John Jones Surgical Society 2007 Symposium: Dick Edie, Dave Carberry, Lou Del Guercio, Jack Jacobson, Sherman Bull, Craig Smith, and John Schullinger listening to a question from the floor with varying intensity.

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Surgical residents enjoying lunch Alex Iribarne, Keith Kaenzler (faculty), Ryan Davies, Brian Cohen, Audrey Rosinberg, and Amanda Powers

John Jones Surgical Society opens its doors to medical students

Warren Widmann

Prashant Sinha, Chief Surgical Resident

Bob Smith and Bob Mulcare

Soji Oluwolé and Hector DePaz

Jean Emond and Benjamin Samstein

Herbert Mendel, Anne Larkin and Carey Dolgin

Gabriel Toma, (Post Doctoral Research Scientist) with Maurizio Miglietta

Steve Novak and Marianne Wolfe

Spencer Amory

Alan Benvenisty and Ruth Hardy

Charlie Stolar
John Jones Surgical Society Day
At The New York-Presbyterian Hospital/Columbia Campus


May 18, 2007

The day began with breakfast in the Faculty Club and opportunities to tour Morgan Stanley Children’s Hospital or the Surgical Department’s laboratories, try your hand in the Skills Laboratory, observe procedures in the operating room, or see a display of exceptionally well-illustrated 15th to 19th century surgical and anatomical texts. All were lightly attended, suggesting that next year’s advance program should better define what each selection will involve, for example, visits to whose laboratories focused on what, and scheduling an unusual or innovative surgical procedure like NOTES (Natural Orifice Trans-Endoscopic Surgery) that could be projected on a large monitor and still allow discourse between the operator and the observers.

A lovely lunch in the Club really kicked off the day with a welcome by Craig Smith, Acting Chair of the Department and Eric Rose describing his enlightened sabbatical as Chief Executive Officer of a company focused on the “Development of Small Pox Anti-viral Drugs.” We then moved across 168th Street and Fort Washington Avenue to the Julius and Armand Hammer Health Sciences Center auditorium for an excellent afternoon program entitled “Where We Have Been and Where We Are Going” moderated by its principal designer, José Guillem, Professor of Surgery at Memorial Sloan-Kettering and JJSS Program Committee Chair. President Ken Forde then held a brief business meeting, at which revision of the Society’s Bylaws were unanimously approved. Appreciation was expressed to John Schullinger for the fine work of his committee. The meeting ended just in time for everyone to get to the dinner party at the spectacularly situated Terrace in The Sky.

Development of Small Pox Anti-viral Drugs

Eric A. Rose, Morris and Rose Milstein and Johnson & Johnson Professor of Surgery, Columbia University

The Greek historian Thucydides chronicled a pustular disease outbreak during the Peloponnesian War in the fifth century BC, noting that a person who contracted the disease and survived was called “fortunate and happy,” since he could never get it again. Smallpox was a devastating disease in various places throughout the world for millennia, primarily affecting children and young adults. It had a lethality rate of 30% and was highly contagious, commonly infecting other family members. The virus was spread primarily by saliva droplets and was most contagious immediately after its 10- to 14-day incubation period, when sores developed in the mouth and throat, which broke down, shedding large amounts of virus. A papular skin rash followed, spreading from the face to cover the body within 24 hours, signaling a massive viremia that is now known to have potentially caused focal infections in the intestines, lungs, kidneys, and brain, as well as the obvious skin lesions. The papules turned into pustules and eventually sloughed their spines, accounting for their typical umbilicated appearance. The shed virus persisted on clothing and bed linens for up to a week and could be easily acquired by casual contact, well apart from the patient.

The causative virus, variola is a member of the Orthopoxvirus genus, which also includes vaccinia (cowpox), monkeypox, ectromelia (mouse pox), and molluscum contagiosum. The members of this genus have 200 kilobase (kb) DNA genomes enclosed in a double membrane layer, are the largest viruses infecting animals, and the only viruses that can replicate in cell cytoplasm without need of its nucleus. Prior to Jenner’s discovery of cross immunization by scarification with live vaccinia virus, in 1796, 18th century Europeans and Colonial Americans often purposely allowed themselves and their children to be variolated with pus from active mild cases, accepting several weeks of severe illness, knowing that it would protect them against recurring smallpox epidemics.

A massive vaccination, detection, and containment program launched by the World Health Organization in January 1967 eliminated endemic smallpox throughout the world. The last known naturally occurring infection occurred on October 26, 1977 in an unvaccinated hospital cook in Somalia. Recommendations for routine vaccination in the US were rescinded in 1971, based on the lack of a reported case since 1949 and a low probability of importation, but the military continued to vaccinate routinely until 1990. Official variola repositories are kept for research at the Centers for Disease Control and Prevention (CDC) in Atlanta, GA, and the Institute of Viral Preparations in Moscow, Russia. Variola stocks are also known to exist at the Russian State Research Center of Virology and Biotechnology in Koltsovo.

At least 43% of the US population is unvaccinated and the durability of immunity to smallpox conferred by a single vaccination is disputed. The CDC estimates that the mortality in immunologically naive individuals would still be about 30% despite antibiotics to control bacterial super infection and maintains a supply of vaccinia vaccine, which is known to attenuate the disease if given within four days of exposure. There is currently no curative drug; pooled human vaccinia immune globulin (VIG) and cidifor (a nephrotoxic drug approved only for treating molluscum contagiosum retinitis in AIDS patients) are effective in mitigating systemic vaccinia infections but are not known to be efficacious against variola. Resumption of routine vaccination of the general public is unattractive because of a 1% incidence of myocarditis. The US military resumed routine vaccination in 2003, and an effort to vaccinate essential civilian health care personnel is underway; both are acknowledgements of smallpox’s

incredible terrorist potential.

Dr. Rose currently serves as the CEO of a group directing the development of an orally bioavailable, low-molecular-weight antipoxvirus compound known as ST-246. In single-cycle cell culture, ST-246 reduced extracellular virus by 90% but had little effect on the production of intracellular virus. Oral administration of ST-246 protected mice from intra-nasal vaccinia inoculation of ten times the LD-50 dose but required twice daily treatment for 14 days. Surviving mice were highly immune to a subsequent viral challenge. The drug's apparent target is a highly conserved F13L gene that encodes for a peripheral membrane protein that envelopes intracellular mature viruses to render them egress competent. Extracellular virus particles are essential for dissemination within the host, and a higher proportion of extracellular to intracellular particles is a marker of virulence. The requirement for extended dosing is consistent with targeting a virulence factor. The drug's continued presence is needed to inhibit virus spread for a sufficient time to allow the host immune response to clear the intracellular infection and ensure durable immunity.

Further development faces two formidable challenges: the first of which is developing convincing evidence of safety and efficacy against variola infection in exposed humans without a controlled clinical trial for a drug that would have to be massively stockpiled against the possibility of an unwanted, poorly controlled trial. The second is the questionable wisdom of counting on a single-target drug that can quickly become obsolete through viral mutation or by genetic re-engineering, which was readily accomplished with vaccinia as part of the proof of concept process. A multi-targeting drug would obviously be preferable but the more likely solution might be a cocktail approach.

Thus far, the drug is without toxicity in mice and other animals in amounts as high as three logs greater than the therapeutic doses. In addition to its efficacy against nasally introduced vaccinia, ST-246 has been effective against nasal and footpad inoculations of ectromelia in mice, vaccinia infections in rabbits, subcutaneous monkey pox inoculations in ground squirrels and intravenously induced monkey pox in monkeys. More recently, working in conjunction with the CDC, it has proved effective against huge intravenous variola inoculations that are required to produce a reliably lethal infection in cynomolgus monkeys. Inoculation routes other than oral or nasal are troublesome confounders in studying a drug directed at preventing within-host dissemination because they bypass the respiratory tract endothelium, omitting a critical vulnerable phase in the naturally occurring disease.

An opportunity also arose to use (not test) ST-246 in a case of eczema vaccinatum in a 28-month-old boy. The apparent source was the child’s father, who played with his eczematous son over a period of four days, after having had a primary vaccination three weeks previously, in anticipation of overseas deployment. Eleven days after the father left, the child developed vaccinia-like lesions about his face that rapidly spread over his body. The diagnosis was confirmed serologically, and VIG infusions were initiated, along with supportive care including intubation and mechanical ventilation, but he continued to deteriorate. Cidofovir, and then, ST-246 were added sequentially along with the VIG infusions, and his condition improved after a week on this regimen. He was discharged after 48 days of hospitalization with no known sequelae other than skin scarring.


Medical School in Colonial America. His medical school lectures anticipated, in many ways, topics with which we wrestle today – medical student education, the training of the surgeon, specialization in medicine, and surgical innovation.

Jones published the first North American surgical textbook covering the treatment of wounds and fractures in 1769, and along with Bard and others, founded the New York Hospital in 1771. When the Revolutionary War erupted and the Kings College closed, he became active in the New York Legislator, and he organized the medical department of the Revolutionary Army. In fact, he was a patriot and fought with the Sons of Liberty.

His later years were spent in Philadelphia where he was respected and sought after as in New York and became a friend and physician to Benjamin Franklin. His most famous patient was President, George Washington, for whom he rode to New York to consult with Bard regarding the treatment of an abscess of the President’s thigh. Jones died in 1791 at the age of 62.

Origins of Pediatric Surgery: Patient, Doctor and Hospital

Robert J. Touloukian, Professor of Surgery and Pediatrics, Yale University School of Medicine

Bob Touloukian began by directing attention to seven good reasons for studying our professional history - to:

1. Gain perspectives for new direction
2. Avoid repeating errors
3. Better define ones subject
4. Identify the origin of relevant knowledge
5. Understand the events of our time
6. Be inspired to exceed the accomplishments of others
7. “Stand on the shoulders of giants”

He then traced the history of pediatric surgery and children’s hospitals from the founding of L’Hôpital des Enfants-Malades in Paris, in 1802, through the opening of Babies’ Hospital in New York in 1887. His talk was particularly well illustrated, drawing upon many of the same texts featured in the admittedly “Columbia-centric” coverage of the same topic in the Fall 2006 News Letter, available on line at http://www.columbiasurgery.org/alumni/newsletter_jjss.html

Dr. Touloukian’s paper about 19th century pediatric surgery was a primary portal to the issue’s historical information and he was the subject of Eric Liu’s accompanying feature: “Where are they now?” This review focuses on Bob’s comments about the remarkable support given to The Great Ormond Street Hospital For Sick Children (GOSH) and circumstances surrounding the founding of Babies’ Hospital. Dr. Touloukian’s presentation was recorded, as were the others, and all will be available on the Department’s web site.

GOSH opened its doors to patients on Saint Valentine’s Day in 1852, at 49 Great Ormond Street, in London’s Bloomsbury district. Charles Dickens (1812-1870) heralded its opening in his weekly magazine, “Household Words,” with an article entitled “Drooping Buds” that both lamented and celebrated the fact that all of England did not have a hospital devoted to the care of children despite the presence of such hospitals in continental Europe for as many as 50 years “until [just] the other day.” After equating the allegory of a rose dropping a third of its petals, before fully opening, to childhood mortality in mid-19th century London, Dickens concluded Drooping Buds with a plea for additional funds to “plant the roses in the garden and to plant the roses in the cheeks of many children…”

House Hold Words was edited by Dickens, along with John Wills and Dickens’ father, and appeared every Wednesday from March 1850 through May 1859, comprising 24 two-column pages, with sales reaching 100,000 copies weekly. Dickens had good reason to be sympathetic to the needs of children, having fathered ten himself, the second to last dying in infancy, and the last born one month after GOSH opened. His prominence as a prolific author (25 books and stories – three especially for children), as well as the broad distribution of House Hold Words, attracted many supporters for GOSH, including Lord Byron’s widow, Oscar Wilde, and Queen Victoria’s consent to become the Hospital’s first royal patroness.

The Queen was also well acquainted with the needs of children, as well as children encumbered by incurable disease. Her own childhood was spent in remarkable isolation overseen by a domineering mother, her father having died eight months after her birth, and ended abruptly when she became Queen at age 18, on June 23, 1837. She bore nine children. Her eighth child, and fourth son, Leopold had hemophilia. Unbeknownst to the Queen, her genome included an x-chromosome with the hemophilia gene, which would pass to Princesses Alice and Beatrice, and be carried through them to many of the royal families of Europe. The Queen did everything possible to protect Leopold from minor trauma, but he died of an intracranial hemorrhage after a minor fall, at age 31.

5 http://www.fidnet.com/~dap1955/dickens/minor_works.html
6 Charles Dickens

Queen Victoria, circa 1839, age 20

http://www.columbiasurgery.org/alumni/newsletter_jjss.html

http://www.columbiasurgery.org/alumni/newsletter_jjss.html
GOSH instituted a regular annual February Festival Day, which often raised a third of its annual budget. At its 1858 Festival, held in the hall of St Martin in the Fields on Trafalgar Square, Dickens made a special plea for additional funds to purchase adjacent, 48 Great Ormond Street for much needed expansion: “Ladies and gentlemen, such things need not be, and will not be, if this company, which is a drop of the life-blood of the great compassionate public heart, will only accept the means of rescue and prevention which it is mine to offer.” He concluded his appearance with a toast to the Hospital and offering to hold a reading of “A Christmas Carol,” for the Hospital’s benefit. The reading occurred in April, contributions flourished, and the second building expanded GOSH’s capacity from 22 to 75 bassinettes and beds.

There is no dearth of novelty in GOSH’s funding history. Queen Victoria’s 1887 Golden Jubilee was celebrated, in part, by children throughout the nation showing their affection for their Queen by sending money to GOSH to care for those less fortunate than themselves. Fast-forwarding to 1929, Sir James M. Barrie’s (1860-1937) gift of all rights to GOSH to care for those less fortunate than themselves. Fast-forwarding to 1929, Sir James M. Barrie’s (1860-1937) gift of all rights to GOSH to care for those less fortunate than themselves.

Dr. Touloukian pointed out that the 1887 founding of Babies’ Hospital and its “Summer Branch” in Oceanic, NJ were the result of remarkable “women’s work.” Two unmarried physician sisters Sarah J. McNutt and Julia G. McNutt, Mrs. Thomas E. Satterthwaite, Mrs. Andrew H. Smith, and Mrs. James Lenox Banks (Maude) worked together to raise sufficient funds to start a hospital dedicated to the care of children. At the time, only 27 hospital beds were available for children among all the hospitals in the city when infectious disease was rampant and many newly arrived immigrant families were both fecund and poor.

Dr. Sarah McNutt was an 1877 graduate of the Women’s Medical College of the New York Infirmary and Julia is thought to have graduated several years after her. Sarah developed an interest in pediatric neurology and, in 1884, became the first woman to be inducted into the American Neurologic Association, 19 years after its founding and 51 years before the next woman would be admitted. Less is known about her sister, Julia, but she obviously was also interested children’s medicine. Maud Banks was the wife of the Presbyterian Hospital founder James Lenox’s grandson, who was born in 1861, making him 26 in 1887, and his wife probably a little younger. Mrs. Satterthwaite was Mr. Banks sister and probably not too dissimilar in age. Sarah McNutt was 48, and her sister was probably no more than several years younger. This female pentad of middle aged physicians from a prominent New Hampshire family and young matrons of wealth proved to be highly successful fundraisers. There are contemporary newspaper clippings of successful teas given by young socialites, who comprised “The Crib Side Committee,” one such single event raising $400.

The five women committed themselves as the incorporators of Babies’ Hospital on June 23, 1887. They may have been a little shy on real estate acumen, as their first building purchase came to naught, when they found themselves served with a legal injunction forbidding its use for hospital purposes. They were able to rent a building on East 36th Street, where patients were accommodated until they could dispose of the original building and purchase 657 Lexington Avenue on the northeast corner at 55th Street in 1889. In the same year, the Hospital’s Board of Managers rented a property comprising three buildings in Oceanic, NJ. This “Summer Branch” served seasonally as both a hospital away from city clatter and a convalescent home. It may have subsequently been gifted to the hospital. In 1894, the hospital purchased the adjacent building at 659 Lexington Avenue. Both buildings were destined to be torn down and replaced in 1902 by a new building, which, although no longer a hospital, remains on the northeast corner site today.

Mrs. Satterthwaite’s husband, Dr. Thomas E. Satterthwaite became the first director of Babies’ Hospital. Dr. L. (Luther) Emmet Holt, an 1880 P & S graduate, became its principal attending physician and did much to promote Babies’ Hospital with his 1894 book, “The Care and Feeding of Children: A Catechism for the Use of Mothers and Children’s Nurses.” It rapidly became a very popular mothers’ hand book and an international best-seller; and is still available, scanned in as a PDF file, on the web.

Dr. Robert Abbe, an 1874 P & S graduate, became the first consulting surgeon to the Hospital. The McNutt sisters eventually moved to Albany, New York where they practiced until 1930, when Sarah died at the age of 91.

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10 http://onlinebooks.library.upenn.edu/ authors.html
11 http://www.gosh.org/about_us/peterpan/history.html
13 http://onlinebooks.library.upenn.edu/ authors.html
Lessons Learned

Murray F. Brennan, Benno C. Schmidt Chair in Clinical Oncology, Memorial Sloan-Kettering Cancer Center

Dr. Brennan’s first lesson: Understand the nature of birth: it was completely beyond your control, so don’t take yourself too seriously; you might have been some one else! The rest is up to you: your work and decisions direct your life towards hoped for goals and unforeseen consequences, as amply exemplified by his own odyssey. Murray Brennan was born in Auckland, New Zealand. He received his medical education and basic surgical training at the University of Otago Medical School, located in the city of Dunedin, near the southern extreme of the Country, making it the world’s most southern medical school. His skill and hard work as a surgical resident caught the attention of his professor, who in turn introduced him to visiting professor, Francis D. Moore. Murray accepted Dr. Moore’s invitation on the spot to become a research fellow at the Peter Bent Brigham Hospital. In Dr. Moore’s words: “He came, married a beautiful American surgeon (one of our interns), raised a large family, and soon became Head of Surgery at Memorial Sloan-Kettering Cancer Center in New York. Quite an import.”

Dr. Moore’s summation echoes Plutarch quoting Caesar’s: “veni, vidi, vici,” but Dr. Brennan sees it as another lesson: “Lucky Breaks Help - the journey starts with a single step.” This very productive and exceptionally durable mentor-mentee relationship began in 1970, 11 years after the publication of Metabolic Care of the Surgical Patient, which, as a compendium of individual case studies, evoked another lesson: “You can learn a lot from a case well studied.”

The lessons of mentoring derive from its origin in the person of Mentor, who was the adult advisor to Telemachus, the son of Odysseus and faithful Penelope in Homer’s Odyssey. The story tells of a passage from childhood to manhood guided by an experienced and trusted counselor. The interaction must focus on the mentee’s future, not that of the mentor, and should have customized goals and measurable outcomes. The enduring nature of the Moore-Brennan relationship is well characterized in Murray’s response, written more than a year after Dr. Moore’s death, to an invitation to write something funny about Frannie Moore for the “Moments in Surgery” feature in the journal, Surgery. It begins with: “Brilliant, erudite, but funny? No, not really,” followed by several anecdotes, and concludes with “We shall not see his like again.”

“To truly know something you need to record observations, gather the data, and look at the findings.” Ernest Amory Codman (1869-1940), a Boston surgeon, presaged now fashionable outcomes data, in 1910, by proposing that hospitals should track every patient treated for a sufficient time to determine if the treatment was effective. If it was not, the system should attempt to determine why, so that future similar cases can be treated successfully. Dr. Brennan took this lesson to heart, establishing an all-encompassing database, almost before unpacking, when he went to Memorial Sloan-Kettering. It now includes more than 7,000 sarcoma patients, among its compendium of malignancies, constituting the bulk of our clinical knowledge about these tumors. Data derived from these patients eliminated justification for the acceptance of debilitating surgical deformity in the management of extremity sarcomas by showing that major amputation added no advantage over limb salvage surgery in terms of local recurrence, disease-free survival, as well as overall survival, when both types of surgery were followed by similar chemotherapy.

Two more lessons from the sarcoma database: “Statistical significance is OK but the eyeball test is key.” and “The benefit accrues to the few [while] the consequences affect the many.”

### Ten-year Survival Benefit of Adjuvant Chemotherapy

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<th>With chemotherapy</th>
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<tr>
<td>Relapse free survival</td>
<td>70%</td>
<td>60%</td>
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<tr>
<td>Overall Survival</td>
<td>54%</td>
<td>50%</td>
<td>0.19</td>
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<td>Individual gain</td>
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<tr>
<td>None</td>
<td>46% died despite chemorX</td>
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<td>None</td>
<td>50% were to survive anyway</td>
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<td>Benefited</td>
<td>4% (only 1 of every 25 treated)</td>
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Parting Admonitions: “Do not be afraid of the data. Be willing to challenge accepted concepts. Without change there can be no progress, [and] change requires challenge.”

### Turning Surgical Training Upside Down: A Changing Model For Changing Times

Richard K. Reznick, McLaughlin Professor and Chair, Department of Surgery, University of Toronto

Dr. Reznick began by noting that traditional surgical training’s inefficiency, long inter-assessment intervals, perchance disease encounters, reverence for broad-based training, and learning techniques across the table from the master face too many threats to survive. Surgical training is simply too long, too strenuous, and not sufficiently protective of the public good, so it has to go. Our trainees finish beyond the apogee of chest master performance, and it is the master level that we seek as our educational deliverable.

Here is his eight-point restructuring plan to better and shorter training:

1. Take on politics and finance issues right at the start
   Teaching is undervalued and not properly remunerated. Faculty compensation has to be linked to validated-result educational activities. Provision of low cost service by residents must be abolished and assumed by an expansion of appropriate service personnel and technicians.

2. Modular-based training with specific objectives
   Here’s where things turn upside down. An experimental program will begin in July 2008, wherein three supra-numerary resident positions will be grant funded in the divisions of general or orthopedic surgery to explore a wholly new, competency-based, rather than time-based, training paradigm, targeted towards achieving competency within 3 years. It begins with setting specific, streamlined, modular objectives, driven by the desires of the trainee, at the inception of training, which will then constitute an individualized learning contract between the learner and the Department.

   As a hypothetical example, for which Dr. Reznick bears only partial responsibility beyond inspiration: New trainee: “I want to be a pediatric cardiac surgeon.” Program director: “Here’s how we will get you there in 3 years, with the cooperation of neonatology, pathology, and cardiac surgery at the Hospital For Sick Children. Afterwards, having fulfilled your responsibilities under the learning contract, you will join the University faculty’s pediatric cardiac surgery group, operating, caring for your patients, and teaching your house staff and our students, while you wait for the certification processes to catch up with your knowledge and skills.

   Your first year will be split into thirds: you’ll spend the first four months in our skills lab and virtual reality (VR) library. Our educational resources people will search the world for VR demonstrations of the embryology and developmental anatomy of normal and abnormal hearts, as well as web-based studies of pediatric cardiac procedures and pathology for your use. You will apportion your time between the skills lab and the study of these materials in accord with the progress of your skills development as judged by you and an expert on a daily basis and formally tested each month. There will also be assessment sections in the VR materials that will measure your comprehension of the segments you have studied to aid you in parsing your time for maximum achievement.”

3. Dramatically accelerate skill acquisition
   “Once you have satisfied yourself and us that you have mastered the skills lab’s basic unit, your blocks will be tailored to focus on the vascular system, including tiny vessel access, suturing graft materials, abattoir, and cadaver vessels, and special modules for learning cardiac endoscopy and catheter-based interventional procedures. You will find yourself immersed intensively in successive modular blocks because we know that concentrated, rather than strung-out learning, results in significantly higher skill levels and superior retention.”

   Your progression in the skills lab will be burnished by giving you clinical experience in constructing vascular anastomoses for dialysis access and performing catheter-based diagnostic procedures in radiology. Your next 4 months will be spent on the neonatology service, where you will be the belle of the ball because of the ease with which you can obtain venous and arterial access in preemies. You’ll complete your first year by spending 4 months in pediatric pathology where we expect you to be teacher, as well as student, based on your VR-acquired comprehension and ability to demonstrate cardiac anatomy and its congenital variants to others.”

4. Minimize wasted time
   “You will be returning to us for your second year, which will be split between adult general and cardiac surgery and advanced interventional radiology procedures, during which you will be expected to hone your skills further in the laboratory and participate in our skills training development and assessment studies. Esteem for your time is inherent to our abandoning the totipotential gateway and not making you stand in a hierarchical line waiting to get into the game. We know that you are unlikely to ever have greater demands on your time. We are actively studying programmatic changes to lessen the risk of sleep deprivation, which is much more pervasive and debilitating than is generally appreciated, with the exception of the Federal Aviation Administration, airlines, and the Interstate Commerce Commission.”

5. Incorporate day-to-day assessments
   Objectivity has been a long-standing hurdle in assessing surgical skill (“He has great hands” or “He’s really a klutz”), as well as our ability and means to improve it. Reznick’s group’s early efforts at Objective Structured Assessment of Technical Skills (OSAT) are being picked up by others and tearing down the bar. 15

6. Promote a culture of collegiality
   “Your final year will be entirely on the pediatric cardiac surgery service, where we believe you will be both personally comfortable and very well received by Dr. Glen Van Arnsdale and his - soon to be your - colleagues.”

7. Address “If it’s not broken don’t fix it” criticism intelligently
   Paraphrasing the noted Swiss philosopher-psychologist, Jean Piaget (1896-1980): True learning occurs when we are deeply perturbed; when our world view is so challenged that we must reject our current conceptualizations, and we then must (painfully) rebuild our knowledge structures.

   Surgical educators: Do not delude yourselves; we are there and need to capitalize on this opportunity

8. Serially address potentially adverse by-products of the changed paradigm

When we wrote “Two Years Into the Process” for the Summer 2006, John Jones Surgical Society News Letter, we were eagerly anticipating the transition into our third year clerkships, where medical students trade in their books and highlighters for stethoscopes and reflex hammers. Now, with our first clinical year behind us, it is exciting to reflect on the differing experiences that have shaped our interests and understanding of our chosen profession.

Rob: I did my surgery rotation at the Mary Imogene Bassett Hospital in Cooperstown, NY, where I participated in a broad array of operative procedures, from appendectomies and gastric bypasses to cardiac and trauma cases. Willing teachers and this well-rounded surgical experience in an enlightened referral and trauma center, in a semi-rural environment, also broadened my perspective on the various lifestyles that are open to surgeons. Based on my prior surgical subspecialty rotations at Columbia, my sense was that, as anticipated, NewYork-Presbyterian Hospital seemed to have a higher volume and more complicated patients, as well as a greater emphasis on the academic side of surgery, from the number of lectures to frequent references to the latest evidence in the literature. This aspect piqued my interest, and I found the faculty to be very receptive to students becoming involved in research. After exploring various options, I joined trauma surgeon Dr. Maurizio Miglietta’s research program and am currently working on two studies: Deceleration injuries following falls from New York City bridges and vehicular pedestrian injuries.

Joe: I stayed at NewYork-Presbyterian for my five-week surgery rotation, and the experience proved to be as challenging and rewarding as I expected. I was assigned to the Hepatobiliary and Endocrine (Red) service, where I participated mainly in endocrine operations and long and complex procedures on my home and other services, including a Transverse Rectus Abdominis Myocutaneous (TRAM) flap breast reconstruction. I was most impressed with the willingness and dedication of both the attendings and house staff to take time out of their incredibly busy days to teach the students. My experience on “Red” provided a less representative general surgical exposure than Rob enjoyed in Cooperstown. For instance, I scrubbed on five Whipple procedures but only saw one laparoscopic cholecystectomy. Breadth and intensity each have their advantages, and I have submitted a proposal to the Dean’s office for a research month with Dr. John Chabot, chief of the division of Hepatobiliary and Endocrine surgery, to explore post-Whipple procedure complications.

We had a great introduction to clinical surgery this year, but we concentrated on learning as much as possible about the trees, rather than stepping back to look at the forest. Issues such as academic or private practice remain nebulous, and probably will stay that way for the next year, awaiting our early residency experiences.

Once again, we are eagerly anticipating – this time focused on fourth-year surgical elective opportunities and beginning the residency application process. We approach these challenges with excitement and confidence because Columbia P & S has provided us with a solid foundation of surgical knowledge beginning with early exposure through the Whipple Society and continuing in our varied third-year clinical clerkships.

Where Are They Now?

Eric H. Liu

Ed Note: Eric Liu recently interviewed Julius H. Jacobson, II, MD for his regular feature in the midst of moving back to NewYork Presbyterian from his NIH Fellowship. Jack finished his residency at Columbia Presbyterian in 1959 and is widely known for his pioneering work in microvascular surgery. He and his wife Joan are significant supporters of surgical research and innovation as well as the arts, so his interview will be appropriately integrated into the Fall 2007 News Letter, which will focus on the role of philanthropic gifts in the development of the Columbia University Medical Center.

Where Are We Now?

John Jones Research Fellowship Update

James G. Chandler

LADIES AND GENTLEMAN: WE HAVE A FELLOWSHIP. If we were sitting together in an auditorium, the speaker at the rostrum would ask you to “Turn to your left, shake hands, express thanks for your fellow member’s generosity, and congratulate each other.” It’s our achievement, solidly branded, and offering a promise of eventual durability, as an investment in youthful excellence in our shared passion.
Note that John Jones looks pleased but not elated, in this one of only three known existing three-quarter-facial portrayals of our Society’s namesake. We have accumulated almost $70,000, which is sufficient to fund one Fellow and one... actually two months for a second recipient, taking into account the sponsor-matching requirement. Our goal is too lofty to engage in a “fund and run” bestowal, but many of us also believe ourselves to be too old to wait for a full, self-perpetuating corpus, so an early middle ground will be sought.

We want to pursue a balance between cash in the bank, reasonable expectations for additional contributions, and a commitment to earlier funding for the tangible pleasure, and gifting stimulus, of having an outstanding achiever reporting at our annual meeting in one to three years. Stretching out the funding interval or looking for further partnering could facilitate this, but a far more satisfactory solution would be to broaden the Fellowship’s appeal among our membership. Judging by the individual contributor amounts and the total dollars accumulated during the past year, the Fellowship is felt by many to have strong merit, but let’s examine its qualifiers and attributes and query our collective wisdom as to how its appeal among the membership might be broadened. For instance, it is unlikely that many candidates will be in the running, as the qualifiers are quite restrictive, demanding a record of past achievement, detailed advance planning, and considerable enterprise. Are they too stringent and elitist to be attractive to the best and brightest in the context of the target generation’s values?

The candidate must:
1. Be in the second or third year of residency.
2. Be recognized by the surgical faculty as having excelled in these years.
3. Commit to two years away from the regular clinical program.
4. Have identified a mentor committed to supporting the second year.
5. Submit a written proposal, detailing how the time will be spent.
6. Appear before a granting panel to include at least two JJSS members.
7. Compete on the project’s merits and a personal record of past academic achievement.

The Fellowship has two rather unique attributes:
1. It need not be done at Columbia, or even in the US, and deciding to go elsewhere cannot be a negative selection criterion. However, the Fellowship cannot be done in an institution, which normally funds its fellows from its own resources and cannot be part of a for-profit enterprise, except for an unforeseen very exceptional opportunity.
2. Research is to be broadly interpreted: the Fellow could be transfecting fibroblasts in tissue culture to make super healers, operating on Zebrafish hearts, assessing the efficacy of NO in mitigating critical limb ischemia, or studying a novel technique under the tutelage of a master to bring it back to NewYork-Presbyterian and Columbia.

Is the design too freewheeling? Is there sentiment against even 50% funding for work done elsewhere. Is there skepticism that the John Jones “brand” will not endure, or not be a marker of likely Columbia faculty appointment? In my view, the Fellowship materially enhances our Society’s raison d’être and will serve to protect us from ecumenical obsolescence, as could be inferred from the absence of an “s” in recent branding: “NewYork-Presbyterian, the University Hospital of Columbia and Cornell.”

Send your comments to Ms. Hargaden (tjh2104@columbia.edu) I assure you that your thoughts will be as welcome as your money.

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Charles A. Slanetz, Jr. was a beloved and respected practitioner of surgery at Glen Cove Community Hospital, on Long Island, NY for 41 years. He suffered a fatal episode of ventricular fibrillation, while asleep in his home in Locust Valley, NY on June 12, 2006, at age 73; otherwise, I am fairly certain that he would be visiting his patients in the hospital today. He is survived by Nancy Edwards Slanetz, his loving wife for 46 years, his son Alfred - a PhD immunologist, and three daughters, Priscilla, Carolyn, and Phoebe - all graduates of Smith College, and holders of advanced Harvard degrees, respectively, in Medicine, Public Health, and Education.

Charlie grew up in Sayville, on Long Island’s south shore, where his father, Charles A. Slanetz, Sr., PhD commuted daily to the Columbia College of Physicians and Surgeons as the Director of the Medical Center’s Animal Care Facility. After graduating from Sayville High School, as the class Valedictorian at age 16, Charlie went to Yale University for his undergraduate and medical education. He came to the Presbyterian Hospital in 1957, as a surgical intern and completed his residency in 1963. In the interim, he became particularly interested in colon surgery and immunology, interests that he was later to pursue in tandem with a busy surgical practice. The Berry Plan, in effect from 1954 to 1974, named for Frank B. Berry, a thoracic surgeon at Roosevelt and Bellevue, and later Assistant Secretary of Defense for Health Affairs, allowed Charlie to have an uninterrupted residency but committed him to two years of active duty in the Navy. Those years were spent at the Newport, Rhode Island Naval Hospital. LCDR Slanetz’s nautical adventures were generally limited to Narragansett Bay and took place on private craft. His sole sea duty was to be “the-physician-on-board” when the Kennedy family was taken out on a Naval ship for a day cruise to watch the America’s Cup races, soon after he reported for duty.

Upon discharge in 1965, he opened his solo practice in Glen Cove, which grew rapidly, as patients recognized that he really cared deeply about them and their families, in addition to functioning as a skilful manager of their disease entities. Referring physicians were quick to note these qualities and the good outcomes that Charlie obtained for their patients. Despite a burgeoning practice he chose to tread in his father’s footsteps, although not on a daily basis, and renew his association with Columbia. Fred Herter and Charlie confirmed the works of Vink and Isidore Cohen, Jr. relating antibiotic bowel preparation to suture-line cancer implant vulnerability in two publications in the late 1960s. Decades later, Charlie was still at it, pursuing a means of preparing autologous anticancer antigens and laboriously computerizing all the operative variables, pathologic findings and outcomes from the mesenteric node clearing studies that Robert Grinnell and others had carried out from 1951 through 1975 on 2,400 resected colorectal cancers. His initial analysis pointed to the disastrous effect that intraoperative perforation of the colon, or more commonly, the rectum had on five-year survival and local recurrence. More than a dozen years later, working on the same cohort by himself, or with a statistician, he showed that ligation at the inferior mesenteric artery origin, in colon cancer cases with less than five positive nodes and no apical involvement, and Turnbull’s “no touch” double ligation of the colon before mobilizing it were each independently associated with increased survival and fewer suture line recurrences.

Sounds like a workaholic, absentee husband and dad — no way! He loved all three roles and typically did what was needed to have a top-quality part in each. The picture shows Charlie, having gone directly from Saturday morning hospital rounds, to sail with his look-alike son, on Alfred’s boat. The Slanetz family traveled the world together from the time the children were young, until their careers made them busier than their parents. They fished, boated, birded, and got as close as possible to nature. Charlie was a pillar in his community. He took a tremendous interest in his children’s Portledge School, donating its Science Center and having a prize for scientific scholarship named for him. He and Nancy provided a cultural rearing that has allowed their children to thrive in advanced education and to pursue interesting lives.

Charlie’s funeral service at Christ Church in Oyster Bay was a standing room only occasion, attended by an enormous number of patients and his many friends on Long Island’s north shore, as well as his extended family, which includes ten grandchildren. Charlie lived his life well, added value to his community by his presence, and left an enduring legacy of achievement and protean interests that will live on in his children and, likely, in their children as well.
