our professional careers. Our experiences here are largely responsible for the standards we set for ourselves. Very few of us would have it any other way.

We plan to publish the “Newsletter” twice a year, spring and fall. Not only will it have news from within, but also will have news by and about outsiders, those of us who no longer are in Boston.

There is an information form on the back page of the Newsletter. Please use it. We want the Newsletter to be informative and entertaining. We want it to strengthen our traditions and deepen our attachments to the MGH. With your help we believe that it will.

Jack Burke
Robb Rutledge

A MESSAGE FROM THE PRESIDENT

It is now more than two years since the first meeting of the MGH Surgical Society and we at the MGH are very much looking forward to the next meeting on June 6-8, 2002. Do save the dates as it promises to be an interesting program at a very exciting time in the history of the MGH.

I should like to take this opportunity to give you an update on some of the happenings at the MGH and also at Partners HealthCare System. Partners is now more than 7 years old, having been founded in March of 1994 by the MGH and BWH. Since that time, we have added the North Shore Medical Center (the Salem and Lynn Union Hospitals), the Newton-Wellesley Hospital and the Faulkner Hospital. We have also created a joint venture with the Dana Farber Cancer Institute, known as Dana Farber/Partners Cancer Care, that encompasses all adult cancer services, clinical trials, and the very successful medical oncology fellowship program. In addition, we have developed a large primary care network of over 1000 primary care physicians.

There is no question in my mind that this is by far the most successful merger of major academic medical centers in this country to date. Essentially all support services have been centralized, including biomedical engineering, community benefit programs, development, finance, human resources, information systems, legal, materials management, medical records, real estate and facilities, telecommunications and treasury. This has resulted in substantial savings and a very successful combined investment program. Integration of a few clinical services has occurred and quite a number of residencies and fellowships have integrated. However, except in a few instances, the general philosophy of Partners has been to not mandate integration but to encourage cooperation and collegiality as well as enhancement of quality of care. MGH Surgery has followed this latter course.

Very importantly, over the past year we have been able to negotiate extremely favorable contracts with our three major non-government insurance carriers – Blue Cross Blue Shield, Tufts Health Plan and Harvard Pilgrim HealthCare. Clearly, the market clout of Partners as the dominant health care provider in this region has been key in achieving the major improvements in the level of payments to the Partners hospitals and physicians. This will now allow Partners hospitals to receive fair payment to cover their legitimate costs and will also significantly increase Partners physicians’ fees after many years of flat physician payments (continued on page 6)
REFLECTIONS ON A HAPPY ACCIDENT

There will be a symmetry to this writing, four quadrants - serious and less serious, and on the opposite axis, in-loop and out-of-the loop; the latter due to my two editors, apparently I must get past both of them.

Serious because a fellow physician, luncheon partner, and long time friend dropped dead while getting out of a taxi at the airport last week, not a bad way to do it, but a reminder to say some things before, on some sunny afternoon, it is too late.

It has always been a source of enormous pride that I was once a part of the distinct and different world that is the MGH. I have always had the feeling that I did not really deserve to be there, that it was some sort of happy accident. First of all I came late to HMS, entering the third year, I was quickly and completely accepted - I think mostly due to my very handsome wife - nevertheless I belonged; although I still wish they would not have referred to me as a metastasis. I then did a bit of research with Francis Moore, and Arthur Ellison - a fellow patient-subject, well-informed, savvy, a fully credentialed class member - who advised me, "Jack, if you ever get a shot at the MGH, for God's sake, take it!" We recruit football players the same way out here at Ohio State. Dumb, but willing to pay attention.

And not an inconsequential part either. Every dog has his day. Among other things a Mr. Bird was the first patient to survive a ruptured aortic abdominal aneurysm at the MGH, I happened to be the surgeon, Robert Linton and Hawk Shaw notwithstanding. Clem Darling couldn't believe it either when he stumbled across it. The truth of the matter is that it could have been any one in a white suit. It is the glory of the MGH that as quickly as Kurt Isselbacher made the diagnosis, there was in place a mechanism for that event to occur and to be successful. Dr. Linton was delighted if somewhat disappointed. I had been across the table from him several earlier times when he had tried. I knew exactly what was expected of me. For the rest of my professional life it has never been any different. That is what I mean by the place of pride that the MGH holds in my heart.

I wish to skip over the professional years, the long wonderful partnership with Walter Haynes, the medical school association, the rehabilitation of an inner city hospital, or medical politics, to speak perhaps not too wisely but seriously about 'retirement'.

It is a simple matter to save up for retirement. First of all, don't get divorced. Some people do it two or three times, I will admit it gets cheaper each time you do it. Calculate how much to save to retire comfortably then double it.

Don't retire until you are willing to give up who you were for who you are. I have been retired for ten years and nobody has paid any attention to anything I have said since the Friday night of the first week. Some of the younger grandchildren fake like they are, but they are not. It has its benefits, for example when you are driving and someone gets irritated and lays all over the horn, the proper move is to give an Alzheimer's stare out the window as they zoom past. If you are lucky the guy's wife is giving him hell as they go by for 'being so mean to that old man'.

As soon as you retire, move out of town (this does not apply to in-the-loops, they never leave Boston, and never should). Those motor home campgrounds can be real mean for someone who has always led a sheltered existence. And as Dorothy Parker is said to have remarked about Oakland, there is no 'there' there. Stay put. We like to come to visit. You are already there. You have to be understated and nice, there are few places left where that works.

Get a dog. The dog doesn't give a damn if you're retired or not, as a matter of fact he prefers it that way. Get two dogs. Have puppies.

Buy a large place. The good news is we have a hundred acres of forest, some second growth, some prairie filled with wildflowers, and six acres of lawn; filled with deer, wild turkeys, coyotes, rascoons, fox, bluebirds, and requiring a full time gamekeeper. The bad news is I am the full time gamekeeper. Or as Clem Hiebert says, he is running a hundred acre amusement park for his grandchildren.

There has been some notice that I have written two short novels. Don't do it. Editors and publishers have the opinion that writers have no feelings. We are not dealing with Arnold Relman here. These people are mean. They insist that you remove two chapters and add a third. Like asking you to remove a piece of your own liver.

Go to all of the Ohio State football games. Get a sense of the sounds of Rome when the mob was in full cry.

We have an abundance of quality time together, more than we ever had earlier. In the winter we sit and talk in front of a huge blazing fire, burning wood we have cut and split and stacked, and in warmer weather we sit on the porch and watch the evening creep up the valley. Small bats flit from the woods over the grassland and we hear the tiny sad call of a screech owl, reminding us once again of how much everything on the planet wants to live and raise its young.

I write a letter to my grandchildren every week and I copy Walter Haynes, Clem Hiebert, Giles Toll, Helen's siblings, and some other friends. I have done this for five or six years, starting when my son went to Alaska for three years. It contains photographs, gossip, unsolicited advice (ignored), stories, opinions, as well as feedback from the participants. It is actually a diary of the passing years. It is extremely easy with today's printers and scanners. What it makes is an archive much treasured by my children. I strongly recommend it. It does take time. Time, finally, is what I have. That and everywhere I go in town and in the country, people call me by my first name.

Jack Tetirick

(Editors' note: Jack Tetirick went through the MGH Surgical Residency Program from 1951 to 1956. In 1990 he retired after a long rewarding career in Columbus, Ohio, during which he rehabilitated an inner city hospital and was a clinical assistant professor of surgery at Ohio State University, in addition to his large clinical practice. He and Helen have been married 53 years, have three children and seven grandchildren. They live on 100 acres of forest in Zanesfield, Ohio.)
THE ETHER DOME

The first public demonstration of ether anesthesia on October 16, 1846 transformed the Massachusetts General Hospital (MGH) from a good New England hospital to a hospital of international renown — a position it has never relinquished. The site of this amazing success is now called the Ether Dome. It was designated a National Historic Site in 1965 and has an interesting history of its own.

Construction: The MGH received its charter from the Massachusetts legislature in 1811. The cornerstone was laid on July 4, 1818 and the hospital was ready for patients on September 1, 1821. Charles Bulfinch, Boston’s preeminent architect, was in charge although Alexander Parris completed the job after Bulfinch was called to Washington to design the nation’s Capitol.

The hospital was built of white Chelmsford granite and cost only $70,000 because all of the stone work was done by convict labor at the Charlestown state prison. Bulfinch put the operating amphitheater on the fourth floor just under the glass dome to utilize natural lighting and to isolate the screams of preanesthetic surgical patients from the rest of the hospital. The amphitheater seating consisted of seven rows of tiered white wooden benches that surrounded about 180° of the operating table. The benches were so close together that most viewers stood rather than sit, because there was no legroom.

Early operations: The first MGH patient was admitted to the medical service of Dr. James Jackson on September 1, because of far advanced syphilis that caused his death the following May. The second patient was admitted on September 20 to the surgical service of Dr. John Collins Warren. The next day Warren performed the first operation in the operating amphitheater. The patient had prolapsed hemorrhoids that were ligated and excised. He did well and was discharged cured on October 20!

After the first six months, Warren reported to the trustees that he had so far performed three capital operations and four of less importance. The three major operations were a lithotomy for a patient with bladder stones, a ligation of the superficial femoral artery for a patient with a popliteal artery aneurysm, and an amputation for a patient with a crushed leg. The first two patients did well, but the third did not survive. Besides the original patient with prolapsed hemorrhoids, the other minor operations were for patients with a fistula, phimosis, and wen.

“Visitors”: Through the years the old operating amphitheater has had three “visitors” that have become permanent and contribute to its lore.

The first of these is an Egyptian mummy that arrived on May 4, 1823 from Thebes, a gift from Mr. Van Lennep, a merchant from Smyrna. His agents gave it to the MGH out of respect for the hospital as an outstanding public establishment. This was one of the earliest Egyptian mummies to arrive in America. The mummy was closely examined by Dr. Warren and found to be in excellent condition. It was loaned for several fundraising exhibitions, but otherwise was kept in the operating amphitheater.

Very little happened until 1931 when Dr. E. D. Churchill became interested and x-rayed him. This was done again more completely by Dr. Jack Dreyfuss in 1976. The most striking finding was a loss of his cervical vertebrae. In 1960 the hieroglyphics on his wooden coffin were translated by Dows Dunham from the Museum of Fine Arts, who believed that the mummy was from the 26th Dynasty (663-525 BC), was about 40 years old when he died, and was named Padhiershef. No guess could be made as to his occupation.

The second “visitor” is a statue of the Greek god Apollo. The statue was cast in 525 BC), was about 40 years old when he died, and was named Padhiershef. No guess could be made as to his occupation.

The third “visitor” is the skeleton that was used to teach anatomy. Details are not clear as to its history but old pictures show that it was there a long time.

The Other Ether Day: Although October 16, 1846 deserves to be called Ether Day because it was the first public use of ether anesthesia, many questions were raised and few were answered by that demonstration. The operation was minor, the result was equivocal, and Morton’s agent was a secret. Three weeks later Morton had admitted that his agent was only ether.

On Saturday, November 7, the Dome’s operating room was packed with anticipation as the first two major operations using the new ether method were to be performed. George Hayward amputated a patient’s leg, and then John Collins Warren resected a patient’s mandible. Both procedures were a total success. The tension and the excitement that were palpable in the operating room that morning have rarely, if ever, been matched. November 7 was truly the “Other Ether Day”.

The Rise of Surgery: After the successful introduction of ether anesthesia, surgical operations increased. The new East and West wings were opened in 1846 and 1847, and the East and West surgical services were born. The bed capacity increased from 93 to 141, and the number of operations increased from about 5 per month to about 15 per month. There were many septic problems until antisepic and aseptic techniques were used. Most of the operations were done on Saturday in the Dome, but some emergency operations were done in the “Bathroom” on the first floor, so named because it had the only (continued on page 7)
THE ACCIDENT happened on Saturday afternoon, August 31, 1974 — Labor Day weekend. The place: the southbound lane of the Maine Turnpike, a quarter of the way down a long hill two miles from the Gray Exit. A Dodge station wagon swerved onto the grass of the median strip, veered across the road, mounted a sandy berm and flipped over.

In the curtained booth, third from the left, in the EW of the Maine Medical Center a physician was about to examine one of the two victims. “Where are you from?” he asked.

“Boston.”

“What do you do?”

“I’m a surgeon,” replied the man with the bloody face.

“What did you say your name was?”

“Linton.”

A surgical resident overheard the exchange. “I’ll take care of him,” he said.

I was in the garden when the phone rang. It took twenty minutes to be at the side of the Lintons, she with a broken jaw and he with fractures of the right zygoma, maxilla, left humerus, left 7th rib, and left index finger. Blood trickled from his nostrils and from numerous lacerations about the face and scalp. Both patients were oriented and alert. Pupils were equal. Vital signs were normal. Dr. Linton’s abdomen was minimally tender and guarded. I remembered that he had asthma, severe osteoporosis and was steroid dependent.

Abdominal sonography and other scans being unavailable in 1974 it was likely that, once serious intracranial injury were ruled out, an exploratory laparotomy would be in order. The question was where? Orthopedic, dental, plastic and medical services would be involved. The MGH was surely the proper place for optimal attention, but, ironically, had his spleen been smashed or if there were a tear in a hollow viscus he might very well die on the way down a long hill two miles from the Gray Exit. A Dodge station wagon swerved onto the grass of the median strip, veered across the road, mounted a sandy berm and flipped over.

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The turnpike section where the accident occurred is five minutes away from our home. I frequently go that way coming or going to Portland. The gouges made by the careening Dodge wagon on that fateful summer afternoon lasted until the winter snows had come and gone.

Clem Hiebert
Clem Hiebert went through the MGH Surgical Residency from 1951-1956. Following retirement he has maintained his busy and productive travel, lecture and writing schedule from his palatial residence in North Windham, Maine.

Alumni Awards and Honors
Dr. John F. Burke was made an Honorary Fellow of the Royal College of Surgeons, (England) in London in January 2001.
Dr. Francisco G. Cigarroa ’91, now a pediatric and transplant surgeon in San Antonio, was named the third president of the University of Texas Health Science Center in San Antonio in 2000.
Dr. William W. L. Glenn ’46. The William W. L. Glenn Chair in Cardio Thoracic Surgery was created at Yale University in 2000.
Dr. Rudy Herrera ’47 has retired as dean of the medical school in Guatemala. He is still active and was decorated by France with the Legion of Honor.
Dr. Jesse E. Thompson ’48 received the Distinguished Service Award from the Society of Vascular Surgery in June 2001. He is the fourth recipient following Drs. Richard Warren, Michael DeBakey, and Emerick Szilogyi.
The Department – 1999-2002

MGH Surgery is in the midst of an exciting growth spurt – new programs, both at home and at our community affiliations, new leaders, and new young staff with fresh ideas and talent in every division.

With the establishment of the Weight Center, a joint venture of surgery, medicine and pediatrics, the surgical treatment of obesity by gastric bypass has grown in just over a year to more than 120 cases/year, an increasing number now being performed laparoscopically. David Rattner, the Chief of General Surgery, is designing an “OR of the future” and guiding the development of new minimally invasive tools under the aegis of CIMIT (The Center for Innovative Minimally Invasive Therapy). Richard Hodin, a funded investigator of intestinal epithelial cell biology has joined us from the BJ/Deaconess to head the Surgical Inflammatory Disease Program. He also brings minimally invasive techniques for endocrine surgery. Sarah Thayer, our immediate past chief resident, is staying on to boost the search for molecular genetic insights into pancreatic cancer.

Ken Tanabe, new Chief of Surgical Oncology, has recruited James Cusack from the University of North Carolina and Kevin Hughes from the Lahey Clinic. Jim’s research interest is on the inhibition of NF-kappa B and promotion of apoptosis to control cancer growth and enhance sensitivity to chemoradiation. With a focus on advanced colorectal cancer, he has initiated clinical trials to test the efficacy of a novel super-repressor of NF-kappa B. Kevin heads the MGH Breast Screening Clinic and the Center for Cancer Risk Analysis, as well as leading clinical trials for breast cancer treatment. The Surgical Oncology laboratories on Jackson 9 are being completely rebuilt in collaboration with Medical Oncology.

David Torchiana, two years into his role as Chief of Cardiac Surgery, is using the Zeus robot to perform coronary artery bypass operations. He is the P.I. of a multicenter trial to test safety and efficacy of robotic internal mammary artery mobilization. Arvind Agnihotri joined the division last year with a principal focus on developing an outcomes research program. Jennifer Walker, a recent recruit, has special interests in congenital heart disease and in bioengineering heart valves from pericardium. The group is preparing to open a satellite cardiac surgery program at North Shore Medical Center (Salem Hospital) in 2002.

The Trauma/Surgical Critical Care Program has been enlarged with the addition of Horacio Hojman from the University of Massachusetts and Ruben Peralta, a graduate of our Critical Care Fellowship. They are working together to develop a simulator for training in the emergency management of trauma victims. Under Rob Sheridan, newly appointed Clinical Director of Trauma and Surgical Critical Care, we now have three dedicated full-time trauma faculty members, for the first time sufficient to provide continuous attending care and supervision for trauma patients, as well as expansion of surgical presence in the ICU’s. Ruben also provides surgical consultation at the MGH Chelsea Health Clinic. A multi-departmental leadership group has been working on a plan for combining resources to improve clinical coordination and promote trauma-related research.

Pediatric Surgery under Patricia Donahoe (recently elected to the National Academy of Sciences) has been building out pediatric surgical services at Newton-Wellesley Hospital (where Division member Dan Ryan has been named Chief) and North Shore in conjunction with the new MassGeneral Hospital for Children. David Lawlor has joined the clinical effort from Halifax, and another recruitment is in the works. Jay Vacanti, who came from Children’s Hospital to head the tissue engineering and pediatric liver transplant programs, is spending his free moments overseeing the 2-million dollar reengineering of the surgical laboratories on Wellman 6.

Henning Gaissert has been recruited from Brown to head Thoracic Surgery at the Newton-Wellesley Hospital and to develop laparoscopic esophagectomy at the MGH. Henning also is working with the MGH Clinical Research Program to create an outcomes research database which will link the MGH and its community affiliates. James Allan, based in part at the North Shore Medical Center, spends half his time at our Department’s Transplantation Biology Research Center working on overcoming chronic rejection of the transplanted lung.

The Transplantation division, working in conjunction with the renal transplant program at the Brigham, has added John Powelson and William Goggins, who divide their time between the two hospitals. The split (cadaver) liver and living-donor liver transplant numbers are rising and will likely be the main contributors to growth in the future. We are currently searching for more help here. Pancreatic islet cell transplantation will be resumed shortly as a facet of a major program to cure diabetes.

Jonathan Winograd, who trained in Plastic Surgery at Hopkins and was a fellow in hand and microvascular surgery at Washington University at St. Louis, has a clinical and investigative interest in nerve injury and repair. He will work under Jay Vacanti in the neural regeneration project.

Along with cardiology, neurology, interventional radiology and the relevant surgical disciplines, Vascular Surgery is in active discussion and planning of the rapidly evolving new directions for the collaborative management of vascular diseases. Endovascular therapies and device development, modifiers of the endothelial and vascular smooth muscle response, and gene therapy will radically change the practice of vascular surgery. Recruitment is under way for a surgeon proficient in endovascular techniques, and there is a perceived need for a basic research-oriented vascular surgeon within a year.


The Department is looking forward to hosting you at the MGH Surgical Society Reunion next June. With the hospital full and the growth of the staff, plan to come early if you hope to find a parking space.

Andy Warshaw

BOOKS RECENTLY PUBLISHED

- William V. McDermott
- Doctors Afield and Afar
- William L. Bauhan, 2000
- Jack E. Tetirick
- Callahan’s Way
- Writers Club Press, 2000
- The Wind is my Messenger
- Writers Club Press, 2000
- W. Sterling Edwards
- What Does my Life Mean? 2000
in Massachusetts. I should add that we have decreased our exposure to full risk capitated contracts, and we believe that this will also be financially helpful to our hospitals and our physicians.

The MGH can only be described as doing extraordinarily well. Our patient admissions from FY1996 to FY2000 have increased by 20.2% to a total of 40,747 admissions in FY2000. In the early and mid-1990’s the MGH decreased its bed capacity significantly to approximately 780 beds. As our admissions have continued to increase, we have expanded our bed capacity to the present number of 868 beds. Over the next six months, we will open 30 additional beds and will have about 900 beds at that time. At that point we will have exhausted all of the inpatient space available. Over the same four-year period from 1996 to 2000, the operative volume at the MGH has gone up 10.3% to 31,446 cases in FY2000. The outpatient volume has increased even more over the past few years, going up at the rate of 5-10% per year.

We simply do not have enough ambulatory space at the MGH and, in addition, our ambulatory care services and testing facilities are scattered throughout the hospital complex. I am happy to report that the MGH is embarking on a major building program for outpatient services. We plan to construct three new ambulatory care buildings with total space of about 420,000 square feet at a cost of something over $300 million dollars. The first phase will be built on the former Charles St. Jail site and will include an underground parking garage for approximately 720 cars and two buildings. The first building, with 170,000 square feet of space, will house cardiac services, women’s health, pediatrics, and musculoskeletal care. The other building will have about 90,000 square feet of space for our cancer program. Phase One began in June of this year and will be completed in 2004. At that time, Phase Two will begin by demolishing the Vincent Burnham and Clinics buildings and then a 160,000 square foot building will be erected in the vacated space. This building will include 16 new large, state-of-the-art ambulatory operating rooms on the third and fourth floors. Additional ambulatory care activities will occupy the remainder of the building. This Phase Two construction will allow a new separate entrance to the emergency department for ambulances and an enlarged White Building front entrance.

In recent years, the MGH has been fortunate to have done quite well financially. In FY2000 the MGH had a gain from operations of $24 million dollars and excess of revenues over expenses (including investments, other income and gifts) of $123.4 million. In FY2001, which ends on September 30, 2001 it is likely that the MGH will do even better in terms of operating income than in FY2000.

The MGH research program is also flourishing. From FY1996 to FY2000, the NIH awards to the MGH increased by 64.2% to a level of $180,539,000 in FY2000. This makes the MGH the number one ranked recipient of NIH awards for independent hospitals for FY2000. Indeed, the MGH has held this ranking for a number of years. In FY2000 the MGH total research expenditures (from NIH, other federal government agencies, industry, endowments, philanthropy and foundations) was $278,388,000. The MGH training programs continue to be among the nation’s most sought after graduate medical training opportunities.

Of course, there are many challenges facing medicine today, and the situation in Massachusetts is no exception. However, the MGH seems to be coping pretty well and I am very optimistic about the future of the MGH and its professional staff.

Jerry Austen
of physicians of the time of the anesthesia discovery.

A major renovation of the Ether Dome was undertaken for the 150th anniversary celebration. Current audiovisual equipment is in place for the conferences. New light fixtures, motorized louveres, and a complete refurbishing inside and out make the Ether Dome a sight to behold.

Future: What is next for the Ether Dome? A new 10X7 foot mural that will hang on the open north wall. The mural is a gift to the MGH from the chiefs of service and the other physicians in the hospital, and is being painted by Warren Prosperi. It is to be historically accurate, unlike the famous Hinckley painting, "The First Operation Under Ether", that hangs in the Countway Library. The new painting will be unveiled on Ether Day, October 16, 2001. It will be exciting to see. The Ether Dome doesn’t stand still.

Acknowledgment – The author is grateful to Jeffrey Mifflin, the archivist and curator of special collections at the MGH for his help and advice.

EDWARD GILBERT ABBOTT

Much has been written about Ether Day but very little of it is about the patient, Edward Gilbert Abbott, known to us as Gilbert Abbott. He was born in Cambridgeport, Massachusetts on September 2, 1825. He had no siblings. Both of his parents died of phthisis in their early 30s when Gilbert was six or seven. He was a sickly youth, raised by guardians and apprenticed to a printer.

According to John Collins Warren’s notes, he first saw Abbott for a cervical vascular tumor on September 7, 1846. Abbott had a large congenital arteriovenous malformation involving his left upper neck, tongue, and floor of the mouth. The indication for surgery at that time was not clear, but he became the willing subject for the first public ether trial on October 16. Warren made no attempt to excise the mass. Through a three to four inch left cervical incision he undersewed its base with silk ligatures passed on a curved needle. The incision was apparently left at least partially open and covered with a lint compression dressing.

There were no specific postoperative problems and Abbott was discharged on December 7, his 52nd postoperative day. The final progress note mentions that the incision was well healed, and that the arteriovenous malformation had regained its preoperative size, although with fewer visible vessels. His total hospital stay was 74 days, not unusual then for someone in poor health, but unallowable now with our current managed care.

After his recovery Abbott worked as a journalist and printer in New York City, Philadelphia, and Worcester. He married in 1850, and he and his wife, Mary, settled in Malden and had two children. Back in the Boston area he became an assistant editor of the Boston Herald and then the proprietor and editor of the Cambridge Mercury. His health deteriorated, and he died of consumption on November 27, 1855, when he was only 30 years old.

John Collins Warren died at 77 years the following May. There is no record of any communication between the famous surgeon and his patient after Abbott’s discharge from the hospital back in 1846.

There are no known photographs of Abbott. On December 1, 1855, the Boston Herald ran the following brief report of this death:

Death of a printer: Edward G. Abbott, well known as a printer and editor, died at Maplewood, Malden, on Tuesday of consumption. He was 30 years of age and leaves a widow and two children.

No mention was made of Gilbert Abbott’s role in the introduction of ether anesthesia, a far cry from the media attention he would have received today.

Robb Rutledge
INFORMATION FORM
FALL 2001 NEWSLETTER

Name _______________________________________
Address ____________________________________________
E-mail _____________________________________________

Request for honors, comments, personal notes, anecdotes, current activities, suggestions, etc.
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