ORAL HISTORY PROJECT

W. Hardy Hendren III, MD

Interviewed by
Howard A. Pearson, MD

June 16, 2006
Duxbury, Massachusetts

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PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

ABOUT THE INTERVIEWER

Howard A. Pearson, MD

Dr. Howard A. Pearson is a pediatric hematologist oncologist and a professor of pediatrics at the Yale University School of Medicine in New Haven, Connecticut. He was graduated from Dartmouth College and received an MD degree from the Harvard Medical School in 1954. He served a rotating internship and then a two-year pediatric residency under Thomas E. Cone, Jr., at the US Naval Hospital in Bethesda, Maryland. He had a fellowship in pediatric hematology under Dr. Louis K. Diamond at the Boston Children's Hospital. He then spent six years in the department of pediatrics at the University of Florida College of Medicine in Gainesville. In 1968, he came to Yale as professor of pediatrics and chief of pediatric hematology oncology. Between 1972 and 1985 he was chairman of the department of pediatrics and chief of pediatrics at the Yale New Haven Hospital. In 1991, Dr. Pearson was elected vice president of the American Academy of Pediatrics and served as AAP president in 1992-1993. In 1993 he was appointed to the AAP Historical Archives Advisory Committee and served as its first chairman.

Interview of W. Hardy Hendren III, MD, FACS

DR. PEARSON: This is Dr. Howard Pearson. I'm at the beautiful home of Eleanor and Hardy Hendren in Duxbury, Massachusetts, looking over Duxbury Bay. The date is June 16, 2006.

Hardy, in reading your CV, I realize that we have had many common if not shared experiences: Eagle Scout, Dartmouth College and Medical School, living in Wigwam Village in Hanover, Harvard Med [Medical] School, and The Children's Hospital [Boston]. I've also read and enjoyed the book about you, *The Work of Human Hands*, by G. Wayne Miller. I've got a cheat sheet in front of me with chronologic data. We will try to follow that, but one of the great things about modern word processors is that if a thought occurs to you that refers back to a previous time, we can just cut and paste.

Let's start at the beginning. You were born in 1926 in New Orleans. Tell me a little bit about that and your family.

DR. HENDREN: My father was a mechanical engineering graduate of the University of Virginia. His ancestors came to Norfolk in 1732 from Northern Ireland. The family moved to New Orleans when Dad was about six years old, when his father entered the steam shipping business as general manager of Texas Terminal and Transport Company. Dad's mother, Mabel Toy Hendren, died from an osteogenic sarcoma of a leg in March 1906 when my father was nine-and-a-half years old. Dad attended Woodberry Forest School in Orange, Virginia, and today there is a scholarship fund at Woodberry in his memory. After World War I, during which dad trained as an Army Air Corps pilot, he worked in Detroit for Packard Motor Car Company. He then returned to New Orleans as the first distributor for the new Chrysler automobile. Later he entered the motion picture advertising business in New Orleans.

My mother was from New Orleans. She was of Scottish descent. Margaret McLeod was her maiden name. Her paternal grandparents had emigrated from Glasgow to America in about 1840. Her father, William McLeod, was a law graduate of Tulane. Her mother, Elizabeth Fentress, hailed from Bolivar, Tennessee, where her father was a lawyer and judge. Mother graduated in 1919 with a degree in music from Sophie Newcomb College of Tulane University. She was the oldest Alumna when she died at age 105 in 2003.

I was the second of three children. My older sister, Peggy, was born in October 1924. I followed in February 1926; my younger sister, Carol, in

August 1928. This was just before the Depression. I can remember vividly our family listening to election returns on the radio in 1932 when Franklin D. Roosevelt beat Herbert Hoover and was elected President. Those were tumultuous times. Even little kids were aware of that. Peggy had orbital cellulitis and was operated upon at Touro Infirmary by Dr. Hardin, an eye doctor, and Dr. Carney, an ENT [ear, nose, throat] surgeon. Over $7,000 in bills had accumulated, which my father had to pay in time. His bank had failed, as did many, wiping out family assets. Yet we had two cars, a cook and a nursemaid, Alice, and went to a private school.

I went to kindergarten and first grade at Miss Aiken's School, in New Orleans. It was a small private school only a few blocks from our house at 5325 Coliseum Street. In August 1933 we moved to Kansas City where dad took over a film company, United Film Service, in Kansas City. He was made president and given stock with the expectation he would put the company back on its feet, which he did. The trip was about nine hundred miles in a Packard touring sedan, much of it on gravel roads. We would drive a few hundred miles and stop to fix a flat tire. The car was one of these nifty Packards with two spare tires, one on each front fender, and a trunk on the back. There was a luggage rack on the right running board. That way we drove to Kansas City. We hit a cow along the way but it didn't hurt either cow or car because we were going slowly. I can remember the trip as if it were yesterday. I was in the back seat, with my sisters. Mother had a moist cloth over my face to prevent my breathing road dust, because I was just recovering from bronchial pneumonia. My pediatrician in New Orleans was Dr. Ludo von Meysenbug. I learned many years later that he trained at Boston Children's Hospital, but the registrar's records don't have a record of that. Many doctors, especially surgical observers, can spend considerable time at Children's without having their names listed anywhere.

We spent the first night in Little Rock, Arkansas. As we left Little Rock we were celebrating my little sister's fifth birthday, August the 17th. I remember seeing a flock of bluebirds sitting on a fence on the right side of the road as we were driving along. The bluebird signifies happiness. We were happy because the trip seemed like a big adventure to us kids. Incidentally, I have never seen another bluebird since then, although they were said to be plentiful in Duxbury many years ago.

We got to Kansas City late in the evening on the second day. We were greeted with the news that the safe in the company had been blown open by a thief. The money set aside to pay for the trip had been stolen. My memory is that it was about $75 in cash! The other event I remember, when we arrived at the house we were going to move into the next day, is that there had been a murder in that house some years before. When mother learned that she said we wouldn't move into that house. We stayed at the Stueben Club that night.

DR. PEARSON: The glass company? Steuben Glass?

DR. HENDREN: No, it was named after [Friedrich von] Steuben, a German who helped with the military drilling of George Washington's troops in the Revolutionary War. He is described in David McCullough's recent book, *1776*. He had claimed to be a former general in the German Army, but he was not. Yet, he was able to get good discipline from the troops and proved very helpful to General Washington. I think it was he for whom the Steuben Club was named.

I was disappointed that we were not going to move into the original house, because it was a large one, not at all like our house in New Orleans. The New Orleans house was a so called shot-gun house. That implies that a shot gun could be fired at the front door and pass down a long hall for the full length of the house. My parents had sold it for four thousand dollars, losing thirty five hundred dollars over its cost a few years before. That is the way things were during the Depression. We have visited that house several times in recent years on trips to New Orleans. It recently sold for about four hundred thousand dollars! The special reason that I was disappointed not to move into the big house at age seven-and-a-half, was that there was a rifle range in the basement. I was anxious to try that out.

At any rate, Mother and Dad went out with a flashlight at night looking at houses listed for rent in the *Kansas City Star*. They found a little house to rent at 5911 McGee Street. We three children walked to the William Cullen Bryant Public School about a mile away. That was a real shock going to a big public school, having been in a little private school previously. The first day was memorable. The fellow sitting behind me picked his nose and wiped it in my hair. His name was George Kerdolf. That nasty trick is memorialized in Wayne Miller's book. I came home and told my mother that I was not going back to that school because they were very rude. I remember also on the first day of school being overwhelmed being in a class of forty kids. It was a big change from Miss Aiken's School. I was looking around and the teacher asked me if that was the way I was brought up at the school where I had gone previously. I said, "Oh, yes ma'am and sometimes worse". That put me on her list. Her name was Miss Walley. She used the ruler liberally. If you were a boy you got whacked on the bare legs with a yardstick. If you were a girl you would get spanked on your hands with the ruler.

Despite the initial culture shock at Bryant, starting in the second grade, I graduated in 1939 at age 13 from seventh grade and had many good friends whom I still cherish. One is Margaret Virginia Major, daughter of Dr. Ralph Herman Major. He was the professor of medicine at the University of Kansas School Of Medicine, and also the Professor of the History of Medicine. Dr. Major was one of the most scholarly men in American medicine and the most outstanding physician I knew while "growing up." He was quiet, contemplative, intellectually brilliant, but with a great sense of humor. I have several of his books signed by Dr. Major. Imagine my

surprise in 2004, when I received an honorary degree from Drexel University in Philadelphia and gave a short address to the graduating class, to see Margaret Virginia Major once again. Her daughter was in the graduating class. Virginia was always the smartest one in our class. I can remember many times paging through books in her father's library at their home. Surely Dr. Major was one of those who influenced me to study medicine. I can still see Dr. and Mrs. Major in their customary pew at St. Paul's Church in Kansas City, where I had a bird's eye view from the chancel where I was one of the boy sopranos for several years.

In the first year in high school, a big public school, Southwest High, I flunked Latin and algebra. I had to repeat them in summer school and just barely squeaked by. The problem was I just wasn't working hard enough! The next year I was thrilled to be able to go to Woodberry Forest School in Orange, Virginia, where my father had gone. I had heard about Woodberry from Dad for many years and longed to go there.

DR. PEARSON: Tell me a little bit more, because you do mention that you have to know Latin to be a doctor.

DR. HENDREN: Oh yes. The word was that to be a doctor Latin was a prerequisite! Every student at Woodberry had to take Latin for 3 years. My grandparents also had Greek studies while growing up.

DR. PEARSON: You had an inkling that that is what you wanted to do, even that early?

DR. HENDREN: Oh yes, I knew I wanted to be a doctor. In fact I knew I wanted to be a surgeon.

DR. PEARSON: Really?

DR. HENDREN: Yes. Some of my father's doctor friends were very good to me and let me come to St. Luke's Hospital to watch them operate. Dr. Lawrence Engel was an outstanding general surgeon in Kansas City. He invited me to watch him do a mastectomy. I was very young, perhaps early high school. As he made the incision, I guess the lady had hypertension, a bleeder squirted past his elbow and hit the front of my observer's gown. I had to excuse myself from the room because it made me feel very faint.

DR. PEARSON: Well, I guess many of us have a memory of the first time in the operating room when we saw actual blood gushing and got a little faint.

DR. HENDREN: Exactly. I also felt faint watching a baby come into the world some years later as a medical student at the Mary Hitchcock Memorial Hospital in Hanover, New Hampshire.

Also there was Dr. John Swan Knight, who did ENT surgery. He took me to the OR several times to hold retractors as he did T&As [tonsillectomy and adenoidectomy]. I had met Dr. Knight in the summertime just before going to fifth grade when I developed an abscessed ear. He came to our house, put on his mirror with the hole in the center of it, and lanced my ear in the bed. He had been a football player at the University of Missouri. He restrained my head by holding it in his large left hand previously used for catching the football as an end on the team of the University of Missouri. Whatever anesthesia was used, if any, I can still remember the awful pain caused by plunging a sharp knife through the eardrum. But, of course, there was relief as the pus dripped out in long stringy blobs. There were no antibiotics in those days. The postoperative treatment was to irrigate the pus using a rubber bulb ear syringe to wash it out and let it go into a kidney basin held on the shoulder. Then the second ear got abscessed. We had a repeat performance of this whole scenario a few days later. That was even worse. A year or two later I had some tonsillar tags which were thought to be responsible for my getting recurrent sore throats. I was given the choice of doing it in his office with local anesthesia injected into the back of the throat or going to the hospital for general anesthesia. When he told me it would cost my parents an additional twenty five dollars to go to the hospital, I elected to grin and bear it in the office. It wasn't very pleasant. He wore a plastic shield over his nose and mouth to protect him from breathing what the patient was exhaling. That was lucky, because I coughed just as he snared a tag, and it splattered against his plastic protector, like a bug against a car windshield. Another important medical figure was Dr. J. [John] Milton Singleton, an outstanding obstetrician and friend of my parents. He told me about his specialty as we sat together in a duck blind in central Missouri near Swan Lake Refuge on several occasions. It was Dr. Singleton who taught me to never be in a room with a female patient without a nurse being present. As a young man while examining a patient his nurse temporarily left the office to answer the telephone. The patient ran out of the examining room, and through the office where there were a lot of ladies waiting, with nothing covering her lower half, claiming that the doctor had inappropriately touched her. I have always emphasized Dr. Singleton's admonition to all of our medical students and residents.

DR. PEARSON: Also, tell me about your Eagle Scout award, another thing we have in common.

DR. HENDREN: I joined Boy Scout Troop number 149 which met at the Country Club Methodist Church at 57th and Wornall Road, just across the street from Bryant School. I found that I did not know many of the fellows in that troop, and so later I switched over to Troop 188 at Pembroke Country Day School. We had a Boy Scout Camp at Osceola, Missouri, which I attended for part of two summers. It was a good place to get the life-saving merit badge and several others that I can't remember, such as public health, first-aid, and basket weaving. It was interesting, and fun, to get merit

badges. Some were mandatory, such as life saving, and others were elective, such as photography. It was an excellent program, in which we could read about a particular merit badge in our manual and then get the requirements for it, and learn something about the subject. As you remember, we were first a tenderfoot, then second class, and next first class. For the Star rank, five merit badges were necessary; ten for Life Badge, and 21 for Eagle. For five more badges, a bronze palm; ten more a silver palm; and 15 more a gold palm. Being away at Woodberry Forest School during the school year, I could work on the merit badges during the summer. I remember particularly the cooking merit badge. It was an exam given to me on the front porch of a man's house on a very hot August evening. He was sitting on the front porch in his underwear, to keep cool. He was a short order cook at the Toddle House, a hamburger chain in the Midwest. Mother sat in the car at the curb having driven me there. She took no offense at his being in his underwear to greet us. She thought instead of the positive aspect of it, i.e., what a nice man he was at the end of a long day's work sitting out and interviewing some kid for a cooking merit badge! You know, having had that merit badge, I still remember how to cook a potato if you are out camping. You wrap it in mud and just toss it into the fire. It bakes just as if it were cooked at the Ritz. I got my Eagle Scout badge after my fifth form year at Woodberry, i.e., a junior. I still have my merit badge sash, with tenderfoot, second class, first class, star, life, and eagle badges, plus 30 merit badges, riflery badges, and so forth, and the buglers emblem. The best actual use for my bugle was the lamp you will see downstairs in our living room. It was made into an attractive lamp. I was never a very good bugler. The bugle was one of life's early lessons. My wealthy great aunt, Mrs. Thomas D. Toy, who lived at 1185 Park Avenue in New York, had given me ten dollars for graduation when I finished Bryant School. That great sum was "burning a hole" in my pocket when we went to New York to the World's Fair in 1939. I went to FAO Schwartz, the famous toy store, to buy a genuine Rexcraft bugle. I paid five dollars for it, a lot of money in those days. Later in the afternoon I went browsing at another store, Macy's. There I was shocked to find the same bugle for $3.95. That was a lesson in comparative shopping which cost me a dollar and five cents.

At Woodberry Forest I got straightened out academically and ended up in the top part of my class. At the end of the first month at Woodberry I had a Latin test and scored only 56. The Latin teacher, Mr. Hubert Covington (we referred to him as Mr. Hub or Mr. Cov) called me in and said we are going to have to do some extra work in his Latin. I said, "I just can't get Latin. I flunked it last year in public high school and just can't get it."

He said, "There is nothing wrong with your brain, you are just lazy." That was quite a shock to be told that I was lazy, but he was right. He made me come in every afternoon right after lunch before athletics to spend an hour with him. The next month I got an 86 on the Latin test. On the paper he

wrote "nice going!" He underlined it with a red pencil. I still have that exam paper today.

DR. PEARSON: Have you found that you needed Latin to be a doctor?

DR. HENDREN: Emphatically no! I know prn, ac, pc, and a few such abbreviations. But "Mr. Cov" turned me on academically. My third year of Latin I had a 90% average for the year. He really bailed me out academically and I was no longer content if I didn't get good grades. That was the turn key. Also he saw that I was very small. When I went to Woodberry as a fourth form student, I weighed only 105 pounds. That was as a sophomore in high school.

DR. PEARSON: How old were you? Sixteen?

DR. HENDREN: No I went to Woodberry as a sophomore. That was in the fall of 1940, so I was 14. My voice was just beginning to change. It changed by the time I went home for Christmas. I was too small to play varsity football, and so I played midget football with the younger kids. I was only five feet six inches tall, not a very good height to play basketball either. Mr. Covington said, "Why don't you go out for wrestling?" So I went out for wrestling. One day he said to me, "We have a match with the Severn Academy coming up. It is a prep school in Maryland for the Naval Academy. What would you think if I call their coach and ask if they have a man they would like to wrestle at 105 pounds? Would you like that?" Of course I said that would be just great. So he worked with me for a couple of weeks, and taught me some basic wrestling moves, takedowns, escapes, pinning strategies, and so forth. We had the match with the Severn Academy. I won my match decisively, pinning the opponent. Previously the lowest normal weight class was 121 pounds, as it is in college. Of course it made good sense to have a lower weight class when you are dealing with kids who are smaller. Ultimately I became the varsity 121 pound wrestler in my senior year and won the varsity "W." Several years later when I was in the Navy at Iowa [US Navy] Pre-flight School, I got the top athletic grade in our battalion where grades in the ten different sports activities were averaged. It was all about the degree of competitive spirit that you demonstrated, something the Navy feels is important when you are training young pilots, particularly those who want to become fighter pilots. Wrestling became my favorite sport. I was pleased that my own four sons took to it, and one of my own grandsons is currently becoming a very good wrestler at 140 pounds. It is a great sport which requires developing self reliance, when you are one on one on the mat with no one else there except the referee. But at the same time you are also a member of a team, which is what is required in many activities, the operating room, flying airplanes, team sports and so forth. I am very proud to be a Trustee at Woodberry Forest today. About thirty years ago I wrote to Mr. Covington to tell him what an important influence he had been on my life.

Six years ago I dedicated a chair in the new auditorium in his memory to acknowledge what a genuine catalyst he was for me.

DR. PEARSON: So you graduated in 1943?

DR. HENDREN: Yes. When I was a senior we got used to airplanes coming over to buzz the school because there was a student in a class below me who had an older brother who was stationed at an Army Air Corps base in Virginia before going overseas. He and some squadron mates would buzz us at low altitude in P-40s and P-47s, because Woodberry is out in the country where they could do that without much danger. Several in my class got hooked on aviation as a result of their buzzing the school. Just a few days after I graduated from Woodberry, on June 5, 1943, I enlisted in naval aviation at the Cadet Selection Board in Kansas City. (That building was just a block away from where I used to go to the orthodontist for three years during grammar school. The cost to straighten my teeth was three hundred dollars. That was a lot of money then.) The Navy medical corpsman who weighed me during the physical examination told me to go downstairs, drink water, and eat bananas, because I weighed only 117 lbs; the requirement was 120. When I came back after filling my stomach with as much water and as many bananas as I could, I tipped the scale at 119. He fudged the one pound for me.

The next week I went off to Dartmouth [College] to start the freshman semester and await military call. My roommate was John Crowe who was also from Kansas City. John's mother was very liberal. She put us on the train and handed John a bottle of Bushmill's Irish whiskey. By the time we got to St. Louis both of us were pretty well tanked. We got off the train briefly in St. Louis so he could mail a postcard to his girlfriend, Dotty. He was ahead of me as we were scrambling back up the Pullman steps onto the train. His heel came up and caught me under the chin. I bit hard on my tongue. When we arrived in Hanover, my first stop was Dick's house, the student infirmary to have my tongue inspected. It healed, but it was sure sore for a few days.

DR. PEARSON: Tell me a little bit about going to Dartmouth College. You had no personal connections.

DR. HENDREN: No, I had no connection with Dartmouth and didn't even know where it was except that it was up in the north in New Hampshire where it was cold. My dad wanted me to attend the University of Virginia where he had gone. I wanted to do something different than my father had done. My stereotype of Harvard [University] was not such that I wanted to go there. One of my dad's friends from Kansas City, who was somewhat of a pompous, stuffed shirt type, frequently reminded all that he was a Harvard graduate. As a matter of fact he was on the board of overseers. I did not know it at the time, but the man who was in charge of the Naval Aviation

Cadet Selection Board in Kansas City was a Harvard graduate also. He was Mr. Edward Washburn. After the war he became the treasurer of my father's company. Ned was not at all pompous. When I told dad that I did not want to go the University of Virginia or to Harvard, he told me that another friend of his, Mr. Joe Holiday, who worked for Bemis Bag Company in Kansas City, said that Dartmouth is a great school, and suggested that I apply there. That is what I did.

DR. PEARSON: Only one application?

DR. HENDREN: Yes, I applied to only one. There wasn't any need to apply to more, because colleges weren't getting many applications because of the war. This was 1942.

DR. PEARSON: Just after Pearl Harbor.

DR. HENDREN: Yes. I can remember listening to the radio on Sunday evening, December 7, 1941, when President Roosevelt announced that the Empire of Japan had just attacked Pearl Harbor.

DR. PEARSON: I think those of us who were alive that day remember that Sunday afternoon very clearly.

DR. HENDREN: It was the impetus to start thinking about enlisting in a service of one's choice before age 18 when the draft kicked in. My enlistment was just four months after I became 17, and I was on active duty for three months before reaching age 18. So were most of us.

DR. PEARSON: So, now you're at Dartmouth.

DR. HENDREN: There were only 156 "civilian" freshmen in our class of 1947. Most of us had already enlisted and were waiting to be called. The college was filled with students in uniform, Navy and Marine V-12 students and Army ROTC students. I looked up a first year medical student, Ed Price, from Kansas City. He let me go to the anatomy laboratory, where they were dissecting a body. The smell of the embalming fluid, the vista of a partially dissected human body, and the spectacle of the four men on his cadaver eating their lunch from a bag at the dissecting table, was too much for me. I slipped quietly out of there and wrote home to my family that I was not sure I would stand up to becoming a medical student some day after the war.

After the first semester, which I passed but did not do anything very spectacular, I went home for a short vacation between semesters, taking a friend, John Wolfe, with me. John came from Honolulu and had lost a leg when hit by a bus on his bike. My Dad took us duck hunting. We were wading across some shallow water when John's prosthetic leg buckled under him in the mud. As he fell, his shotgun discharged just behind my head at a

very close range. That underscored the danger of hunting with a novice who was not schooled in gun safety. During this brief vacation I went to the Cadet Selection Board and asked when I was going to get called. A seaman clerk pulled up my file and said, "We have you listed as being in college, and so we are going to let you finish the first year before we call you." I was still three months shy of being 18, and so that was not unusual. I told him, "I want to be called now." He said, "I will see what I can do." So he extracted my folder from the file and put me on a list to be called. John Wolfe returned to Dartmouth. I got called two weeks later, in November 1943. It was a big relief. The attitude of most fellows of my age group at that time was very positive about getting into the fray. At that age, the idea of getting killed seems remote and unlikely.

DR. PEARSON: You spent two-and-a-half years in the Navy?

DR. HENDREN: No, three years. When inducted I got put in charge of a group of 120 of us. I was not particularly happy about that. Orders sent from the commandant of the 9th Naval District at Great Lakes, Illinois, read: "To Seaman second class, William Hardy Hendren, III; you will proceed from the Union Station in Kansas City to the Naval Air Station at Hutchinson, Kansas, etc." My name was at the front of the orders which all of these guys had and made me a real target. They piled us into a train and locked the doors so we could not wander. We filled an entire car. When the train stopped in Topeka, Kansas, some scalawags selling food knocked on the windows. We handed out dollars for sandwiches which they said they would bring to us, but they were crooks and just ran away and left us with nothing. This was an early lesson in life.

We had been seated in alphabetical order as we were marched onto the train. When we were rolling, a fellow sitting near me, Richard Roth Hooper, from Adrian, Missouri, said "I wonder who is William Hardy Hendren III? That is a pretty name," or some such wise guy remark.

What do you do under those circumstances? Well you have no choice except to respond. So I stood and sized him up. He was about my size. I said, "That is me. Do you want to do something about it?" He threw a fist at me. I grabbed his arm and had him down on the floor of the train very quickly, because he did not know the first thing about wrestling, but I did. I got him tied up with my left arm, with both of his arms upward and behind his neck. I then put my right fist in his face and asked, "You want me to pound your face in with this?"

He said, "No that's it." It was interesting because all the other fellows sitting there were watching, waiting to see how this was going to evolve. That is just typical male behavior, isn't it?

DR. PEARSON: Yes.

DR. HENDREN: Young males with too much testosterone. And I remember the other fellows sitting with us, Hall, Hauer, and Hokr. Frank Hall, who came from a Kansas wheat farm, was a big strong fellow. He could have taken just about anybody around us, but he was very mild mannered and easy going. Dick Hooper, on the other hand, evidently felt compelled to establish himself as "the cock of the walk." We became very good friends, once the introduction was over! Dick dropped out of training ultimately. I saw him a few times after being discharged from the Navy. He worked for General Tire Company in Kansas City. He flew a couple of times with me at the Naval air station in Olathe, Kansas.

We arrived in Hutchinson at about 4:00 am, having sat up all night. They had no uniforms ready for us, and so we were walking around in civilian clothes for several days. We slept in a bed with no sheets. The bed was a mattress, with a canvas cover over it. During the day the mattress was folded over. The blanket was put at one end, folded. Each of us lived out of a footlocker and a little vertical locker in which a uniform could be hung. Reveille was sounded at 0530. The first day it was the Boatswain ("bosun") mate running a Billy stick around inside the GI can at the end of the room. That is truly a rude awakening. Later it was a record with a bugle blowing reveille over the PA system. We would jump up, throw on our dungarees, wash briefly, and then head for the dining hall. There was a lot of drilling at first. Then we had various classes to learn how to behave in the military. We also had mess cook duty, which was working in the mess hall with a group of swabbies who were not of a very high social order, one might say.

Soon we were tending airplanes. These were open cockpit biplanes, the Stearman, with fabric covered wings. They were called "Yellow Perils." Two of us would have a group of six of these airplanes. In the center was a gasoline pit, in the ground, with a hose that would roll out enough to gas up six airplanes. Our job was to ready the planes. This involved taking the covers off the engines, removing the spoiler boards from the wings, and then warming up the aircraft. First you had to pull through the propeller 2 or 3 turns, to flush any oil that might have settled in a dependent cylinder during the night. One of us would sit in the cockpit, and the other would begin cranking the inertia starter. That is a heavy fly wheel which was put into motion by a hand crank of the other one of us, standing on the leading edge of the lower wing. It was cold, very cold in Hutchinson in December, January, and February. The man on the crank would start cranking. It would be slow going. Finally, when the starter wheel was turning fast enough, the man in the cockpit would turn on the ignition switch and the wing man pulled the starter lever. It would engage and turn over the engine. In the cold that usually took 2 or 3 attempts before we got the engine going. Then we'd warm up the engine. This was done for all 6 planes. Then the aviation cadets would arrive, plus their instructors if it was to be a dual flight. Two hundred of these trainers would taxi out and take off like a swarm of bees from a mat, not a runway. The mat was tar and macadam. In

truth, this was a boot camp for us and a way to keep us busy for a few months. Fellows who enlisted just a few months before us skipped that part of "flight training." Our official designation was "tarmacs." All of the two hundred planes would come back in about an hour and a quarter. We would scramble to get them gassed, and get ready to dispatch the second flight. When the day ended after the sixth flight, we had more than earned our pay of "54 dollars a day once a month." At the end of this four month indoctrination into the Navy as "tarmacs," we were supposed to go for several weeks of flying small planes for enough hours to weed out those who obviously should not go further. That was then to be followed by going to one of the four Navy pre-flight schools (Chapel Hill, North Carolina; Athens, Georgia; Iowa City, Iowa; or St. Mary's near San Francisco).

When our four month stay at Hutchinson was finished we were unpleasantly surprised with the news that we were not headed down the same path as the previous group whom we had replaced as tarmacs. Because the war in the Pacific was going better than expected by February 1944, our syllabus was changed and lengthened. This was an enormous disappointment, but there was no way we could change the bureaucratic edicts from on high. We were transferred to Washburn Municipal University in Topeka, Kansas, which had a V-12 program. We were labeled V-12 A, which meant that after one year, we would be returned to aviation if we wished. Since I had one semester at Dartmouth, I did not have to take the same course as the other men, most of whom had been to no college at all. I decided to make the most use of this enforced time in Kansas, recognizing that Washburn is an excellent school, to knock off some of the premedical courses that I would normally be taking after the war. I took inorganic chemistry, qualitative analysis, and quantitative analysis with Professor Reid, an excellent teacher. I was the only male in his chemistry classes. I took German and French, completing my college language requirement. Professor N. E. Saxe, who was German, taught me those courses. There were no other students in the classes! I also took a zoology course. I got three semesters of college credit. Later Dartmouth would not transfer my numeric grades as such (which were excellent) but they did transfer the credits to Dartmouth when I returned. After Topeka, those of us who had lasted were finally transferred to Iowa pre-flight school, battalion 3A, beginning March 1945. We were now finally aviation cadets, after being in the Navy for 16 months! When I enlisted, flight training was advertised as being 9 months in length. Most of the men who enlisted just a few months earlier than our group were in the Pacific by the end of a year or so.

Pre-flight school had each day, half a day of athletics and half a day of ground school. It had been ten weeks. For us they made it six months! The academic courses included aircraft and ship recognition, aerology, engines, aeronautics, navigation, code and blinker. The sports included soccer, water polo, gymnastics, track, obstacle course, football, boxing, wrestling, hand to hand combat, and swimming. Swimming included jumping from a high

platform in the gymnasium, holding your scrotum with your left hand and your nose with your right hand to keep from jamming water up your nostrils when hitting the water. During ship sinking, often men were frightened to jump from the deck of the ship into the water and swim clear. This was the reason for teaching us to jump from a high platform.

Grading of the different athletic events really depended more on how hard you were trying, that is how aggressive you appeared to be, rather than specific skills in a particular sport. I had no specific skill at boxing, but that did not matter. What mattered is that you went after it as if you really meant to clobber the opponent. My roommate, Bill Shank, and I were about the same size, so we really went at it. With big, pillow type boxing gloves, you should not really hurt each other. Both of us got a 4.0. In hand to hand combat, they would give one fellow a Billy club and say "ready, strike." The striker was supposed to come straight down at the head of the opponent, who was supposed to deflect the club with his arm to protect his head. One man, Red Kennedy, jumped the gun after ready and hit his partner over the head. He got a 4.0 and the victim got a 2.0, plus scalp sutures. Another sport was water polo. There was only one rule, namely that you could not hold onto the spit gutter and at the same time hold your opponent down under water. A lot of the fellows were non-swimmers, amazingly. This included one of my roommates, Al Busby, who had been a rear seat gunner in the fleet, and whose pilot had to ditch their SBD [Scout Bomber Douglas] dive bomber. Wearing a Mae West [life preserver], he ran along the wing of the plane while it was still floating and made a long broad jump into the life raft already deployed by the pilot. The non-swimmers would play water polo wearing water wings. The technique for winning at water polo was to swim fast towards opponents with water wings, strip them of their water wings, push them underwater; then get the ball. In soccer the coach said, "Don't worry about the ball. Get the other man first and then get the ball." Other sports included gymnastics, track, the obstacle course, football, and swimming. I actually ended up coaching our battalion wrestling team because the real coach got transferred, so a substitute was needed. Our team won the battalion championship. I wrestled at 140 lbs. This was the long-term result of my Latin teacher, Mr. Covington, who introduced me to wrestling. I gave him the follow up many years later.

On weekends we had limited liberty in the college town of Iowa City. I met a lovely, refined girl, Irene Connors, from Clear Lake, Iowa. She was a Wave (Women Accepted for Voluntary Emergency Service). She was the secretary of the commanding officer. Dating a nice person for six months in those days did not mean that you jumped in bed with her. We simply did not do that. That was not the culture I had been brought up in at home or at Woodberry Forest, a school with a highly cherished and respected honor code. More of that culture is needed today. When the war in Europe ended on VE [Victor in Europe] day, April 1945, Naval Aviation training continued unchanged. There remained the formidable job of finishing the Pacific War. To be sure,

cessation of fighting in Europe was a big step forward, but the certainty of needing to invade Japan loomed large. The enemy's do or die for the emperor attitude, amply illustrated as Japan's island outposts fell, made likely huge losses of lives, both military and civilian, in achieving surrender of the Japanese mainland. Good examples were the battles for Okinawa, Saipan, Iwo Jima, and many others, as well as the Kamikaze pilots, or today's suicide bombers. Suddenly the outlook changed abruptly when on August 6, 1945, the first atom bomb was dropped on Hiroshima leveling the city and killing over 80,000 people. When three days later the second atomic bomb was dropped on Nagasaki, Emperor Hirohito announced Japan's acceptance of an unconditional surrender on August 15th. Critics of President Harry Truman's decision to use this ultimate weapon overlook the huge number of lives, both allied and Japanese, saved by the abrupt ending of the war without an invasion.

At Iowa pre-flight school, rolls of toilet paper were draped over the buildings to celebrate the war's end. We had just completed our pre-flight school syllabus. We were given a choice: 1) Immediate mustering out of the service; 2) Continuing with flight training, but at completion signing over for an added four year enlistment. Having been in uniform for 24 months already, I was anxious to finish what I had started. Therefore, I signed up immediately to get on with flight school. I was, in fact, gambling that after finishing we would probably be able to choose between staying in the "peace time Navy" and signing over to a reserve squadron.

Orders were issued for a week of home leave and then transfer to the Naval Air Station at Norman, Oklahoma. Oklahoma is tornado territory. The day we arrived, eager to begin flying, a tornado hit the air station. The 200 "Yellow Peril Primary Trainers" were tossed around like leaves in the wind, smashing most of them beyond salvage. Indeed a sizable transport plane was parked and secured with tie downs, but was picked up and landed on its back a good distance from where it had been parked. The job at hand now was to get a new complement of trainers. They were ferried down from Glenview, Illinois, a former primary training base which had just been phased out. I am sure that being at the American Academy of Pediatrics office in Elk Grove Village, you know just where Glenview is. It is not far from there.

DR. PEARSON: Near O'Hare [International Airport]?

DR. HENDREN: Yes.

My first flight was on October 2, 1945, with my instructor, Ensign Harry Bruder from Long Island. Primary flight training has multiple parts, stages A to E. I passed my A stage check ride with Ensign Love on September 24th with an accumulated flight time of 14 hours. The next flight was 1.3 hours SOLO on September 25th. What a thrill! I still have my aviator's flight log book with all of the entries from 61 years ago. The primary syllabus

included precision landings, simulated engine failure with an emergency landing in a 50 foot circle, acrobatics, formation flying, a cross country flight, and several hours of night flying. The last flight at Norman was logged on December 21st. I had 102.5 air hours, 54 solo and 48.5 dual (with an instructor). It was bitterly cold in an open cockpit trainer in Oklahoma in the winter. I was admitted to "sick bay," the small base hospital facility, with a high fever and strep throat. I was put on frequent injections of penicillin, a new drug at that time. I was getting a homeopathic dose with each injection.

DR. PEARSON: Ten thousand units a day?

DR. HENDREN: A sailor in the next bed was getting the same penicillin shots for "the clap," i.e., gonorrhea. He bragged that "You are not a man until you get the clap!" In several days I was released to take a train to Kansas City for Christmas leave, and then go onto to Corpus Christi, Texas. Significantly at every physical exam after that strep throat at Norman, a systolic murmur was heard. Each physician reassured me, "Don't worry, it is just a functional murmur." In retrospect I am convinced that the strep throat had produced the murmur and had damaged my aortic valve, but I am getting ahead of myself.

Corpus Christi, Texas was a delightful switch. Now we were flying the SNJ (a T-6 Texan to the Army Air Corps). It was "a real airplane" with retractable landing gear, flaps, a variable pitch propeller, and a 650 horsepower engine. It was inspirational to see famous Navy pilots who were stationed at Corpus Christi. One was Commander David McCampbell, the Navy's top scoring ACE (34 Japanese aircraft), another was Lieutenant Commander "Jimmy" Thatch, who had skippered the carrier Yorktown's fighter squadron. He developed the fighter tactic known as "The Thatch Weave" in which two planes weave from side to side to cover each other's tail, to be able to shoot down any enemy who might be following the tail of one's partner.

At Cuddihy Field at Corpus Christi I got my only down check during all of flight training. In every stage of training there is a check ride. If a check pilot puts a down arrow after the cadet's name on the scheduling board, one must then fly two successive "up flights" with two other instructors. Failing to do that, was an automatic washout of flight training and reassignment to the fleet as a sailor. My heart sank when I saw my check pilot was Lieutenant (JG) Harrison. We called him "down check Harrison." He came trudging out to the plane with a grumpy look on his face. There was no small talk or words of encouragement. He had red hair. In retrospect, getting him for a check pilot was a good life's lesson. I had known what a bastard this fellow was, and I was all psyched up in advance that he was going to flunk me. He had me spooked from the take off on, never saying a word except barking commands as to what he wanted next. When we landed he put a down check by my name and trudged away without saying a word to me.

The next two check pilots were reasonable people. The first was Ensign Swenson and the second Lieutenant (JG) Irving. I did fine with both of them. (I tried to keep this in my mind during a 52 year career in the operating room; to remind myself that good people can get flustered if a mean check pilot, or senior surgeon, over stresses them!) After being at Corpus Christi from January to April 1946, I had a total of 119 flights and 164.6 hours of flight time. Next we were transferred to Pensacola Naval Air Station in the panhandle of Florida, traveling by train, with a few hours of liberty in New Orleans en route to Florida.

At Pensacola, we were greeted with another new change in the syllabus, namely we had to take a twin engine syllabus also. I was lucky to get twin engine land airplanes, and not the PBY Catalina "flying boats," which had been used for long range patrol flights and air sea rescue. The Catalinas were slow planes, with a cruising speed of 160 knots, two engines, and a wingspan of 105 feet. I was happy to get the Beechcraft SNB, which carried a pilot, copilot, and 5 passengers. It was a nifty plane, with two engines and a twin tail. Many of them are still in use today, like the DC 3 airplanes that have been flying since 1935!

We were at Corry Field for May and June for the twin engine syllabus. Two of us did it together, Cadet Feifert and me, alternating flights as pilot or co-pilot. It was at Corry Field that the Blue Angels – the Navy's crack exhibition flight squadron – were formed in 1946. They started in the F6F. I've watched them many times, in several generations of new fighters, over the past 62 years. Their current commanding officer is Commander Steve Foley. He's a great person. By chance, he lived with his brother here in Duxbury in a house across the street from us when he was a boy. I expect him to become an Admiral some day. He has "The Right Stuff!"

Then we went to advanced flight training out at Barin Field in Foley, Alabama, close to Mobile. This base had the nickname "Bloody Barin" because so many fellows got killed there in advanced training. That's the place where I got really hooked on seatbelts. One night one of the Cadets crashed in the woods. He got vertigo in the traffic pattern. If you're flying at night and don't have the moon, stars, or land lights for visual reference, then you can get vertigo and become disoriented. That's what killed young John Kennedy [Jr.] coming into Martha's Vineyard. He couldn't see the lights of the land because it was foggy. He was not an experienced instrument pilot and it killed him, his wife, and another person. Well anyway, this pilot got vertigo. He went on instruments, which is the proper move to make. You can tell by altitude, airspeed, and the gyro horizon what you're doing. But he'd forgotten to uncage his gyro horizon. In the caged position the gyro horizon shows the little airplane climbing, so he nosed his airplane down. It went into the woods doing probably 160 miles an hour. It was scrub pine. The wings were stripped off the airplane. The engine came off. The tail came off. The only thing that was intact was the cockpit, and he survived.

His only injuries were a broken arm, because his arm was flailing around the cockpit, and a fractured ankle, because he was flying with loafers instead of regulation high top shoes. When I saw that airplane, and saw him survive and live to fly again, I said I'm going to put seatbelts and shoulder straps in my first automobile. I did, by the way, later on in 1950. I secured them, with permission, from a scrapped Navy plane when flying in the Navy Reserve.

We did a lot of flying in June, July, and August at Barin: aerobatics, instruments, formations, combat, cross country, and gunnery. We were feeling then like real pilots.

Next we went to Saufley Field for carrier landing training. We had to do one hundred field carrier landings. We would fly the airplane to an outlying field where a carrier deck is marked out on the ground. There is a landing signal officer who has paddle-flags. With his flags he indicates whether you are too high, too low, too fast, too slow, or okay. The two mandatory signals are a <u>cut</u> and a <u>wave-off</u>. The L.S.O. is a very experienced pilot, incidentally.

You fly an approach pattern at a very low altitude, less than 50 feet. When you're doing carrier landings, you're flying very slowly, the nose of the plane comes up, and you can't see straight ahead. So, you design your pattern to be turning all of the way to the point where you come over the fan tail of the carrier. You're looking down the left side of the nose of the airplane at the landing signal officer. So we each had to complete one hundred field carrier landings before going aboard ship. We took off our parachute because we were so low it would be a hindrance in getting out in an emergency. There were no ejection seats then.

The above describes the way it was with World War II carriers with a single deck. Jet aircraft prompted the current design of a second, angled deck on the port side. There is still an L.S.O. but the aircraft come in straight, not turning, at about 165 knots (1.15 times greater than speed expressed in miles per hour). Full throttle is added just before the landing hook catches a cable so that take off speed is maintained until the cable abruptly stops the plane. That way, if the tail hook misses the several cables stretched across the deck, then the plane is still at flying speed and can go off again.

We were told to practice slow flight on the way back to the base. We knew when the airplane was about to stall because it would usually give a little shudder when stalling. So I was practicing slow flight back to the base when the plane stalled. When an airplane stalls, it drops right out from under you. In some aircraft, particularly the beautiful gull winged Corsair, it flips over and spins. If you are close to the ground, you are dead! The Corsair was sometimes called "the Ensign killer."

As the plane dropped, I floated above my seat, reflexively grabbed the hood over the instrument panel and slammed myself back into the seat, and then

recovered from the stall. Then I realized that I was still just sitting on my parachute. I had forgotten to buckle it on again. Then I noted that the sleeve of my flight suit had caught and opened the lock for the seat belt and shoulder straps. God was with me that day! I wondered what they would have thought to find my body in the woods several miles away from the crashed airplane, without a parachute. So that was a good life's lesson, to be careful. We were constantly reminded that flying is not inherently dangerous but the airplane is unmercifully unforgiving of human error. Of course the same is true of surgery!

The final phase of training was making six carrier landings on the USS Saipan, skippered by Captain John G. Crommelin, a highly decorated naval aviator. He was one of four brothers who had all graduated from the naval academy. Captain Crommelin told us that morning in the ready room, "One of you will make the 2,000th landing on my ship today." When it came time for our group of six to fly after lunch, we were told one of us would make the 2,000th landing. My first landing was fine. I came around in the groove and landed. My tail hook grabbed an early wire and jerked me to a stop. A deck man released the hook, another dropped the barrier, and I took off again. On my third landing, as I came around in good position, looking down the left nose of the airplane, the landing signal officer suddenly gave a wave-off. A wave-off is a mandatory signal. You're supposed to flare left for a wave-off. I reflexively and quickly glanced left before turning left. It was lucky that I did because there was another airplane not thirty feet from me. It was one of my good friends, Peterson, who had miscounted the number of thirty seconds that you're supposed to fly out on take-off to get the proper interval between the airplanes circling downwind before the final turning to land. He was making a picture perfect approach, and so was I. We were not in radio contact with the carrier because the whole idea was to be learning to follow a landing signal officer's flags. We were both intent on watching the L.S.O. and were oblivious of each other. The L.S.O. gave the wave off and hoped we would see each other. It might have been safer if he had done that sooner, in retrospect. I flared right and went around the island of the carrier on the starboard side. Peterson flared to port side. Some on the carrier thought we were two hotdogs vying for the 2,000th landing! Neither of us had a clue what the numbers were! Both of us got back into the pattern, aware of each other now. It happened that my next landing was the 2,000th. The pilot who makes a thousandth landing on a carrier is the captain's guest for dinner. The ship's cook baked a cake saying, "Congratulations Ensign Hendren – 2000th Landing." I didn't have a clean shirt with me, and so I had to borrow a shirt to dine with the captain. The only neck size that I could get was a 14, and I had a 16 ½ neck.

DR. PEARSON: You'd grown a little since high school.

DR. HENDREN: Yes. I was now almost 21 and weighed 150. To conceal the large collar gap I tied a big Windsor knot in my tie. When I joined

Captain Crommelin, the ship's doctor, and the executive officer, Captain Crommelin said, "Is this a new style that you're introducing to the navy?" I laughed, and said "I'm so sorry but this is a borrowed shirt. The man I got it from is considerably skinnier than I am." He thought that was a good solution. Then he wanted to know what my next plans were and I said, "You're probably not going to like this, but I'm going to elect to get out and go into the Reserve, while going back to college and medical school. I wish to become a surgeon." Well, he didn't think too much of that, but that was what my plan was. We got our wings on October 4, 1946.

From October 1945 to September 1946 we had logged 312 flying hours and checked out aboard ship. On enlistment in June 1943 we had been told the whole program would take less than a year! We were all disappointed to have missed action in the Pacific war, but that had been out of our control, and it likely saved a lot of lost lives in our group.

On October 7th, three days after we were given our wings of gold, a hurricane alert came for Pensacola. All of us awaiting reassignment or discharge orders were told to report to squadron headquarters to be assigned a plane to fly to an air force base at Monroe, Louisiana. Sixteen of us were bused to Whiting Field; briefing and maps were given to one pilot, a LTJG who had allegedly been teaching navigation. He got us lost!

It was nightfall when he suddenly peeled off and went down. He was out of gas and didn't bother to explain what he was doing. He landed wheels up in a dirt field near Tchula, Mississippi. It was now clear that this was one big foul up. I saw two planes land and leave their landing lights on as a guide. I nearly landed in the same field until at the last moment I realized it was cotton. Ray DeGroot, one of our group of six from Barin Field and carrier landings the week before, was nosed up in the cotton, hanging forward on his shoulder straps and unscathed. His wing had just leveled an outhouse next to an unlit sharecropper house. We later mused that the luckiest person was the one not in the outhouse at the time!

It was very clear that there was no semblance of even a small airport and that this was a very dangerous situation. My gasoline supply was about half way down in the reserve tank, i.e. about 10-15 gallons maximum remaining. I ascended to about 1000 feet, slowed the air speed to conserve fuel, and just thought for a couple of minutes about my possible options. I could jump out – not a happy thought at night over questionable terrain; I could fly a reciprocal course – one man did that and found Jackson Air Force Base – but with no maps and no idea where we were that seemed unwise. Suddenly a set of landing lights from another plane went on. I watched him. He landed on a two lane highway! A local former B-29 pilot had seen the planes in trouble and sent some friends to barricade a stretch of straight road just north of the tiny town of Tchula, Mississippi. Of course we didn't know that. The pilot left on his lights for me as a target. I flew over him, saw no obstacles such as

a bridge or wires crossing the road and then flew a carrier approach, low and slow, and dropped onto the road just beyond my friend. The concrete was only a few feet wider than my landing gear. My right wheel went onto grass next to the highway. The right wing noisily cut through weeds in a wide ditch. I kicked the left brake, got the plane back to the middle of the road, all in a couple of seconds, and then stopped. My feet and legs were shaking uncontrollably from fear and excitement. The ditch was a "borrow pit," common in the Mississippi delta area where fields often flood in spring when the river is high. The highway crews "borrow" dirt on each side to elevate the highway above the level of the adjacent fields. The wing dipping into the ditch was an ideal set up for cart-wheeling the plane, which would have exploded. I taxied down the road, making small "s" turns to see ahead, and in a short way found a dirt cross road. I turned in to it, set the brakes, and cut the engine. In a short time I was surrounded by a big group of young black kids. One cute little one gingerly touched the plane and exclaimed, "Whoowee, am dis ting big." I was so grateful to be alive that I picked him up, hugged him, and gave the Lord a silent prayer of thanks. I've often thought at various times I was spared to accomplish bigger things. This has perhaps stirred me onto continue working!

Soon a "man in charge" arrived, Dr. J. J. Kazar, the town's only doctor. He wore army fatigues; he had served in the China-Burma-India theatre during the war. He had delivered many of the locals. He "assigned" watch duty over our planes and invited us to his home nearby. The next morning the two planes in the cotton field were towed out and lined up with our two on the highway's edge. Many passing cars stopped to inquire what we were all about. One thought it might be an air show about to happen. A gasoline truck arrived from Jackson, Mississippi, about sixty miles south of us. However, engineering at Pensacola insisted that the flyable aircraft should be jacked up to test the landing gears before being cleared to leave. We were flown back in an SNB from Greenwood, Mississippi where there was a then closed up Army air field, just 20 miles north of Tchula!

Test pilots were later dispatched to fly back the planes, as if those who landed them safely were not able to take them off! We had been very lucky. Fifteen planes (one never took off as it had an engine problem) had made forced landings at night and no one was hurt! One Catalina dispatched to Corpus Christi hit a marker pylon in the water. All aboard were killed. The hurricane never hit Pensacola. Forecasting then was not like that of today! The officer who dispatched our group with insufficient briefing and maps for only the leader, was later court marshaled. One of our group of new pilots was showing off for his girl friend on a Pensacola beach and crashed doing a slow roll at low altitude. That ended the romance. There are old pilots and bold pilots but no old, bold pilots! --- Especially foolish ones.

Going back to the highway landing for a moment: at daylight the next day we saw a lumber mill just to the left of the highway. It had a tall boom-like

structure with steel cables to support it. Both of us who landed there must have been very close to that unlighted hazard. In 1943 Col. Robert L. Scott of the Flying Tigers wrote a book, *God is My Co-Pilot*, about his wartime experiences in the single seat P-40 Warhawk fighter plane. I think God was in my back cockpit that night. Regarding the briefly considered option of bailing out, by daylight we saw just to our left a large swamp. In it were burned out cedar trees sticking up ready to impale an imprudent parachutist! About 20 years later I met the wife of Dr. Steve [Stephen] Dretler, a prominent urologist at MGH [Massachusetts General Hospital]. She was from Greenwood, Mississippi, just 20 miles up the highway. She related how her father on Sundays would sometimes take her in an "airboat" to cruise in that swamp to shoot alligators and cottonmouth water moccasins!

For many years I exchanged Christmas cards with the nice Kazar family who had been so hospitable. Also they sent a bag of pecans at Christmas for some years. On two occasions when I was flying in the summer in the Navy Reserve, I flew over Tchula and changed the propeller pitch, which makes a loud noise. The Kazars knew whose greeting that was.

On March 27, 1981, I was visiting professor of surgery at the University of Mississippi in Jackson. The day is fast in my mind because as I was talking with Dr. James Hardy, the department chairman, by the OR desk, the telephone rang for <u>me</u>! It was my son Douglas calling to announce the birth of our first grandchild, Sarah Grace! Several days later Eleanor and I drove to Tchula. It had changed little since 1946. The multiple sharecropper houses previously scattered through the large cotton field were now located to the east side of the highway where the "borrow pit" had been. A man in the drug store, an important landmark, remembered the planes which had landed like a swarm of locusts that night 35 years before. No Kazars lived in Tchula any longer. Mechanized farm equipment had replaced many of the sharecropper families who had picked the cotton. Otherwise Tchula looked about the same as I remembered the little town where I nearly met my maker.

For the next two weeks we were assigned to towing targets over the Gulf of Mexico for gunnery practice by a carrier squadron.

By late October, orders were issued for those signed up to go with the fleet and those electing discharge and returning to school. I was tempted to stay but resisted. I loved military flying and so that was a tough choice.

I bought a 1934 Harley-Davidson motorcycle for $300. I drove it from Pensacola to Kansas City. As I reached Missouri, the muffler blew out, so it was pretty noisy. As I approached Kansas City the rear fender struts bent, weighted down by my luggage, and the fender was rubbing on the tire. So I came up West 58th Street in Kansas City, driving a motorcycle one handed and holding the fender off the back wheel, roaring in at supper time in a

sedate part of town. My father walked out and said not, "Hello son, glad to have you home after these three years." Instead he said, "You're selling that thing tomorrow." I didn't. He was annoyed because I had visited my maternal grandmother in Memphis en route, and had told Granny I'd be a day getting to Kansas City. I ran into rain, not a good situation on a motorcycle, even in a flight suit and wearing a helmet and goggles. It changed my schedule. Therefore, I stopped in Pinckneyville, Illinois, to spend the night with the family of Bess R., whom I'd known well while at Topeka two years before. It's easier now, with sons and grandsons, to appreciate how parents worry about their offspring, even when they're in their 50s and 60s! I was two days overdue by his calculations, so they were worried.

My father said the next week, "Woodberry Forest is having the annual Woodberry Forest-Episcopal High School football game. Would you like to go?" I said "Sure." He said "I have some business in New York, so we'll go to the Woodberry Game, then to New York, Chicago, and then back home." So Dad, Mother, sister Peggy, and I set out for Virginia. When we arrived, I drove them to Shackelford Plantation near Woodberry and I went over to our school.

There was a cocktail party in full swing at the Residence. The Residence is where the head master lives. It was designed by Thomas Jefferson for the brother of President Madison. As I entered the Residence I saw a friend, Fairfax Aikman. He had lived right across the hall from me at Woodberry. With him was Eleanor McKenna from Wilmington, Delaware. Fairfax and I stayed together that night in the Alumni room of the gym. Eleanor stayed with a faculty family. He told me that Eleanor had recently started flying with TWA in Kansas City and didn't know anybody out there. "Would you look her up?" he asked. I said, "Sure I'd be happy to take her to some of the Christmas parties that are coming up." This was Thanksgiving time. I had breakfast with Fairfax and Eleanor on the front steps of the school the following morning. Then we went to a chapel service in memory of the alumni who had died during the war. I heard Eleanor singing the hymns. She had a beautiful singing voice. And I thought to myself, "My, that's an attractive girl." I talked with her enough to know that she was of Scottish background. Her mother and father were from Scotland. They were Scottish Presbyterians, same as my mother. She really impressed me.

DR. PEARSON: Love at first sight?

DR. HENDREN: I couldn't say that at that point. But I would say that I was very impressed with this girl who suddenly appeared out of nowhere, with a background similar to my own in many senses, and obviously from a close-knit family. Her father, like mine, was an engineer. He worked for DuPont. I learned that during the war he had been very involved with the

atom bomb. He later worked for several years at the plutonium plant in Hanford, Washington.

About ten days later, when I was back in Kansas City, I called Eleanor and asked if she would go out with my sister, her fiancé Leonard Lombardi, and me. Leonard was the only other Eagle Scout in our troop, by the way. When I was driving her back to where she lived with three other TWA stewardesses, I stopped the car at a busy intersection, and I said, "You're the girl I'm going to marry!" She probably thought I was just out of my gourd. She laughed, and she didn't say anything. I had three months before going back to Dartmouth during which I had no official duties of any kind. I had missed the fall semester because this was November. Most of the days I would go out to the Naval Air Station at Olathe, Kansas and fly, which I enjoyed. I flew in the Reserves until I was a surgical resident and the schedule became too full to keep that up. Eleanor and I saw each other frequently and decided to get married. We eloped on my 21st birthday, and then returned to Dartmouth where I was a premedical student once again. We lived in a one room apartment, 12 feet wide and 20 feet long, #23 Wigwam Circle.

DR. PEARSON: My wife, Anne, and I lived a year in Wigwam Village too and it was Spartan. This was pre-fabricated housing put up during the war and used for married students after the war.

DR. HENDREN: My father had said to me originally when I told my parents I was serious about getting married that I might as well give up the idea of being a surgeon some day, because, "There's no way you're going to be able to go through all of that training." I said, "Sure I will." When Mom and Dad visited us at Dartmouth in 1948 when I got my BA and was all set for medical school, Dad said, "You know, the best thing that ever happened was for you to marry Eleanor. You would have never made it without her." That is true.

We had a bicycle because we couldn't afford a car. I bought the bike for ten dollars, a women's bike. It was our transportation. Sandy was born the next winter. We had moved to one of the double decker buildings, #128. It had a bedroom, living room, tiny kitchen, and a bathroom. The rent went from $20 a month up to $30. Heat was a kerosene space heater which burned heating oil which cost five cents a gallon! Every apartment had its own 50 gallon barrel outside. Red Bomhower, who drove a Shell oil truck, kept it full. In the winter when Eleanor went shopping, she would drag a little sled along with a box on it for Sandy. A lot of the mothers did the same. We had some good friends in our building. You got to know pretty well the other seven families in the building with you. The couple who lived just across the hall from us were Jack and Barbara Kent. Jack just died and it was a sad occasion to go to his funeral.

We had some other friends, Earl and Ann Reynolds, who had a car. Earl had flown a B-17 over Germany. Earl and I went to an auction where we bought a cow. She was a three year old, unbred, Ayrshire. We got her for $250. She dressed down to two-hundred pounds of beef for each of us. Of course a lot of it was hamburger and stew meat, but there were some steaks. So that's how we got a year and a half supply of meat which was stored in the new frozen food locker at the split in the Lebanon Road just past the gym. I worked in the medical library for 65 cents an hour, which was minimum wage in 1947. Do you remember Mrs. Robinson in the medical library?

DR. PEARSON: Yes.

DR. HENDREN: Two of us shared that job, splitting the time from 4 p.m. to 10 p.m. daily, and the same on Saturday and Sunday. It paid our rent.

DR. PEARSON: I did the same.

DR. HENDREN: Did you for sixty-five cents an hour?

DR. PEARSON: Yes. And I also did baby-sitting for twenty-five cents an hour for college professors. Like you I also sold my blood as often as I could for $20 a pint.

DR. HENDREN: One day I looked at Mrs. Robinson as I was relieving her and I said, "Excuse me, Mrs. Robinson, this is none of my business, but there's something on your nose, and I suggest you ask one of the doctors about it."

She looked at me and said, "You're absolutely right, Mr. Hendren, <u>that is none of your business</u>. If I had anything worrisome, one of the doctors would have already told me that." I just crept away, having been chastised by Mrs. Robinson. The next day the phone rang at our apartment. "Hello, Mr. Hendren, this is Mrs. Robinson." I thought that I must have misfiled some books or something else bad but she said, "I'm calling because I owe you an apology. I did speak to Dr. Tanzer. You know, Dr. Tanzer is the chief of plastic surgery."

I said, "I know, I've checked a lot of books out for him."

And she said Dr. Tanzer said, "Why my goodness, Mrs. Robinson, you do have a cancer there on your nose, and I will take it off for you. And isn't it interesting that a medical student saw that, and none of us doctors noticed it?" For the rest of my time in the library job, I couldn't do any wrong. She thought I was okay. That was an early lesson for me – to look for pathology.

DR. PEARSON: Looking at people directly in the face?

DR. HENDREN: Looking at people and spotting pathology!

DR. PEARSON: When you came back from the Navy, you took two years of general college before going to med school?

DR. HENDREN: Yes. I came back as a junior, and they gave me credits for the three semesters that I'd had in Topeka at Washburn University, which is a very good school. They also gave me a freebie credit for a year as an officer in the Navy. I got a lot of credits, but I had to take certain courses. One was organic chemistry. In the summer I took parasitology with Dr. Connel, do you remember him? One of the best courses I've ever had. And I took embryology with Norm Arnold. It was a split major termed "chem-zoo," i.e., half chemistry and half biology. The head of the zoology department was Bill Ballard. Roy Forrester taught physiology. These courses were in preparation for medical school. I worked hard and got straight As, once I had gotten through the first semester, which was lackluster. I still remember a few things that came out of the Great Issues Course my senior year. Shepard Stone, the managing editor of the *New York Herald Tribune*, talked to us. He was a friend of Dartmouth President John Sloan Dickey. The message of his Monday evening talk in Dartmouth Hall was that to sell newspapers, the three R's - Rape, Robbery, and Reno - had to be emphasized. He said "The tabloids have a much higher circulation rate than we do because of that. That's what they're selling."

DR. PEARSON: Yes. We were told we had to read the *New York Sunday Times*.

DR. HENDREN: We had to read either the *Herald Tribune* or the *Times*. So you take your choice. I too took the *New York Times*. Everything you needed to know was in it. The exams were made up from the *New York Times* current events section - "who's who and what's what?"

DR. PEARSON: So then you entered Dartmouth Med [Medical] School?

DR. HENDREN: Yes. I applied only to Dartmouth Medical School. We started in the fall of 1948. There were only 24 in our class, all from Dartmouth. I figured that Dartmouth gave us the better of two worlds. It gave us the first two "preclinical" years in Hanover and avoided going to "the big city" until the last two years of medical school.

DR. PEARSON: Tell me about your interactions with Dean [Rolf Christian] Syvertsen.

DR. HENDREN: I thought he was wonderful.

DR. PEARSON: A great man.

DR. HENDREN: He was a lovely man, and he didn't miss a thing! He perceived one afternoon that the whole class was goofing off in the sunshine, taking a break from our cadavers that fine spring day. He came out and he

said, "Well, we're going to have a little quiz. I'll bring you in one at a time." So I came in. He said, "Which is your cadaver?" Well, he knew perfectly well which my cadaver was. Our cadaver's name, by the way, was Emil Fischer. Do you remember the name, Emil Fischer?

DR. PEARSON: Yes. I remember.

DR. HENDREN: Dr. Hartschorn, who taught us organic chemistry, had a reverence for Emil Fischer, the organic chemist who first synthesized urea. We were so tired of hearing about Emil Fischer that we named our cadaver Emil Fischer. He was at the third table on the left in the dissecting room. Dr. Syvertsen knew my cadaver, and so he said, "Well, let's go to another one that you don't know so well." So he bent over the cadaver's right knee, rearranged the tissue, and draped it, leaving only a small window for me to look through. He said, "Now, is that the tendon of the semimembranosis or the semitendonosis muscle?" I looked at it and I took a guess.

DR. PEARSON: Fifty percent chance.

DR. HENDREN: Yes – except it wasn't either! It was the tendon of the vastus lateralis. Dr Sy said, "That's all."

I said, "You're not going to give me any more questions?"

"No. Go on out and tell the next man to come in." His wake up message to all of us was that we still had another month on the cadaver, so we had better get in there and get on with it. Well, that was wonderful. Were you on the burial detail for the cadavers?

DR. PEARSON: No, I never did that.

DR. HENDREN: Well, I've forgotten the name of the "society." I think it was the 12x12x12, for the hole to be dug. On the golf course, near the ski jump, we dug a big square hole. All the cadavers, each in a separate metal can labeled with the name and number, we buried deeply, and in silence. We then held a nice service in their memory. I never saw anybody who didn't like Dr. Syvertsen. We all mourned his death in an auto accident in January1960.

DR. PEARSON: I told you the story of the acceptance of my class into Dartmouth Med School. I'm a member of the Yale Med School [Yale School of Medicine] admissions committee now. We get four thousand applications. These are whittled down to 800 for interviews. We interview each of them with two people; look at MCATs, GPAs, and recommendations; and pick out two hundred, of which one hundred will be the class. Sy picked his class for three years hence on the basis of a 15 minute interview with incoming freshmen who had declared pre-med even before we'd really been in Dartmouth. It was amazing. And all of

us did well – five professors, several department chairs, one dean, and the rest fine practitioners.

DR. HENDREN: That's amazing. Eight of my class transferred to Harvard Medical School in 1950. As you know Dartmouth was then one of seven two year schools. All 24 of us went to excellent schools for the next two years.

DR. PEARSON: And you didn't live in Vanderbilt Hall?

DR. HENDREN: No, Eleanor and I lived in Hancock Village. The father of one of my Dartmouth friends, Larry Denton, was an executive of John Hancock. He arranged for us to get a unit in Hancock Village in Brookline. The rent was then $125 a month in "the big city."

DR. PEARSON: We called Dr. Syvertsen the mole, by the way.

DR. HENDREN: I never heard of that. He slouched down in his car, so that all you could see was the brim of his hat. He got killed by a car he did not see.

DR. PEARSON: Probably because of some high snow drifts. It was a typical Hanover winter, and as he was coming out of his driveway he got hit by a car going by. When did you get your first car?

DR. HENDREN: After graduation from Dartmouth Medical School. My father gave us a 1950 Ford. It cost $1,200! I put seat belts and shoulder straps in it, which I took with permission from a wrecked airplane at the Naval Air Station in Olathe, Kansas, where I flew as a Navy Reservist.

DR. PEARSON: Let's talk about your Harvard Med [Medical] School experiences. You came down as a third year transfer student, and had assigned rotations through medicine, surgery, pediatrics and that sort of thing. At one time, you mentioned that you attended lectures by Dr. Robert E. Gross, Surgeon in Chief at Children's [Hospital Boston].

DR. HENDREN: That's right. It was in the spring of the third year. There in the Brigham Amphitheater, Dr. Gross gave two lectures. The whole class would attend the eight o'clock, common curriculum lecture, which included a series of lectures on various specialties. They don't do that anymore sadly. I thought it was a good thing for all of us to share certain key lectures despite widely different eventual plans.

Gross gave two lectures covering pediatric surgery. He was a very impressive man. I learned that there was an elective course you could sign up for to get a month's rotation in surgery at Children's. I saw Dotty Murphy, the registrar. She signed me up for it, for July of 1951. I literally lived at the hospital that month. Eleanor was up in Bar Harbor, Maine, with

her parents and our two children. It was a wonderful month where I saw so much. I decided that I was going to make pediatric surgery at least a part of my work as a surgeon. My plan at that time was to go back to Kansas City to work with Dr. Larry [Lawrence] Engel, a distinguished general surgeon.

In October of our fourth year, the dean of the medical school, Dr. George Packer Berry, announced the matching plan. Do you know about that saga?

DR. PEARSON: I think I've heard it, but I'd like to hear it again. This was "Dean George Peckerberry," right?

DR. HENDREN: That's what we called him. He called our class for a meeting with him, on October 15, 1951, in Building C to tell us about the matching plan. As he described the matching plan, it seemed to me that what he was describing wouldn't work. In the first pass through the data, the IBM computer (punch cards then) would match the 1:1 choices of student and training program, no problem. But in the second pass, they were going to match the student's high preference with the training program's second choice alternate list. They thought this was favoring the student, but that was false! This meant that a good student, who might be number one on a lot of lists except the one he put down as number one, could miss out completely. The reason was that if he missed his number one choice, it was not until the third run of the machine that he was going to get a shot at his next choice. And that next choice, if it was an excellent hospital, would have already filled with alternates who placed it as their first choice.

Dean Berry couldn't see that. I was disbelieving as I listened to the dean of the Harvard Medical School missing this so completely. So I put up my hand, and I went down to the blackboard, and said that I think that the mechanics of this are flawed. I started drawing boxes with choice A, B, C, and so forth. He kept interrupting me saying that I just didn't understand. Finally I said, "Dr. Berry, I don't mean to be rude, but you've had 45 minutes to talk without interruption, I need five minutes to talk without interruption. I can't present this idea if you keep interrupting me." He didn't like that at all. When I was finished, he told me again that I just didn't understand. I said, "Well, excuse me, Sir. Let me ask for a show of hands of our class. Is there anybody in the room who does not agree with what I just said?" And they all did. Everybody in the room saw it except Berry! Associate Dean, Dr. Reginald Fitz, who was a little deaf - did you know he was the son of THE Reginald Fitz at MGH?

DR. PEARSON: The pathologist who first **described** appendicitis.

DR. HENDREN: Yes, but by the way, it was Dr. John Hunter who described appendicitis in the mid 1700's in London.

Fitz said in a stage whisper to Berry, "You know, George, I think this young man may have something here." Berry was really angry. Meanwhile, we had a tape recorder going on the counter and recorded it all. He said that they had spent $100,000 of money from the Association of American Medical Colleges in working out the details of this plan, and he didn't give a damn if any of us got an internship! Then he walked out of the room and slammed the door. I got all of that on the tape recorder.

That evening, several of us had a meeting. We were each interested in exploring whether we could change the mechanics of the plan. We somewhat immodestly called ourselves the National Student Internship Matching Committee. I called my father in Kansas City and asked him for a loan of $3,000. He wired it immediately. We got a telephone and a secretary, Ms. Terhune. We soon learned about the Rapid Service Press, a printing service just off what is now the Southeast Expressway. The manager there was Bill Krusell. If we gave him print today, it would printed, collated, and ready to mail tomorrow. They were great folks and fun to work with.

We mailed a letter to the class president of every medical school to assess sentiments from other schools, and asked for each school to send a delegate to a meeting to be held on October 21st, just a week later. It was obvious that we had to work fast.

We planned the meeting in Bard Hall at Columbia P&S [Columbia University College of Physicians and Surgeons], with the help of Leslie DeGroot and others in the senior class at Columbia. We picked that location because it was a more easily reached destination than Boston. We had 43 of the then extant 72 medical schools represented, despite such short notice, and we hashed this all out. Dean Berry had asked us if we wanted him to attend the New York meeting. Bob Dudley, our class president, said yes. I said only if he could now support our point of view. Later today, in my office downstairs, I will show you the records and transcripts of the meeting, which I have saved since 1951. Those archives will go to Countway Medical Library, where interest has been expressed in getting them.

The matching plan had been set up by a prestigious group of senior people. They included: George Stalnaker, head of the Princeton Educational Testing Bureau and operations director for the plan; Dr. William Crosby, president of Johns Hopkins Hospital; Dr. Joseph Mullen, Dean of the University of Chicago School Of Medicine; and Dr. George P. Berry. They simply could not see the thrust of our proposal. They had an IBM expert from Chicago who said that you couldn't set the machine up the way we proposed, which was to maintain a name on a hospital's preference list unless the student got matched at a higher choice. So, if you put down as your fourth choice a top notch hospital, you would stay on that good hospital's list if they had put you down as their first choice, unless you got accepted at one of your first three choices. The IBM "expert" rose and said it couldn't be done. I had

anticipated that and had gone to the accounting department at Mass General Hospital a couple of days before. There I met with Mr. Louis Servesio, who was the head of the accounting department. He said, "I can set that up." He set up a run on IBM punch cards for 100 mythical students with ten mythical hospitals. He gave me the cards. When the IBM man finished, I said I had taken this problem to Mr. Louis Servesio. I gave his credentials. Among other things he was a former naval aviator! I said, "He has run this, and it can be done, and I'd like to submit these cards to corroborate that." The IBM man studied the punch cards and realized that it was correct. He said, "It's true."

I've often wondered if the authorities had been bluffing us or whether they really just didn't "get it!" The meeting ended up with about six hours of verbiage, and we all went home.

Ms. Terhune typed the meeting transcripts. On November 2nd these were mailed to all class presidents, along with ballots to assess how students felt about the plan. Sixty-one schools voted. Out of 4827 students, 4275 actually voted. Only 317 favored the matching plan as presented to us on October 15th; 3735 voted no. Our modified plan, which we called the Boston Pool Plan, got 2380 votes. The old plan got 692; 648 voted for no plan!

On November 9th, a meeting was scheduled at the Palmer House in Chicago. Present were the executive committee of the National Interassociation Committee on Internships (Mullen, Crosby, and Stalnaker) and representatives of all hospital associations (Catholic, Protestant, Independent, Armed Forces, etc.). We at Harvard were notified at the last moment. I got two tickets, for Bob Dudley, our class president, and me. The meeting started with a lot of foolish talk. The gist of it was that it was too late to change the plan. After all, "This is October and there is no way that we can suddenly switch gears and change all of the mechanics of the plan. We would consider it for the following year, but we'll have to proceed the way it is."

I quietly said to them, "If you don't change the plan, it will be the end of the plan. I have votes from 95% of the students in the country. The vast majority will go along with the plan only if the obvious mechanical changes that we have proposed are made. These same students have said they're going to bolt if you don't change the plan. We're not going to sacrifice our futures because of the errors you all have made in setting this plan up the way you have." Then, after our short stay in Chicago, Bob and I flew back to Boston. We were called in several days later and were told the plan had been changed to what we had proposed. I've got the personal letters sent to me by George Stalnaker which I will show to you. November 19th was set as the date student and hospital choice lists were due.

Then things were quiet until March 14th. I was on medicine at the [Peter Bent] Brigham [Hospital], when I was summoned to go to the dean's office. There was George P. Berry sitting in his chair looking very important and philosophical, and very angry. He said that he had reason to believe that the plan was going to blow up tomorrow. He added that if that prediction became true, he would hold me personally responsible for having created the opposition to the plan they had put together (which was not so), and that I would not graduate from the Harvard Medical School! So I went home and told Eleanor that the dean of the medical school had just threatened me with non-graduation because we tinkered with his plan and I was outspoken about it.

The next morning the plan worked beautifully. Dean Berry began to get congratulatory telephone calls and telegrams from all over the country from other deans extolling how well the plan had worked, how their classes were all matched within three or four runs of the machine, and everybody was amazed at how well it had run. He also had praise heaped upon him for "letting his students carry the ball while he himself remained in the background!" He never apologized to me!

DR. PEARSON: He never called you again?

DR. HENDREN: No, he did not. He gave a special award at graduation to Bob Dudley for his role in the matching plan deliberations. Actually, Bob had chronic osteomyelitis and excused himself from all the backbreaking effort of scripting our literature, arranging the mailings, making innumerable phone calls, etc., from October 15 to November 20. He was concerned that long, hard hours would make his osteomyelitis flare, and I did not blame him for that. Bob and I were on an obstetrical rotation at the Providence Lying in Hospital. I delivered all of "my own" babies plus those of his which came at night. Bob became a pathologist, first at the MGH, and later as professor and chairman at Emory University. Sadly, Bob died from a ruptured cerebral aneurysm on September 11, 1961, only nine years after graduation. What a great loss of a brilliant physician and fine person.

We paid back the money owed to my father. Dean Mullen's school, the University of Chicago, refused to pay the small sum owed "because we did not ask you to do what you did." I have all those telegrams and letters from 1951. They are very interesting to read. Columbia, before our meeting there, had expressed <u>unanimous</u> opposition to the plan! Fortunately I was on an elective in orthopedics and was able to devote myself full time to the project from October 15th to December 1st.

About five years later, at the dean's Christmas party at Vanderbilt Hall, I said to Dr. Berry, "You never acknowledged that what we did was the right thing." He said, "Ha, ha, ha. Well, let's let bygones be bygones!"

DR. PEARSON: Good story. And it's still working pretty near perfectly.

DR. HENDREN: Do you know about those people who tried to torpedo it recently?

DR. PEARSON: No.

DR. HENDREN: A group of dissident resident doctors tried to torpedo it. They filed a class action lawsuit against the matching plan, the medical schools, and the big teaching hospitals. And this got all the way up to a federal court, where the judge ruled in favor of the dissenters. It created multimillion dollar legal bills for all parties being sued, especially the hospitals. They declared the match was discriminatory, unconstitutional, and prevented young doctors from demanding more salary benefits from the hospitals. I have it all downstairs. The executive director of the matching plan and the lawyer from Chicago, Catherine Austin, who was carrying the ball for the matching plan spent several days with me here in Duxbury to review the archives. Ultimately, thanks to efforts of Senator Edward Kennedy and Senator Judd Gregg from New Hampshire, a law was passed in congress that the matching plan cannot be sued, thereby preserving it. Kennedy is a great friend to hospitals and doctors.

DR. PEARSON: I hadn't heard that story. It's a great story. So, through the matching plan you went to the MGH with Dr. [Edward] Churchill?

DR. HENDREN: Yes.

DR. PEARSON: I remember that he used to lecture at the med school Quadrangle, and then he would drive his jeep back to the hospital.

DR. HENDREN: Yes. The MGH was the residency that most of the surgery bound students wanted in 1952 because you got to do a lot of surgery there. I did 156 cases as an intern, including three gall bladders, two with common duct explorations. That was more than you got at some of the other programs.

DR. PEARSON: At the MGH, they had a private pavilion, an ultra private pavilion, and the general wards, right?

DR. HENDREN: Yes. It was all according to your income. If your income was more than $7,500 you were in the Phillips House. Your physicians could charge you whatever they wanted to. In "The Baker," for those of moderate means, patients were placed in category 1, 2, 3, or 4. In Baker category 1, the maximum professional fees during a three month hospitalization were limited to a total of $250. In Baker category 4, the maximum total was $450. So if a patient entered with an aortic aneurysm, had a heart attack, and had various other complications, then the doctor who admitted the patient would instruct the billing office how to divvy up the fees

between the various doctors who cared for the patient. This all became outmoded when most patients had health insurance, which was then less common than today.

And we had the Ward service in the White Building, which was a wonderful experience. The chief's office would schedule residents to alternate assignments between assisting on private patients and being on the wards where the chief resident was in charge. The chief resident answered to three "visits" (visiting surgeons were synonymous with attendings at other hospitals). The nice thing about the private service was we worked with several world class surgeons: Richard Sweet (thoracic), Leland [S.] McKittrick, Claude Welch, Marshall Bartlett (all G.I.), Robert Linton (vascular), Oliver Cope (endocrine), and many others.

When I was a medical student, Dr. Linton showed us a patient with an aortic aneurysm. The treatment in 1950 was to introduce a needle into it and wind in 400 feet of silver wire as a nidus to cause a clot to form, which would hopefully delay rupture of the aneurysm. Aortic grafting wasn't extant at that time. Dr. Robert Gross at Children's introduced grafting for coarctations that were too long to resect and then primarily reanastomose the aorta. We obtained fresh grafts from cadavers in the autopsy room. The grafts were freeze dried, packaged, and processed by radiation at MIT to sterilize them. Homografts were outmoded by synthetic grafts by the end of the 1950s.

In 1954 I visited Dr. Gross at Children's to find out about fitting pediatric surgery into my training. He opened his desk drawer, pulled out a sheet that was like a shirt cardboard. On it were starting times for senior residents. He said, "Well, how about January 1955?"

I said "Great." I then saw Dr. Churchill, and he said that would be fine.

"We'll give you a two-year leave of absence so you can go over to Children's and spend two years with Gross." Residents at Children's then included six juniors, a preliminary one year job; four seniors, a job with much more responsibility; and a chief resident, usually one of the four seniors who stayed an extra year. The seniors each had six months on the wards, six months running the outpatient clinic and emergency room, six months on plastic surgery, and then six months as Dr. Gross' own assistant. Gross did everything in general surgery, urology, etc, but also a very large number of cardiac cases.

During the last six months with Gross, he let me do many cases. Gross was flooded with patients with patent ductus arteriosus, coarctation, vascular rings, and blue babies. He really had more than he could do. Therefore, when he got a resident whom he could trust, he would let him do a lot, often solo. I remember my first ductus. Gross said, "Go on in there and start that

ductus." I started the surgery in OR 8 and got everything all dissected out. Meanwhile Gross was doing a hernia in OR 3 across the hall. When I got the ductus all ready to divide, I covered the field with a towel and told the circulating nurse that we're ready for Dr. Gross, whenever he's ready. When he entered and saw that it was all laid out, he said, "Hmm, very good, very good." Then he went to the other side of the table and assisted me doing my first ductus.

I had learned a big lesson six months previously. The resident who preceded me was a very fine surgeon. But when told to start a case he wanted to show Dr. Gross how quick he was. He put a clamp through the ductus and the child quickly bled to death. Dr. Gross came in, desperately tried to save the day, but could not. He closed the heart service for one month as an admonition to all the resident staff. The message was, "You screw up and there's going to be a big penalty for it." I had a wonderful time during my six months with Dr. Gross. The resident who had that unfortunate experience was one of the very best men in pediatric surgery and had a brilliant career. I would have trusted him implicitly with a member of my own family.

Then I went back to Mass General for the fifth year as if I'd never been gone. Dr. Churchill appointed me as the chief resident, which was nice because only two out of the eight people in each year got to be the chief resident. The two services were the East and the West. I was the chief resident on the East for 1958. Meanwhile, Dr. Gross had offered me the chief residency at the Children's also. I asked him what he would advise me to do. He said, "You should take the General chief residency. That's the best chief residency in Boston. You can do mine a year later if you wish, or you can come on the staff without it." I said I'd prefer to do both, not wishing to go on the staff without having been chief resident. He agreed. Dr. Churchill couldn't understand why I wanted to do a chief residency at the Children's when I'd already been his chief resident. And I just said, "I think that's the best way to prepare for what will probably be a career in pediatric surgery." So that's what I did.

In the week after finishing as the 1958 East resident, I went to Kansas City to assess the Children's Mercy Hospital as a job offer by Herman Sutherland, head of the board of trustees. We had met in December at the Pierre Hotel in New York City for a long discussion about that. He was in the lumber business; he and my father were friends.

As my mother, father, and I were having dinner (pheasant which dad had hunted) I got suddenly very sick. As I lay down in the guest room, I could hear loud rhonchi as I exhaled. I then coughed up blood! I called mother and asked her to get me a ticket for that night to Boston. I wanted to be in Boston where the latest drugs might be more available in case this was an unusual organism. I had been bronchoscoping some sick, elderly patients

just ten days before. TWA had a Constellation scheduled that night. Mom went with me. I remember little about the trip except having shaking chills despite wearing an overcoat, gloves, and a woolen cap. My temperature was 106 degrees on admission to the MGH. Mr. Stewart on the emergency room desk didn't recognize me although he knew me well. I was sick! I felt much better immediately when the East Surgical Service arrived, now under my successor, Dr. George Zuidema, one of the smartest doctors I ever met. It turned out to be viral pneumonia in the left lower lobe. Dr. Morton Swartz, head of the infectious disease service, cared for me. He's still a highly admired physician who continues to come in to the MGH.

When I got over the pneumonia, I reported to Dr. Gross in February 1959. During the five months from February to July, when the chief residency year started, I did some work in the lab (until a lab remodeling started), looked up some statistics, took thoracic surgical boards, and wrote a few papers. The coauthor on my first published paper in *JAMA*, September 1958, was Bob [Robert J.] Haggerty. In May 1959 Bob asked me to see a problem patient with him. She was his private patient, so I suggested one of the other surgeons who could see private patients. Bob said he wanted me to see this child. I, therefore, presented this quandary to Dr. Gross. He said to by all means, see her. He added that he needed another surgeon who could see private patients because there were then only three, namely Drs. Gross, [Luther] Longino, and [Samuel R.] Schuster. "Anything you get is fine." (That did not prove to be the case, incidentally.) He added, further, that he had done the same with Dr. [H.] William Scott, professor at Vanderbilt [University School of Medicine], who had been chief resident during the war and saw private patients while he was still a resident.

So I saw this little child, Kerrie G. She had enormous ascites. I asked Dr. Anna [J.] Hauck to see if this might be cardiac, possibly constrictive pericarditis. As it turned out, she had a huge pancreatic pseudocyst. I explored her and did a Roux-en-Y cystenterostomy. She thrived.

When it was apparent that I could take private patients, I got a moderate number of referrals, all by word of mouth, from Bob Haggerty and staff members who knew me. Dr. Sidney Farber, chief of staff, began sending me cancer patients. He asked me to see a little girl, Susan R. from New York. (Her family gave the Conference Room on the top floor of the Jimmy Fund Building.) Dr. Louis K. Diamond began sending me hematology patients, and Harry Schwachman patients with cystic fibrosis. Dr. Diamond soon learned that I could do spleno-renal shunts, which I had learned from Dr. Robert Linton at the MGH. All of these referral patterns were quickly noted by the other staff surgeons who complained to Dr. Gross and even suggested that I was "stealing cases" from them!

Toward the end of that year I had been referred a little cystic fibrosis boy, Mark P., on Division 25. He needed a right middle lobectomy. I had learned

that a major cause for death in older thoracic patients at MGH was post-op pneumonia. Dr. [Edward] Benedict, head of endoscopy at the MGH, gave me several bronchoscopes so we could clean out their bronchi post-op. There was no respiratory service in those days. He told me how, before antibiotics were introduced, there was a pulmonary clinic where patients with bronchiectasis could come to get their foul secretions suctioned out. First they would lie head down on a seesaw like board to encourage postural drainage, and then they would be sucked out via a bronchoscope. While I was East resident we kept the bronchoscopes in a cabinet in the treatment room on White 7. Every morning after rounds we would suction out the air ways of those elderly patients who were not coughing up their secretions. We saved a lot of those old folks from dying with pneumonia. It was amazing how quickly they learned how to accept a bronchoscope, right away realizing how it was helping them.

Well, I taught little Mark P. how to take a bronchoscope in his bed on the private patient floor. I sprayed his pharynx with cocaine spray and he cooperated beautifully in just a few days. He knew this was to help get him through his surgery. We wanted to avoid a tracheotomy for suctioning because that often caused serious troubles. I had done a lot of bronchoscopy at MGH and at Middlesex County Sanatorium for four months of surgery for tuberculosis. Also I was already board certified in both general surgery and cardiothoracic surgery.

We did Mark's lobectomy and he sailed through it with no trouble at all. Schuster reported to Dr. Gross that I was doing bronchoscopies on the patient floor. But Gross didn't call me in and ask me what this is all about. He sent me a letter: "Dear Hardy, From this date forth, you will not ever perform another bronchoscopy at Children's Hospital. This refers to all classes of patients, whether they are private or on the Ward." He didn't sign it REG, he signed this one Robert E. Gross. I have the letter downstairs. I've saved these things in my archives. I came home and told Eleanor, "I'm not going to be able to stay at Children's. For the chief to send a letter that you can't do something in which you're already a board certified specialist is just nonsense. I cannot put up with that." Drs. Harry Schwachman and Lucas [L.] Kulczycki made special note of how well their lad had done and that practice soon was adopted, and later reported by the next chief resident, Judson Randolph. Incidentally, I had gotten the blessing of Dr. Carlyle [G.] Flake, chief of ENT [ear, nose, and throat], who thought it was a good idea. He said his interest was diagnostic bronchoscopy, not suctioning airways of our post-op patients! (I did no more bronchoscopies at Children's, until I returned as chief of the department in 1982!)

Well at any rate, during the year as a chief resident, I got a lot of private cases referred, in addition to the ward cases. Virginia Dunn, who was Gross' secretary, said to me one morning, "Gee, you better be careful. You did more private patients last month than Dr. Gross did." I laughed and said,

"Well, for heaven's sakes don't tell him that!" She said, "He knows. He reviews the list every month as to who's done what, so he knows exactly what everyone is doing." Does that remind you, Howard, of the letter that Gross wrote to Orvar Swenson about his "excessive surgery volume?"

DR. PEARSON: Absolutely.

DR. HENDREN: This was exactly the same. "You will not do another pull through." He wouldn't let Swenny even do rectal biopsies! That was such a paradox, yet Gross did the first ductus when [William E.] Ladd was out of town.

DR. PEARSON: Without telling his chief, Dr. Ladd, yes.

DR. HENDREN: Gross did the first of a number of things. He was a trailblazer, but didn't want anybody else at Children's who smacked of doing something new or different. That's why he clipped Swenson's wings and forced him to move to the [Boston] Floating Hospital. When I came to be chief resident, there was only one way to do a bowel resection at Children's Hospital. That was the Mikulicz procedure. You probably don't even know what that is, do you?

DR. PEARSON: No. I've heard of it, but I don't.

DR. HENDREN: Mikulicz was born in 1850 and was a leading European surgeon who worked at various times in Poland, Vienna, and Germany. The Mikulicz Procedure is a method of bowel resection where the segment to be removed is clamped and excised; bowel continuity is reestablished by sewing side to side the two limbs, bringing the ends out as a double barreled stoma (like the end of a double barreled shot gun). A two armed clamp is inserted, one arm in each lumen; the clamp is tightened daily until it crushes the wall between the clamp's jaws, thereby establishing an anastomosis. The end still sticking out is later freed from the abdominal wall and closed. This staged technique was the safest way to join bowel in the last half of the 19th century, before there was refined suture material, bowel prep, and antibiotics. Dr. Frank [H.] Lahey in Boston still used that for right colectomy when I was a medical student.

That was the official way to do a bowel resection at Children's when I started. I thought that was nonsense. I started doing primary bowel resections by emptying the bowel, putting clamps on, resecting the pathology, and then doing an anastomosis. One day I said, "Dr. Gross, we've done 65 primary bowel resections this year, and we haven't had a complication." And he said, "Well, that's okay for you to do because you're a very experienced surgeon, but I don't want the residents doing that." I said, "Well, sir, I helped them do most of those cases." He was furious. He just

looked at me with an icy stare and turned and walked away. No conversation.

In Gross' classic book, published in 1953, is shown how to do a spleno-renal shunt. That was not a good technique. It was in my opinion better to do a central shunt as performed by Dr. Linton and also by Dr. Bill [H. William] Clatworthy [Jr.], who had trained with Gross but then gone to Columbus. I took a set of photos to show Dr. Gross a central spleno-renal shunt. He looked at it and said, "You're going to kill some kid doing that, all that dissection. I'll do the rest of them this year." He did.

DR. PEARSON: What was Gross's family? Did he have a lot of brothers and sisters?

DR. HENDREN: His grandfather came from Germany and was a piano maker. His father was also a piano maker and worked for Stieff Piano Company in Baltimore. Gross was one of seven sibs. They were mostly academic achievers.

DR. PEARSON: That's interesting, you know, because among people who came from big families a generation ago, there was often great inter-sibling competition, and sometimes when they later became people of authority, they had the same competitive conflict with their subordinates.

DR. HENDREN: Is that so? Well, one of his sibs was a female medical doctor from Hopkins. Two of them were department chairmen, one at [University of California] Berkeley, and one at the University of Washington. I've forgotten what the others did.

DR. PEARSON: You know I think in my experience, to have someone that wants to emulate and even outdo what you did, you're absolutely elated. It's one of academic medicine's great dividends.

DR. HENDREN: Of course. But some teachers don't realize that.

DR. PEARSON: What you describe about Gross is different.

DR. HENDREN: Oh, it was strange. In my first week as chief resident, Dr. Farber and Dr. Joseph [E.] Murray asked me to care for a child, Ronald P. Ronald had had an orbital rhabdomyosarcoma. An orbital exenteration had been done by Joe Murray and Donald Matson of neurosurgery. The lad needed to have a neck dissection for he had positive nodes in his right paratoid region. So I did a radical parotidectomy, with facial nerve sparing, and lymph node resection in continuity. Joe Murray came in to see how things were going. He then told Dr. Gross, "Your resident's doing a great job with a node resection and parotidectomy." Dr. Bob [Robert] Smith, who was head of anesthesia, later in the day told me, "Hardy, Joe Murray came in

and told Dr. Gross what a great job you were doing on that case. Gross was not pleased. Steer clear of him."

DR. PEARSON: Someone so great and many great things done, yet so petty.

DR. HENDREN: I couldn't understand that. When one of Dr. Churchill's residents did something good, he would be proud and would let everyone know about it. When I was the East resident, a woman came in on a Saturday afternoon, Mrs. Margaret M. She was 69 years old, and came from Cambridge. She had four sons who were Cambridge police officers. Mrs. M. had an obviously perforated esophagus caused during an esophagoscopy performed elsewhere the previous day. The esophageal problem was cancer. She got a pneumothorax, which happens often with a perforated esophagus. She was very sick with mediastinitis. A nasogastric tube was curled up in her left chest. I called my visit, Dr. [Francis] Thomas Gephart, who was a very experienced thoracic surgeon. He agreed that we should operate immediately. We went to Room 5 in the White OR. It's funny how your brain remembers such trivia. We opened her left chest and took out her mid thoracic esophagus which contained the perforated cancer. The anesthesiologist said she was doing well at that point, so we proceeded with a reconstruction, bringing her stomach up to the upper chest to restore GI continuity. She never turned a hair!

We presented Mrs. M. at grand rounds a week later, then taking a soft solid diet. The case was presented but there was no discussion or questions from the front row of senior surgeons. I whispered to the assistant resident, "You better take Mrs. M. out and get the next patient. They don't like this case." I thought that somehow we had laid an egg by having her come to rounds. Dr. Linton, who was not prone to complementing the residents, said, "Wait a minute. I'd like to say that that is the best case I have ever seen at surgical grand rounds." I'm standing there wilting. The silence was because they were stunned at our doing a primary esophagectomy and reconstruction all at once. It hadn't been done at the MGH previously.

Dr. Churchill, later the same day, was speaking at the Annual Ether Day program on the Bullfinch lawn. At the podium he said, "I have a talk that I had prepared but I'm going to discard it. Instead, I'm going to talk about our residency program. In particular, I'm going to describe a case that was presented at grand rounds this morning, because it illustrates better than anything I could say what I have tried to do in the training of surgical residents." He told about Mrs. M. and how her tough problem was solved. "A very experienced mentor, Dr. Gephart, was called. An unusual course of action was decided upon without precedent, but with good reasons. And it was successful."

You see, Churchill's reaction to something new or unusual was to applaud. That was not Gross's reaction however. The other marked contrast was at

the [Massachusetts] General [Hospital] you learned multiple different ways to do an operation, for example, gastrectomy. You could do it the way Sweet did, an anterocolic polya anastomosis; McKittrick preferred a posterior retrocolic gastrojejunostomy; Bartlett often used a Bilroth 1 direct duodenal anastomosis to the proximal stomach. So you learned different techniques to use in different circumstances. Now at the Children's, it was one technique – "The chief's way." To vary from that somehow almost seemed to represent a threat.

When Dr. Swenson was going to do the first pull through for Hirshsprung's Disease, you know from reading Swenny's oral history, Gross actually scheduled himself to do the case although he had no plan for it. It was only because the mother wouldn't grant Gross permission to operate, that Swenny got to do it. This is recounted also in Dr. Swenson's recent book, *From Making Bows to Fixing Babies*. It's a classic each pediatric surgeon should read.

The final unpleasantness with Dr. Gross occurred at the very end of the chief residency. I was about to go to Kansas City on vacation to my sister's wedding. Jud Randolph, who was to follow me in the job as chief resident, asked me if I would mind substituting for him for the first three days, July 1-3, so he could have a few days off between being the heart resident and starting as chief resident. I said, "No, that'll be fine. I'll do it." That afternoon in came a neonate with esophageal atresia. It was a good, big, eight pound, healthy baby that didn't have pneumonia. I told Dr. Arnold Colodny, who was just behind me in the residency, an excellent surgeon, and a good friend, that I would assist him in doing the case. We scheduled it for the next morning. Sam Schuster came in that morning, went over to the OR, and saw what was listed. Sam said, "I'm going to do it. I'm the senior person. I'm going to do that case." I said, "The hell you are. I'm on the staff just as you are, and I'm also doing the chief resident's cases for him for these three days." All of that had been approved by Luther Longino who was second in command of the department. Luther was away, and Gross was at home on vacation over the Fourth of July holiday. And so Schuster called Dr. Gross. Typical! Next, I got a call from Dr. Gross. He said, "Hardy, Sam's the senior man, and he's going to do that case if he wishes." I replied, "Well, if that's the case he can also do the chief residency responsibilities for the next three days, because I'm not going to stay here substituting for Jud for three days and have Schuster steal a case he wants to do. So I'm getting on the next airplane to Kansas City," which I did.

Colodny later told me what happened. Schuster opened the chest and he didn't recognize that there was a right aortic arch. He was about to divide the aorta inadvertently, thinking it was the tracheoesophageal fistula, when Arnold said, "That's the aorta, you better not do that." Sam did the case, which was his first esophageal atresia because he'd never been the chief resident. Gross had brought him from a thoracic training fellowship at the

Overholt Clinic to assist him with his coarctation cases. Dr. Nicholas [M.] Stahl who had done them previously had moved on to Syracuse, New York. Nick had tired of being an unseen surgeon doing Gross coarctation cases behind the scene and getting no recognition for his work.

When I got back from my sister's wedding, I came in to operate. There was a hernia scheduled at eight o'clock, and at nine o'clock Susan R. from New York City. She was a patient of Dr. Farber's. Susan had been operated on at Mount Sinai for ulcerative colitis. They'd done a colectomy, but had not removed her rectum. She developed a rectal carcinoma, which was implanted in several areas of her abdominal wall incisions. She had had a lot of chemotherapy. My job was to try to take the cancer out of her abdominal wall, which I did with help of abdominal flaps. When I arrived at the OR that morning, my name was crossed off the schedule - a big red chalk line was through my name and the two cases listed.

Dr. Robert Smith, chief of anesthesia, whom you probably knew, a Dartmouth man and a wonderful person, asked why I had canceled my cases without notifying anesthesia. I said, "Bob, I don't know anything about it." The OR assistant supervisor, Ollie Kennal, came from her office and said, "Dr. Gross was over here at seven o'clock and he cancelled you."

So I went over to Gross' office. I stood by his desk. He paid no attention to me; I mean I was not there. Finally I spoke up. I said, "Dr. Gross, I want to know why you canceled my cases." He said, "You're doing too much. Somebody that's just finished as chief resident should not have two cases to schedule. What I want you to do is just lie low, and don't schedule any cases for a while. Just get back over in the lab." I had been working in the lab three afternoons a week all during my chief residency, working on chemotherapy perfusion of the lungs techniques. "Get yourself an office somewhere down the street and just work in the lab, and we'll see how things go." I said, "I can take the hernia down to the General and do it there, because I'm on the staff there. The second case may be embarrassing to you because it's a patient of Dr. Farber." He said, "Oh, well, go ahead and do those cases." Gross both admired and feared Dr. Farber who was chief of staff and wielded great power. So I went to the OR and did those cases.

I went to see Dr. Churchill that afternoon. Dr. Churchill sat back in his chair, smiled, and said, "You may remember when you told me you were going over with Bob; I told you go over and get your training, but don't try to stay there, because Bob will never let a good young person come up under him. I want you to come back to the General to start pediatric surgery here. Let's see what you can do with it." And so I came back to the General that afternoon. That's the best professional move I ever made, thanks to Dr. Churchill.

Dr. Nathan Talbot, chief of pediatrics, said he would give me a paycheck for $150 a month from pediatrics to help start me. For an office I got a former patient examining room that had belonged to Dr. Joseph Meigs, former chief of gynecology. He was a world famous general surgeon. I had no grant, no surgical service salary, but I was optimistic and determined to make this work.

To my amazement I got a check for eight hundred and some dollars that month from Dr. Gross; and another for the same amount the next month. I took the checks over to see him, and said "I don't understand what these checks are for." He said, "Well I told you I would support you to the tune of ten thousand dollars in your first year, and that's what those checks are for." And they were his personal checks, not hospital checks. I said, "Well, sir, I've been gone for the last two months, and I don't think it's right for me to take these." Dr. Gross was very preoccupied trying to improve his open heart case results at that time to compare favorably with those of John Kirklin at the Mayo Clinic, [Denton A.] Cooley in Houston, and [[C. Walton] Lillehei in Minneapolis. I don't really think he knew I had relocated to the MGH!

I continued to operate at Children's for that first year. If something was sent to me by a Children's Hospital doctor, I would do it at the Children's. If it was sent by an MGH doctor, I'd do it at the MGH. At the end of that academic year, on July 6, 1961, I was prepping a patient's flank for a nephrectomy. Theresa A. was age 15. She'd had renal vascular hypertension. We had excised a narrow segment of the right renal artery one year previously, and reanastomosed the vessel. The blood pressure normalized, but then it began to creep up again. Arteriograms showed late re-narrowing. A Dacron patch was placed to enlarge it. Her blood pressure came down, but then the graft clotted and her blood pressure came back up.

I was prepping her when Gross walked into the room. He beckoned to me to come out. I went into the scrub room between rooms 7 and 8. He said, "You don't have any right to be here." I said, "What do you mean?" He said, "You didn't receive a letter renewing your staff appointment." I said, "No, I didn't, but I didn't receive one from the General either. I assumed that unless I heard otherwise, I was reappointed." He said "No. You can't operate here anymore." That was the last case I did at Children's, July 6, 1961, until I returned as chief of surgery in 1982.

DR. PEARSON: For a few years.

DR. HENDREN: Yes, 21 years! I talked to Dr. Farber to ask his advice. He said, "Just go to the General and saw wood. Some day we'll get you back here." Dr. Farber continued to send patients to me at the General, especially adult patients who needed big cancer operations. Also he asked me to

accompany him to Houston to speak about pediatric cancer at a meeting at the M.D. Anderson Hospital where he was a senior speaker.

Several years later Children's hired a new president, Dr. Leonard Cronkhite [Jr.]. I knew him well from the MGH. He had been a Colonel during the war and was then a Brigadier General in charge of National Guard troops in New England. He came to see me and wanted to know why I had precipitously left Children's in 1961. I told him the story. He said there was nothing about all of that in Children's staff records, and it was a completely illegal action on the part of Gross. Incidentally, Arnold Colodny had the came mischief occur, but was supported by Cronkhite who threatened to remove Gross. Dr. Swenson's story is identical. Ultimately Gross was designated to become chief of cardiac surgery, and [M.] Judah [Folkman]was appointed in 1967 to replace Gross as Surgeon in Chief.

Several years later I was asked to dinner at the Harvard Club to consider coming to Children's to organize and run urology. However, Bob [Robert M.] Filler, who was still at Children's (later to go to Toronto) and was designated by Judah to run general surgery, insisted that would require my turning down any non-urological case which might be sent to me. His purview was competition, not strengthening the department. I declined the offer.

I had no contact at all with Dr. Gross for ten years. Then in 1970, the phone rang one night. I answered. The caller said, "Hello, Hardy, this is Bob Gross." I jumped out of bed and pinched myself to see if I was having a nightmare. Then he said, "Next Wednesday night I'm getting the Bigelow Medal at the Boston Surgical [Society] and I need your help." I couldn't imagine what kind of help Gross would need from me. He said, "I need somebody I can count on to show my slides for me." Of course I said that it would be an honor for me to do that. Naturally I wondered why he didn't ask one of the young surgeons at the Children's to do it for him. "I want you to go over to Jon Allen Photo Shop and get a new projector. Be sure to have a dime with you to release the carousel if a slide gets jammed. Have an extension cord. I'll bring my old projector so we'll have a spare. Please pick me up at 4:00 and we'll get set at the Harvard Club and I can rehearse the talk." When the time came, I drove him to the lecture hall and acted as his projectionist for a run through. He asked for my critique, and I said, "I think it was fine just the way it is." You know he was a marvelous speaker.

When the real audience arrived, several saw I was the projectionist. One of the surgeons, Kenny [Kenneth] Welch, who had been very badly treated by Gross, came over to me. He opened his wallet and pulled out a hundred dollar bill. He said, "I'll give you this one hundred dollar bill if you drop his slides." I chuckled, and told him I couldn't do that. The end of that story came on April 9, 2001, when I was given the Bigelow Medal. By the way, Clarence Crafoord from Sweden came to hear Gross' talk! It was he who

had reported two successful coarctation cases in Sweden a year before those done by Gross in Boston. But that is another little intrigue we don't have time for today.

DR. PEARSON: This is from the Boston Surgical Society?

DR. HENDREN: Yes. Henry Jacob Bigelow was the premier surgeon at the MGH in the latter half of the 19th century. The medal is given for contributions to the advancement of surgery. It was funded in 1914 by his son, also a surgeon, with the stipulation that it be given no more often than every three years, or less often than every five years. Early recipients included William Mayo, Harvey Cushing, and Rudolph Matas. I showed a list of those honored since I had come to Boston in 1950. I placed an asterisk by those who were my teachers at some time in my career – eight of the recipients! What a privilege! I then added that I remembered most vividly the talk given by Dr. Robert Gross in 1970. I told the story about the unexpected phone call, Dr. Ken Welch's offer, etc. They all laughed – a good way to start a talk. I spoke about John Hunter (1728-93), the first academic surgeon. After my talk I introduced Elizabeth Allen, curator of the Hunterian Museum at the Royal College of Surgeons of England. She had helped me with background materials when Eleanor and I had gone to London for two weeks to study at the museum. As a small favor in return, we brought Liz for a visit of a week with us in Duxbury and Boston. At any rate, after showing Gross' slides in 1970 there was suddenly a thaw in our interpersonal relationship, which had been nonexistent over the previous ten years.

The American Surgical Society met in Colorado Springs at the Broadmoor in 1974. I had been made a member that year. That was the same year that I would get cancer of the colon in December. Dr. Gross was at that meeting. It was the last surgical meeting he ever attended. He said to me, "I see you have a paper on the program." I said, "Yes, sir I do." And he said, "Do you have a copy of it with you? I'd like to read it." He came up to our hotel room and while Eleanor was getting dressed, he read the paper. As we went downstairs, he asked whether it would be okay if he had dinner with Eleanor and me. "I don't know many people at the meeting any more. Most of my cronies are retired or have died." We said we would be pleased. I thought this might be awkward for Gross and Eleanor and me, so I grabbed one of my classmates, Josh Jurkiewicz, who was alone and asked him to join us. Josh was later president of the American College of Surgeons. During dinner, Dr. Gross asked, "What was the name of the Italian who was such a renaissance man as painter, sculptor, and inventor?" I asked, "Do you mean Leonardo da Vinci?" And he said, "Yes, that's the one." Well, I thought he was going to tell us something about Leonardo, but he dropped the subject and he didn't say anything more about it. Gross was such an intimidating man that you just didn't turn and say, "Now why did you ask me that?" You just waited for the other shoe to drop!

The next morning the other shoe dropped! After my paper on *Reconstruction of the Previously Diverted Urinary Tract in Children*, Dr. Gross went up to the podium and said the following:

> **"Obviously, what has been done here required a good deal of initiative, clear thinking, and high technical skill in revamping the urinary systems of some of these unfortunate children and getting them back to near normalcy. As one looks at the field of urological problems in infancy and childhood over the last 20 or 30 years, tremendous advances have been made in corrections of many of the anomalies we have seen. On the other hand, there are a considerable number of malformations, or combinations of different defects, which baffle us. We have operated hoping to improve things; very often we have ended up by doing two or three operations to try to get things better, and in the end, being somewhat overawed by the whole business, have turned-reluctantly, but, we thought, with good advice-to some sort of permanent external drainage of the urine, believing that this gave the best hope for recovery of damaged kidneys and longer life for the individual.**
>
> **It's very refreshing to now see that many of these things which we did in the past in good faith can now be transformed, and patients turned to normalcy, or near normalcy.**
>
> **As I get to the end of an academic surgical career, it has been a tremendous satisfaction to me on many occasions to find young men who have been through the residency training program and on our staff who have taken a new look at things in this field, and other areas in children's surgery, and with vision and thought have made new approaches and new techniques. They have accomplished things which we thought before were impossible. It's a great pleasure to let them have the ball and go toward new goals and get far ahead of us.**
>
> **As I reflect on these things, it is very appropriate to recall the words, uttered so long ago by Leonardo da Vinci when he said: 'The brilliant student will certainly outshine his teacher.'"**
>
> **[Urinary Tract Refunctionalization, Discussion, *Ann. Surg.*, October 1974, p508]**

I nearly fell out of my seat when I heard him say this. That was "the other shoe dropping." The next thing that happened was that the entire American Surgical rose and gave him a standing ovation. I have never before or since seen a standing ovation for a discussion after a paper.

There were several other surgeons who discussed the paper: Victor F. Marshall, Willard E. Goodwin, John Joseph Murphy, John Lilly, and J. Hartwell Harrison. So it gave me time to collect my thoughts, and thank all of the discussers, in particular Dr. Gross.

When the meeting was breaking up about an hour later and I was walking out, Francis [D.] Moore, chief at the Brigham, put his hand on my shoulder and said, "Hardy, you may have thought Bob was discussing your paper, but that's not what he was doing. He was giving you a public apology in front of the American Surgical, and that's the reason they all stood and gave him a standing ovation."

DR. PEARSON: Great story.

DR. HENDREN: That's an interesting evolution, isn't it?

DR. PEARSON: Yes, it is.

DR. HENDREN: And later, when Dr. Gross was invited to present an evening of pediatric surgery at the Boston Surgical, he invited me to organize and run it, but I'm getting ahead of myself and we should go back.

DR. PEARSON: Absolutely, so let's do the Mass General first. You were there from 1960-82.

DR. HENDREN: Yes, I went in 1960, and started the pediatric surgical service. It began with just a few cases, but by the end of the year we were having eight or ten cases a week booked.

DR. PEARSON: One of the things that I noticed, is your concentration on urologic problems, because you said two-thirds of the cases you did at the MGH were urologic ones. Tell me about that. It's very different from the thoracic surgery, the bowel surgery, and the cancer surgery we've talked about so far.

DR. HENDREN: Yes. I had noticed when I was chief resident at Children's that there wasn't anybody who knew much about pediatric urology. As a matter of fact, when I first arrived at Children's, Dr. Lester Martin, who was just ahead of me, said to me, "One of your duties is to run the urology clinic every Monday." I said, "Lester, I don't know anything about pediatric urology." He said, "Don't worry, nobody else does either!"

I used to go to the clinic every Monday afternoon. At the end of the clinic I'd pull out several records in order to try to review them with somebody who could possibly give me an idea about what the long range plan might be for the patients. Many kids had tubes in their kidneys or their bladders. Swenson had done some diversion procedures, using a piece of colon, but he was long gone. That was about the same time that Dr. Eugene Bricker in St. Louis devised the ileal loop for adult cancer patients who had pelvic

exenteration. The ileal loop was then soon used for children with myelodysplasia, obstructive uropathy, and other problems. That was the state of urology at Children's, and every other hospital. So I began to take an interest in it.

When I went back to the General in 1960, I was doing all of the infant cardiac cases to start with. We didn't have large numbers of them, but I was the person who had had the most experience doing them. I spent my first summer vacation, a month in 1961, with Dr. Denton Cooley in Houston. He did an enormous volume of cardiac work in babies. Then in 1962, I spent three months with David [J.] Waterston in England. He was doing a large amount of infant cardiac surgery at Great Ormond Street [Hospital for Children]. When David realized that I was a fully trained surgeon, he put me into a locum tenens for his service during August and early September. We lived in his house at Old Isleworth, with Eleanor and the children. I drove his little Opal station wagon to work, and "did" his operative lists. He was in Aberdeen, Scotland. So, I'd had a good bit of cardiac experience in kids between the time with Denton and working with David Waterston. Initially, I got most of the pediatric cardiac work at the MGH.

This caused friction with the adult cardiac surgeons at the MGH. They weren't doing kids, but they didn't want to see me doing them either. When I was down in Texas with Denton, I interested a very good cardiac fellow trained by Dr. Dan McNamara, to come up to interview at the General so we'd have a highly experienced cardiac person for kids. That was vetoed. Instead, Dr. Allan Goldblatt was brought over from the Children's and he was paid from funds of a cardiovascular grant to the adult cardiac service. My participation in cardiac surgery just didn't make sense any more. It was unpleasant, and would have continued to be so, as the adult cardiac service was constituted.

DR. PEARSON: Despite your board certification.

DR. HENDREN: Yes! It was just too contentious. So I stopped doing it, except for the tiny premie patent ductus cases for which Goldblatt continued to request my help. Pediatric general, thoracic, and urologic surgery was an ample field. I soon appreciated that not doing hearts was more a pride issue than a bona fide matter. It has been well demonstrated that insufficient volume of cases in the cardiac surgical arena yields less than excellent results, whether in adults or children.

DR. PEARSON: There wasn't a subspecialty of pediatric urology at the time?

DR. HENDREN: No. Dr. Guy Leadbetter, Wyland's nephew, wanted to start it at the MGH, but was trying to do it in combination with adult urology. The pediatricians just didn't buy that, so I got the lion's share of

those cases. Guy later went to Vermont as professor and chairman of urology at the medical school in Burlington.

When I was chief resident at the Children's, I had seen a child with a left megaureter, who was referred to me by Dr. Sydney Gellis, who was chief of pediatrics at the Beth Israel [Hospital] at that time. Sydney had told the family that there was a young surgeon at Children's who had a special interest in pediatric urological problems. So they came up to see me. His father was a Harvard Law graduate; mother a very refined, soft spoken southern lady. I explained that I was chief resident and perhaps they would like to see Dr. Gross. They had already scoped that out and told me what Sydney had said.

The patient, Buddy B., had an obstructive left megaureter. I showed the films to Gross. He said, "The right kidney is normal. I'd just take the left one out." The family didn't come up to me to take out the kidney. They wanted me to see if I could fix it. There was nothing of help in the surgical literature about fixing megaureter. That was hard to explain, because surely others had dealt with such cases. I did a kind of half baked procedure on the lower end of the ureter, a Davis intubated ureterotomy. It didn't work. I put in a nephrostomy tube and said, "Go back to Tampa. I'll see you in six months and will figure out something else to do with it." Amazingly they did just that.

When Buddy came back, at age seven years, I was then at the MGH. On September 22, 1960, I removed the narrow lower end of the ureter which caused the obstruction, tapered the caliber of the next 5-6 cm of dilated ureter, and reimplanted it into the back wall of the bladder with a tunnel to prevent reflux. The procedure worked splendidly. Bischoff in Germany had shortened excessively tortuous and dilated ureters, and had made a tunnel of bladder mucosa flap. However, as far as I could tell, a direct excision, tapering, and tunneled reimplant like this had not been done, but seemed both simple and reasonable. Buddy's left kidney and ureter are normal, and his follow up is 48 years! Our families became good friends. Sadly his father, Norman, smoked and I couldn't get him to stop. Predictably he died at age 60 with lung cancer despite resection at MGH.

I didn't get another megaureter case to do until February 26, 1963. Karen A. was seven years old. She had massive reflux up very dilated and torturous ureters. I did the same repair for both of her ureters as we had for Buddy, except her ureters did not have a narrow obstructive segment. Post-op cineradiography, which was used in those days, showed no reflux and excellent peristaltic emptying of the tapered, lower ureters. Conversely the upper ureters churned the contrast ineffectively. This happens the same way in achalasia of the esophagus. Therefore, 8 months later, I tapered both upper ureters. Post-op studies showed remarkably good function of the entire length of both ureters.

Then pretty soon I had more megaureter cases. (Incidentally, there's a book downstairs which is entitled *The Ureter* edited by N. Bergman of New York in which there are two statements about megaureters: 1) that it's rare, and 2) that there isn't anything that one can do about it.) I presented a paper at the American Urological [Association] in Miami in May 1968, reporting repair of 33 megaureters in 22 children. There wasn't any discussion of it because nobody had anything to say. Silence sometimes portends disbelief. I flew to England the next week, and presented some of the same material at the British Association of Paediatric Surgeons. Mr. D. I. Williams from London, a world figure in pediatric urology, rose and said he was very impressed by this work. He added, "We haven't done megaureter surgery at Great Ormond Street, but we will start now." My talk included cineradiography of the ureters before surgery with churning of the urine back and forth, and post-op afterwards milking urine down in a very normal fashion. Professor Michel Carcassonne of Marseille asked me that morning if I would take one of his young men for a fellowship – Gerard Monfort. I was pleased to do this, and it started a long and valued professional relationship.

At the South Central Chapter of the American Urological in the fall of 1968, a surgeon spoke of my paper. He said he had seen and heard my paper in Miami, and was convinced I was a charlatan who had shown pre-op films of megaureter cases and post-op films of others. Fortunately, Wyland Leadbetter cut him down by stating that he had witnessed all of my cases and they were reported honestly and accurately. Several friends called me after that meeting to be sure I knew about it. I was asked to write about megaureter in several books subsequently, including one edited by my former critic above!

So, after my paper was published in the *Journal of Urology*, I started getting many of those cases. I've now collected more than four hundred of them. This together with the Leadbetter-Politano ureter reimplant were essential opening wedges for the field of reconstructive urology.

DR. PEARSON: No one said to use a 400 foot steel wire?

DR. HENDREN: No. So I began to get a lot of pediatric urology. About the same time, obstructive uropathy was being treated elsewhere by exteriorizing the ureters. That was called a "tubeless diversion," as if that was some great thing to have a tubeless diversion. It involved bringing the blocked ureters out to the skin and having the kid leak from a hole in the flank as if that was an advance! Meanwhile I wrote a paper titled "A New Approach to the Infant with Severe Obstructive Uropathy – Early Complete Reconstruction." I got a letter from Dr. Gross: "Dear Hardy: I have just studied your paper on early reconstruction of the infant with severe obstructive uropathy. I hasten to send to you my warmest congratulations. There is no doubt in my mind that this is and will long remain a classic in the surgical literature," signed REG. I've got the letter. That was 1970. It

seemed to me that if we could safely fix small babies with bowel obstruction, heart defects, and many other anomalies, we should be able to do the same with the urinary tract.

At a pediatric urology meeting at the Palmer House in a whole afternoon session, we had a panel to present various ways to treat babies with serious uropathy. My assignment was to talk about immediate repair. The panelists all met the afternoon before, so we each knew what the others would say. After my talk, my former megaureter critic said, "Anybody who thinks he can do surgery of that magnitude on a small baby must think he can walk on water!" With deliberate slowness I reached for a microphone and said, "All of you in the audience (of several hundred) must realize that Dr. G. is at a big disadvantage here." The audience expected a nasty rejoinder. But I continued, "Because Dr. G. lives down south where it's warm! I would like to invite him to visit Boston next January when the Charles River is frozen and we'll walk across it together!" Dr. Victor Marshall in the front row gave me a victory sign. The audience applauded. My adversary came to me after the meeting broke up and declared, "You may be a good surgeon, but you haven't been doing it long enough to develop good judgment." I replied that before being on a panel with others I research their backgrounds, and that I knew his – that when he was an intern, I was a senior resident; that where he trained for five years total, I did eight; and that I was doubly boarded in general and cardiothoracic surgery. Pediatric surgery boards didn't exist before 1975. Finally I suggested that he was irritated that I had operated on his niece for reflux. I told him that his sister, whose husband was an orthopedic resident at MGH, did not inform me of the relationship, and that when I rebuffed her about it, she told me she didn't want him to be involved, which I would have done as a courtesy. I then extended my hand to shake his and suggested we should start all over again. We did. He has been a valued friend ever since! And most amazingly, when The New York Academy of Medicine gave to me the prized [Ferdinand C.] Valentine Medal for advances in urology, it was he who introduced me! "A soft answer turneth away wrath!"

So things gradually changed for the better with Dr. Gross. In 1982 when I was invited to return to the Children's, I went first to see Dean Dr. Daniel Tosteson. He had been on the ad hoc committee to choose a successor for Dr. Judah Folkman, who wished to concentrate on his lab research. Dr. Tosteson said, "In general I don't like to see a lateral move for one of my professors from one hospital in the Harvard system to another. Why are you interested in going to Children's? You're already a full professor. You already have a very good department that is well thought of. What more do you want?" I said, "I can't have a pediatric surgery training program because we don't have that big a volume at the General. We have influenced many of the MGH residents in choosing pediatric surgery (47 as of 2008), but have had to send them elsewhere to approved training programs (now 43 programs in 2008) to become board eligible pediatric surgeons. I could do a

much better job if I could have a program where we could train them." Dr. Tosteson said, "I approve of that. That's okay. Go ahead and do it. However, I want you to know that here at the medical school we refer to the Children's as 'The House of Sorrows.'" I thought that was a very interesting comment. I did not ask him to elaborate.

With very conflicted feelings I went to Children's on July 1, 1982. Only Jay [Joseph P.] Vacanti, the new chief resident and a friend from our working together at MGH, seemed to take any notice at all of my arrival! They hadn't planned an office for me. They hadn't assigned any operating schedule time for me. I just said to myself, "What the hell am I doing here?" I wrote out a letter of resignation with help from my secretary, Paula Zafferes at MGH. I took it to Mr. David Weiner, president of the hospital, and said to him, "It's clear you don't regard this as a very important job, so I don't either. I believe I should stay at MGH." Weiner quickly realized that that would have been a big blow to Children's Hospital.

DR. PEARSON: My favorite Children's administration story is when they got a donation of lollipops, Dr. Lendon Snedeker counted the lollipops and figured the house staff was eating them. He sent this notification to the house staff, "You will cease eating lollipops." Someone wrote back a letter, "Well if you paid us, we wouldn't have to eat the damn things."

DR. HENDREN: Is that true?

DR. PEARSON: Yes. That's a Gerry [Gerold L.] Schiebler story!

DR. HENDREN: Well, I'm not surprised. At any rate, I gave him my letter of resignation. The next morning as I was shaving, my lovely wife, Eleanor, came into our bathroom and said, "I think you should go back to Children's. I don't want to listen to you for the next twenty-five years, saying, 'What if I had done that job.' Return and let's see what you can do." I did. (Much that was promised did not materialize!)

Just six weeks earlier, from May 16-20, 1982, I was in Kansas City for the annual meeting of the American Urological Association of which I had been made a full voting member in 1973. I had three papers on the program, two to be delivered by my residents from MGH urology. We were staying with my mother. The word had just been spread of my incipient move to Children's. Somehow it got to Brattleboro, Vermont, where Dr. Gross and Jean stayed in a guest house on the property of Dr. and Mrs. John Houpis, a Children's trained pediatrician.

Dr. Gross called my mother's condominium and talked to Eleanor for about an hour. He expressed his pleasure about the appointment and added, "I don't know why he left in the first place! This is going to do a lot for surgery at Children's to have him there." When I came back from the meeting that

afternoon, Eleanor said, "You won't believe who called me this afternoon. It was Dr. Gross. He had the nicest things to say about you, and I think you ought to call him right back." So I did. Truly, I don't think he remembered all of what had gone on back in 1960-61.

DR. PEARSON: Interesting.

DR. HENDREN: 1985 was Gross's eightieth birthday; he was born in 1905. Money was being raised for a chair. The amount for a chair in those days was a million dollars (it's 3.3 million now). Half a million dollars had been raised by that point. The Children's trustees had agreed to furnish the salary for the chair until the fund reached one million dollars (that salary did not start when agreed upon). The medical school, hospital, and president of Harvard appointed me to the Gross Chair.

The occasion was a Festschrift that we had for Dr. Gross in the medical school coinciding with his eightieth birthday. I arranged the program, which had papers from many of his chief residents profiling their favorite subjects. That night there was a dinner at the Ritz Carlton. Dean Tosteson announced the Gross Chair and that I was the first incumbent. I'm sure there were some people in the room who were surprised by that long-term evolution. Thinking back to 1960 I couldn't help smiling inwardly myself about it. After dinner, Dr. Gross congratulated me on being given the <u>Ladd Chair</u>.

DR. PEARSON: The Ladd chair?

DR. HENDREN: You got that - The Ladd Chair! I then realized that Dr. Gross wasn't totally oriented. He asked me, "What is the name of that fellow sitting over there who was talking to me a moment ago?" It was Dr. Robert Izant from Cleveland, who had been one of his senior residents 1954-5.

Soon after the dinner, I got a letter from Gross saying what a marvelous evening it was. He said that this was his memorial service while he was still living. He didn't go to church, so that was an interesting comment. He then said, "I want to write a letter to the Dean, but I can't remember his first name. And what's the name of the street that the medical school is on?" I telephoned Dr. Gross and gave him that information. I suspected that this was the beginning of Alzheimer's.

Jean Lootz, Dr. Gross' long time companion, had a house here in Duxbury next door to the historic Governor Bradford House. Dr. Gross entered a nursing home in Plymouth and died there in 1988, three years after the Gross Chair had been activated. He was then 83 years old. Mary Lou, his wife, had also retired to Duxbury many years earlier. She died in the same nursing home a year before Dr. Gross. It was kind of a sad ending for a great man and his own once very supportive wife.

DR. PEARSON: But with feet of clay.

DR. HENDREN: Well, possibly one foot. He was nevertheless a master surgeon, a brilliant innovator, a fantastic speaker and author, and he left an enormous legacy of young men and women, who learned from him and populated the world of pediatric surgery.

DR. PEARSON: You're now the Robert E. Gross Professor of Surgery at Children's.

DR. HENDREN: I did at Children's what I told the ad hoc committee I'd do: get the very best young people, and keep the best of them to rebuild our surgical staff with surgeons who would work together for a common goal of excellence. In the sixteen years that I was chief, we got our number one choice fourteen out of the sixteen years. In retrospect, the two times we got number two from our list I think they were actually more productive than our two missed number one choices who went elsewhere!

DR. PEARSON: Were they all from Harvard?

DR. HENDREN: No.

DR. PEARSON: I look at the Children's Hospital intern list in pediatrics. There are a lot of Harvards.

DR. HENDREN: Yes, but not exclusively. I'll show you a group photo of all of my residents, and can tell you where they all came from.

Jay Vacanti was my first chief resident in 1982-3. He graduated from Creighton University and the University of Nebraska Medical School. He was a surgical resident at the MGH and spent a year in the lab with Judah Folkman. After he finished as chief resident at Children's he remained on our staff until 1999, when he returned to MGH as surgeon in chief at Mass General Children's Hospital [MassGeneral Hospital for Children]. He holds the prestigious John Homans Chair in Surgery at Harvard. Jay also pioneered tissue engineering.

Preston Black was second. Preston was a scholarship student at Exeter, Harvard College, and Harvard Medical School (HMS). He was a Brigham surgical resident. Preston was a fine surgeon. He was the first African American chief resident at Children's and stayed on our staff for two more years, but then was recruited to Chicago to Loyola where he was the first pediatric surgeon. Sadly, Preston died unexpectedly of a heart attack in 2007.

My third chief resident at Children's was Dr. Robert Shamberger in 1984-85. He came to Boston from Missouri where he was valedictorian of his senior class at the University of Missouri. He graduated from HMS and trained in surgery at the Mass General. He had two years in the cancer section at NIH and was chief resident at MGH. His special interests are pediatric cancer,

chest wall deformities, and inflammatory bowel disease. The tenure of my successor was brief. Bob was then appointed chief of surgery in 2001, and Robert Gross Professor. He is doing a fine job leading our department which is very gratifying to me. I am now the Robert Gross Distinguished Professor, a title assigned to those few in the dinosaur class!

The fourth was Craig [W.] Lillehei from Minnesota, HMS, and MGH, where he was chief resident. Craig is on our staff at Children's. He is active in transplantation and inflammatory bowel disease, and coordinates the residency program. His father truly opened the field of repairing complex intracardiac malformations in 1954, using cross circulation between a parent and child for cardiopulmonary bypass, and soon thereafter using the DeWall-Lillehei bubble oxygenator. Wayne Miller wrote a book about Walton, Craig's father, entitled appropriately, *King of Hearts*, in 2000.

Michael [P.] LaQuaglia, number five, came to Boston from New Jersey. He graduated from the New Jersey Institute of Technology and the University of Medicine and Dentistry of New Jersey. At MGH Mike was not only a chief surgical resident, but did three additional fellowships: vascular, transplantation, and thoracic. He is a very accomplished surgeon and practices in New York City as professor of surgery at Cornell [University] Weill Medical College and Chief of Pediatric Surgery at Memorial Sloan-Kettering Cancer Center.

[N.] Scott Adzick followed LaQuaglia, in 1988. He too was an alumnus of Harvard, HMS, and MGH. After working with Michael Harrison in fetal surgery in California, he went to Children's in Philadelphia [Children's Hospital of Philadelphia] in 1995 as surgeon in chief and professor at the University of Pennsylvania.

Jay Wilson was number seven. He attended University of Massachusetts, Amherst [College], and Albert Einstein College of Medicine, and did his general surgery training at Brigham and Women's [Hospital] next door. He is on our staff. Jay has run the ECMO [extracorporeal membrane oxygenation] program and the ICU [intensive care unit] fellowship program, and is an expert on all aspects of diaphragmatic hernias.

Dennis [P.] Lund followed Wilson. Dennis was from Harvard College, HMS, and MGH. At MGH, like Shamberger, Lillehei, and LaQuaglia, he had been chief resident. Dennis is now chief of surgery (and pediatric surgery) at the University of Wisconsin in Madison and professor of surgery. He did an inguinal hernia on me, and also on one of my grandchildren!

Jay Schnitzer was next, in 1991. His background was Worcester Polytechnic [Institute] for an engineering PhD, HMS, and Brigham for surgery. After being our chief resident, he went then to Children's National Medical Center,

Washington DC, and later to MGH. Recently he joined Boston Scientific company.

Steven Stylianos was number ten in 1992. He attended college at Rutgers [University], medical school at New York University, and surgical training at Columbia Presbyterian [New York-Presbyterian Hospital/Columbia University Medical Center]. After he was our resident, he returned to Columbia in New York. Recently he became chief of surgery at Miami Children's Hospital and professor of surgery at the University of Miami.

Michael [G.] Caty was next, in 1993. He received his college diploma from Boston College, medical degree from University of Massachusetts Medical School Worcester, and surgical training at University of Michigan Hospital. Mike is now chief at Buffalo Children's [Children's Hospital of Buffalo] and professor of surgery at the University of Buffalo.

Steven [J.] Fishman was our chief resident in 1994. His college and medical school were Northwestern University, and surgical training at University of Pennsylvania. He is on our staff and runs the large vascular biology program.

Nicholas [C.] Saenz followed in 1995. His college was Harvard, medical school University of Michigan, surgery at New England Deaconess Hospital in Boston. He moved to New York with Dr. LaQualglia and from there to San Diego where he is on the staff currently at Children's Hospital of San Diego. He is a superb surgeon.

Russell [W.] Jennings did his undergraduate work at the Naval Academy at Annapolis, and medical school and surgery at University of California, San Francisco. After completing our two year chief residency in 1996, Rusty returned to California to work further with Michael Harrison (another MGH alumnus). Happily he returned to our staff when administration finally agreed to help support a fetal surgery program which he organized and directs.

Terry L. Buchmiller was our first woman chief resident, in 1997. Her college was Pacific Union College, medical school University of California, Davis, surgery at University of California, Los Angeles. After a sojourn back in California and then New York at Columbia, she is now back on our staff. In addition to being a fine surgeon, Terry runs the marathon, was first violinist for the Pacific Palisades Orchestra, and she directs a laboratory research program.

John DiFiore was the final chief resident on my watch from 1982-1998. His college was Dartmouth, medical school was Columbia University in New York, and surgical training was New England Deaconess. We sought to have him stay on our staff but that did not mesh with the plan of my successor,

whose term as department head ended three years after starting in July 1998. John is now at the Cleveland Clinic. He helped look after me when I got a new aortic valve there in June 2005. He is an accomplished surgeon.

Since a large segment of my work has been pediatric urology and cloacal malformations, I have spent about equal time in the OR with our fellows in pediatric urology as with our fellows in general pediatric surgery. It has, therefore, been a special privilege to have two trainees per year rather than one. Our urology residents have mostly gone on to academic jobs, as have our general surgical residents.

Our residents are an outstanding group of young people, and they're all doing outstanding work. What a privilege it has been to work with them!

DR. PEARSON: I must say that I'm impressed by your being able to list all of your former residents, where they came from, and what they are doing. And virtually all of them are in academic pediatric surgery?

DR. HENDREN: Yes. They're all in academic surgery.

DR. PEARSON: Is there any significant component of pediatric surgery done by private people? I know that a fair number of pediatric hematologists/oncologists and cardiologists now are in private practice; very different than it was twenty-five years ago.

DR. HENDREN: I think that the private pediatric surgeons probably exceed the academic people in numbers throughout the United States. We now have in the neighborhood of five hundred certified pediatric surgeons and I would guess that more than half of them are in private practice. You get a skewed picture here in Boston because most of the pediatric surgeons work in teaching hospitals.

DR. PEARSON: And Dr. Patricia Donahoe?

DR. HENDREN: Pat succeeded me as the chief at MGH. Pat's career has been absolutely outstanding in every respect. After she finished her training in Liverpool she returned to MGH in 1973. From our small initial laboratory effort, extant when she joined us in 1970, Pat built an enormous world class laboratory effort with consistent NIH funding of more than 90 post doctoral fellows. Thirty four of them are now doing pediatric surgery. She is a member of the National Academy of Sciences and also the American Academy of Arts and Sciences. She is the Marshall K. Bartlett Professor of Surgery at Harvard, and a chair has been named in her honor! She has been president of the Boston Surgical Society and president of the American Pediatric Surgical Association. She was awarded the Flance-Karl Award of the American Surgical Association and the [Fred] Conrad Koch Award of the Endocrine Society. Although retired from clinical surgery, she continues full steam ahead in the laboratory.

When Dr. Jay Vacanti, who was one of three strong contenders for the position at the Children's, was not given the appointment, he went to the MGH where he's doing a fine job as the surgeon in chief at the MassGeneral Hospital for Children. His chair as John Homans Professor of Surgery is the oldest in Boston. It's the chair held by Edward D. Churchill, my chief and mentor.

The words attributed to Leonardo da Vinci by Dr. Gross in 1974 would certainly apply to the accomplishments of Dr. Donahoe and Dr. Vacanti.

DR. PEARSON: Famous name, I remember seeing Dr. Homans at surgical grand rounds at the Brigham. He must have been in his nineties.

DR. HENDREN: There are nine pediatric surgeons at the MGH. The most recent to join that staff is Rafael [V.] Pieretti, who was in Caracas, Venezuela, for twenty-five years. Rafael was the outstanding pediatric surgeon and pediatric urologist there. He spent six months with me in 1974, the year I had colon cancer. Before that he trained in pediatric surgery and pediatric urology in Toronto. He has returned to Boston and is on the staff of the MGH where he is head of pediatric urology.

DR. PEARSON: Your accomplishments as a mentor of young surgeons have been outstanding.

DR. HENDREN: As I look back now from age eighty years, I think that the accomplishment that I'm most proud of is having joined with Eleanor, and having our family of five wonderful kids. You know we lost our daughter from diabetes when she was thirty-seven. She was a nurse and a teacher. We have four fine sons, all of whom are quite different, and eleven grandchildren. The oldest son, Douglas, is an orthopedic surgeon. He didn't have the benefit of a Dartmouth education because he went to Harvard.

DR. PEARSON: I noticed there's a strong Dartmouth continuum in your family. Let's talk more about your children.

DR. HENDREN: Jeremiah, son of Douglas, won a Shelby Davis Scholarship to Singapore. The United World College movement was founded in America by Armand Hammer. He was a Russian immigrant, a physician, a business man (Occidental Petroleum), and a philanthropist. His wish was to bring overseas students from abroad to study in America. Shelby Davis, also a philanthropist, funded 50 programs to send American youth to various United World College programs, one in America and eleven abroad. The program awards an international baccalaureate degree for the last two years of high school. Four students from Jeremiah's Singapore class were accepted by Harvard. There are 20 of these students presently at Harvard. President [Lawrence] Summers recently made very positive comments about their activities.

Jeremiah's sister, Sarah Grace, is our oldest grandchild. She's an accomplished musician and teaches music in Virginia.

In the Hendren family there had been only one son for eight generations, but Eleanor turned out to be a son-producer extraordinaire. She had Douglas first. We gave him part of my name, Hardy, i.e., Douglas Hardy. The next one is William Grant Hendren, who had the William part of my name. He's a heart surgeon. You've met all three of Will and Linda's children, three lovely girls, Amy, Katie, and Julie. The next son is Robert Bruce Hendren. You may get the Scottish connection. He's a urologist, and he's also a fully trained general surgeon. He and his wife, Dominique, have three great kids. Their oldest, Lieve, which is a Flemish name because her mother comes from Belgium, has also just completed a Shelby Davis scholarship in Singapore. She is going to Princeton next year. She was accepted at four Ivy League colleges, including Harvard, but chose Princeton, where she will get her degree from Princeton and study voice at Westminster Choir College. She aspires to sing opera. She was also a cross country runner. Their next child is Hardy. He is a very good wrestler. He is also academically very strong. Robby and Dom have another girl, Brigitta, a fiery little red head. All three are very good students.

The last son is David. He is a lawyer. He has three fine children, two girls and a son, Charlotte, Margaret, and James. All are excellent students and good athletes. David quit law because he couldn't stand working with lawyers. He said his life was one big charade in law, so he started his own venture capital company. He has just finished a contentious divorce and has custody of the three children.

DR. PEARSON: Well, those things happen. You know, I think with the fifty percent divorce rate in the country at large, one out of five (twenty percent) is not anywhere near the mean.

DR. HENDREN: It's a sad thing. Do you know anything about the borderline personality disorder?

DR. PEARSON: Some.

DR. HENDREN: Well, that's the problem with the former wife's outrageous behavior.

DR. PEARSON: This brings us to a couple of other things that I want to discuss. You've received an enormous number of medals and honors, and citations. One that I'm familiar with is your [William E.] Ladd Medal in 1983, hence this interview. Also you were president of APSA [American Pediatric Surgical Association]. You gave a talk at that time on the cost of health care. Do you remember that talk?

DR. HENDREN: Yes. "Some Reflections on the Cost of Health Care." Did I send you that?

DR. PEARSON: No, but I found it in the *Journal of Pediatric Surgery*.

DR. HENDREN: I thought that I would talk about something besides surgery. So I chose to talk about the cost of health care. I worked hard on it. I took about a month off and didn't do anything except research it. I thought I had a pretty good talk put together.

My secretary for 40 years, Paula Zafferes Cocoris, is Greek. We also had a surgeon in our department, who was a wonderful person and friend, named Dr. Angelo [J.] Eraklis, also Greek. Anything that Angie said to Paula would be taken as gospel. About four days before I had to give my presidential address, Angie said to Paula, "Why don't you tell him to talk about surgery, which he knows something about, instead of about health care, which he doesn't know anything about." So she came in tears to see me, "Dr. Hendren, I'm not going to go to APSA because I know you're going to make a fool out of yourself in front of your friends, and I just don't want to be there for that." I said, "Well, what do you want me to do?" She said, "I think you should do what Dr. Eraklis says, scrap the talk, and talk about something in surgery." I said, "Paula, I can't do that at this point. I've gotten this whole manuscript done, I've got the talk put together, and that's what I'm going to give." I invited her to come anyway. Paula was sitting in the very back of the auditorium with Eleanor and my mother. Mother was about ninety at the time. As I started my talk, the audience just clicked on to it. As I said various things during the talk, they started interrupting with applause. As you know that isn't very common!

DR. PEARSON: No.

DR. HENDREN: As I looked toward the back row, there was Paula with a big smile on her face because the audience obviously was enjoying the talk. When Dr. Gross received his copy of the *Journal of Pediatric Surgery* (December 1983) with that paper in it, he sent me a long, hand-written note saying how much he enjoyed reading it. He went so far as to say, "It's one of the best papers I've ever read." I showed it to Paula. She laughed sheepishly. I re-read the eleven page article recently. The message is still relevant 25 years later!

I compared the cost of various things. For example, I said the airplane with which I had some acquaintance in 1945, the Hellcat, cost thirty-five thousand dollars. The current F-14 Navy fighter, the Tomcat, according to the Grumman Company, costs 35 million dollars. Each of those was the state of the art fighter in its time. The cost of one Tomcat in comparable dollars is 220 times as much as the navy's top fighter in 1945. Expressed differently, one Tomcat could buy enough Hellcats to fill the decks of two carriers.

Nobody thinks a thing of that, do they? I said then, "I happen to know that three Tomcats went down one night in the Caribbean recently." My Godson, Christopher Browne, was a pilot of one of those planes. It suddenly turned over on its back at 29,000 feet. They were advised by the air officer on the carrier U.S.S. Eisenhower, from which they were flying, to bail out quickly. As they were parachuting down, they saw the plane blow up in mid-air! They were rescued by a frogman who dropped out of a helicopter which arrived quickly from the carrier. That same night two other Tomcats were lost, including the two man crew in one plane who were attacked by sharks. This didn't even get into the newspapers; a loss of one hundred million dollars. Yet look at these things that are in the newspapers about health care spending being so out of whack. They're spending two million dollars for a CAT scanner! I said that those three airplanes would buy CAT scanners for fifty university hospitals. I compared all through the talk the fact that we're all screaming about the cost of health care, but we're not putting it into perspective. For example, we're not putting into perspective the patients that are saved today, who will go back to work, pay taxes, and amortize their health care costs; money was spent doing an open heart procedure, or an aortic aneurysm, or whatever, which couldn't be done years ago.

DR. PEARSON: I also was impressed, as I looked at your bibliography, that you didn't demand to be the first author in many, many of the papers.

DR. HENDREN: No. I put my young people's name as the first one on a lot of papers. You'll see Pat Donahoe as the first author of a number of the papers. I nearly always had her as first, and I usually took up the rear echelon.

DR. PEARSON: Well, it doesn't hurt to have the boss on the paper for young people. I've had enough experience with very senior professors shoving aside people whose idea and work it was, in order that they can be first. I've always kind of resented that.

DR. HENDREN: Yes. I don't think I ever did that.

DR. PEARSON: Since so much in the Miller book is centered on cloacas, talk a little bit about **cloacas**.

DR. HENDREN: Sure. The first cloaca I saw was in 1955 when I first got to the Children's. There was a little baby who came in with a typical cloacal exstrophy. Nobody had a clue what to do for it. I had Dr. Gross and Dr. Longino look at it. Dr. Gross said he didn't know what to do. Longino just shrugged his shoulders. He was a man of few words. The baby died. I wanted a post-mortem in the worst way, but the family wouldn't grant it. The family said, "If nobody knows what to do with it, it can't be very important; it must be pretty rare." So they refused a post. It was shortly thereafter that we got another one, and that baby also died. That family gave

autopsy permission. I went to pathology and they let me dissect out the pelvic organs. The photographs are in one of my papers. I said to myself, "This is something that can be fixed. What you have to do is separate the three structures that come together in the early embryo." The 7 ½ mm embryo has a cloaca. By the time it gets to 25 mm the structures are partitioning. The uro-rectal septum descends, and separates the primitive gut from the primitive genitourinary tract. Later the partitioning occurs between the urethra and the vagina. If these events don't occur, then a cloaca can be present at birth. I figured that it could be fixed.

In my second year back at the General, Dr. Bill [William] Adelson, an MGH trained pediatrician in Marlborough, Massachusetts, referred a problem patient. At birth she had been sent to Children's. A tube had been placed in the bladder and another tube in the vagina. He didn't think this was a very definitive way to deal with the baby and asked if I would see it. It was a cloaca, Christine M. I separated all of the various structures as I thought should be possible several years earlier when studying the baby at post mortem. That was in 1962. Christine is now 46, married for many years, and in normal health. I removed her gall bladder in 1998; she had cholesterol stones. Pretty soon I got another cloaca patient – then twelve more. I wrote a paper about them in *Journal of Pediatric Surgery*, June 1977. As always occurs when you write a paper on something rare, suddenly a bunch of them turn up. Pretty soon I had 35 and reported them in *Journal of Pediatric Surgery*, December1982. I've had over two-hundred cloaca cases, including about 60 cloacal exstrophy cases. One cloaca is born for every 50,000 live births. So, if we've got three million births a year in this country, then that should give us about 60 cloacas in the course of a year.

Even more rare is cloacal exstrophy. They have a constellation of defects which include two exstrophied hemi-bladders, an absent rectum, and a rudimentary colon distal to a cecum which opens between the two little bladders. Often, the terminal ileum intussuscepts out through the cloacal fistula – it looks like an elephant trunk hanging out. The colon itself is a micro-colon which hangs down in the pelvis and is about the size of an adult's appendix. I've had patients where a general surgeon had taken out the micro-colon thinking that it is of no use. That is a disaster because as soon as you functionalize the tiny colon, it will enlarge into a good sized colon. They also have an omphalocele. Cloacal exstrophy occurs only once in every 250,000 births. Thus in a year we have only about a dozen in America. I have two papers on cloacal exstrophy. Dennis Lund looked up the data, 25 in the first report and 50 in the second. Dennis Lund was listed first author to encourage others to send those long term, tough cases to him. I've done my share already! A rare problem like that should be regionalized to just a few surgeons. He had a terrible cloacal exstrophy at Wisconsin when he first went there. He asked if I'd come out and do it. We started one morning at about eight o'clock and finished early the next morning. He said to me, "This is going to be of great help to me because when I do one of these

cases and spend many hours doing this big reconstructive surgery, I won't come under fire if my mentor spent that long doing one here." That was part of the reason that I went out to do it, because it would help him to introduce big reconstructive pediatric urology at Wisconsin. Dennis is a superstar in many ways. Dr. Layton F. Rikkers, the department chair, has made him the chief of general surgery as well as pediatric surgery.

DR. PEARSON: When did you stop operating?

DR. HENDREN: August 12th, 2004. I was age 78 ½ years and had completed 52 years in the OR since my first appendectomy as an intern. I needed two new knees from all that standing, and a new aortic valve. My own had increasing stenosis and regurgitation. Also surgery wasn't the same after Dorothy retired. Our general surgical nurses, especially Karen Zaal, did a fine job filling in for her. It was time to leave the OR and concentrate on new vistas: to fix my heart and knees, and to do some serious writing. My last case was a re-operation on one of my older cloacal cases who had come from Minneapolis after a series of ill starred surgical procedures by a surgeon who should have known better. It was a final pelvic exploration to remove a cystic tube and ovary. My last three cases were all cloaca patients, a type of surgery which had not even existed when I was in training. Karen scrubbed. Dr. Christopher Weldon assisted. Dr. Christian Seefelder, one of my favorite anesthesiologists, took photos unbeknownst to me. I was deeply touched when they presented to me a framed photo collage entitled "The Last Case." It's in our library.

The surgeon who repaired my heart is Dr. Delos (Toby) Cosgrove, CEO of the Cleveland Clinic. If you look in the index of Wayne Miller's book, *The Work of Human Hands*, for Toby Cosgrove, he's there. On the fourth post-op day after my colectomy for cancer, clear liquids were ordered by Dr. George Nardi, my surgeon. Toby and Matt Donnellan, both surgical residents in 1974, came to my room in the Philips House with some clear liquid – Chivas Regal. We three made good inroads into that bottle. I required no sleep medication that night. My path report was available the next day – all 30 lymph nodes in the specimen were negative, although it was a Dukes B lesion up to, but not through, the serosa.

DR. PEARSON: When I was in the navy, there was a navy captain who was head of the base hospital where we had dependents. He would go around to the dependents where the old ladies were and order sherry for them. They'd get a little nipped and happy, and he kept saying, "This is not just a hospital, it's a hospitality center."

DR. HENDREN: The surgeon who did my knees is Dr. Richard Scott. Our son Douglas, an orthopedic surgeon trained in the Harvard program, said Dick Scott is the outstanding knee surgeon in Boston. Dick said that one of his most important rotations was with me in pediatric surgery thirty years

before, but he said he wouldn't do knee surgery until a heart surgeon fixed my heart. So June 24th, 2005, my heart was fixed.

DR. PEARSON: And this was a sequela from your rheumatic fever in the Navy?

DR. HENDREN: It may have been. Interestingly, it turned out to be a bicuspid valve, so possibly it was the normal picture often seen with a bicuspid valve. In my own mind, I think this was a rheumatic episode superimposed on a bicuspid valve. Curiously, none of my echocardiograms described a bicuspid valve, possibly because the leaflets fused to such a degree that the radiologist assumed that it was three leaflets fused together. The aperture was down to 8 mm.

DR. PEARSON: That was a year ago?

DR. HENDREN: Yes. It was an interesting experience to be wheeled into the operating room at the Cleveland Clinic where they're real pros. They do many open hearts a day. My son Will, whom you've met, spent a year of his training at the Cleveland Clinic. He said Toby Cosgrove was the most experienced aortic valve surgeon in the country. When I was wheeled into his operating room, all four of my sons were there. And they bade me goodbye as anesthesia was getting me lined up with the IVs and so forth. I looked over at the pump and I said, "You know this is kind of spooky because I know that in about thirty minutes I'm going to be on that thing over there." And by the way, I didn't mention it previously, but I salvaged the first infant with critical aortic stenosis at the Mass General with Dr. [W.] Gerald Austen many years ago. The baby was in severe congestive failure with tight aortic stenosis. It was a congenital bicuspid valve. We incised the commisures and the baby did well. Toby said "I've been waiting a long time to get even with you, Hardy." We both laughed. He then asked if I had an incision preference. My reply was, "Whatever gives you the best view inside!" He made a long median sternotomy, which I've used for many thoracotomies over many years. It <u>does hurt</u>, by the way.

I woke up in the recovery room aspirating. I knew I was aspirating. I had an endotracheal tube in, but they didn't have the cuff blown up. The tube was gagging me. I could feel gastric juice coming up my esophagus and entering my pharynx. I pointed to the tube trying to ask the nurse to remove it by sign language. She wouldn't pay any attention to me. My son Will was standing there, and saw me aspirating. He told the nurse the same thing. Her answer was, "Why don't you let me do the doctoring here?" So I ended up with big time aspiration pneumonitis. I spent two weeks in the hospital. I was sick. Dr. Donald Hammer, the cardiologist, watched me very closely. He was super. At age 79 I was not exactly a slam-dunk operative risk. The results of the surgery were fantastic. BUN, creatinine, and potassium, all previously elevated, came down to normal, obviously the result of better

renal blood flow. Sleep apnea, which caused me to use a mask for several years, disappeared. I can't explain that. Atrial fibrillation was gone temporarily from a MAZE procedure and atrial appendectomy, but recurred when I returned home. Several cardioversions were done, but it recurred each time. So I'm required to continue coumadin. That's a small price for being alive, and well! By the way, when Toby said I had a valve made from bovine tissue, Eleanor said that "a pig valve" would have been more suitable!

Then I had the knees done three months later. That hurts.

DR. PEARSON: You did them both at once?

DR. HENDREN: Yes. I talked to several people who had had one done at a time. Each said "It hurt so much when I had my first one done that I couldn't get my courage up to do the second." Those who had two said, "Yes it hurts like everything, but grin and bear it. You can get over it." So that's what I did.

DR. PEARSON: And you're walking very well now?

DR. HENDREN: Absolutely. It's a miracle!

DR. PEARSON: I have some very general things to ask you that are more philosophical. What is the future of pediatric surgery? What do you recommend to people who want to be pediatric surgeons as far as training and preparation?

DR. HENDREN: I think that pediatric surgery requires that you know how to do most everything. You don't learn to do resection of the aorta on little kids, but rarely do you have to do it. Thus you've got to have a background of vascular surgery on older patients in order to be familiar with general principles of vascular surgery that you can apply to children. I think that's true with so many things. Occasionally you have to do a radical neck dissection for a child. You don't learn to do that in a children's hospital. You learn to do that in an adult surgical program. It's my firm conviction that to train for pediatric surgery, you should take a complete training in general surgery. It's currently the requirement before you can go into a pediatric surgical program, that you be fully trained in adult surgery. Unfortunately, the scope of an adult program is much more limited than it used to be. In my day, the cardiothoracic surgery was in the general surgical service. And so I was able to get good cardiothoracic training, because it was part of the East Surgical Service at MGH where I trained. But that's all split off now. There are separate cardiac residents and separate thoracic-noncardiac residents. I suppose that that's sensible these days, but the more general surgery you have before you do pediatric surgery the better.

DR. PEARSON: Yes. There's been a splitting off of neurosurgery, orthopedic surgery, urology, and cardiovascular surgery. I hear around my hospital that some of the adult surgeons keep asking our pediatric surgeons why

they are doing so many things. You're a generalist practitioner of surgery in pediatrics. You do many different things that on the adult side would be sequestered.

DR. HENDREN: Yes. Exactly. Urology now is getting sequestered because the chairmen of the pediatric training programs didn't do anything to protect their turf. Orvar Swenson went out to Chicago, where he was perfectly happy to turn pediatric urology over to Dr.Lowell King who got his foot in the door for the adult urologists doing pediatric urology. [C.] Everett Koop did the same thing in Philadelphia. He had Alex [Alexander] Michie doing pediatric urology there. Alex didn't do really big stuff. Alex was a very nice man. He had a huge backlog of patients with big urologic problems. When Dr. John [W.] Duckett came to CHOP, he wasn't very cordial to Alex. I had always been cordial to and supportive of Alex. The result was that I had a pipeline of major pediatric urologic reconstructive cases to do in young adults that Alex Michie was continuing to follow. Dr. Koop turned it all over to John Duckett, so urology there is now a separate service. I was visiting professor at CHOP several times. I did their first megaureter surgery at CHOP. By the way, Judah Folkman was down there for six months getting a crash course in pediatric surgery before assuming the job as surgeon in chief at Children's Hospital, Boston. They had me lined up to do several cases. Dale Johnson, another MGH alumnus, was assisting. In the late afternoon, Dr. Koop asked Dale to drop out to attend a meeting with him. Judah scrubbed in. So there we were with an all MGH team: Judah; my scrub nurse Dorothy, who stayed with the Johnsons; and me, who stayed with the Koops. I wondered if that was really a productive teaching visit.

DR. PEARSON: And what about the future?

DR. HENDREN: I would emphasize again that number one in my life has been our family, and our grandchildren. The second has been surgery. I've enjoyed taking care of children. Many continue to get in touch with me. Yesterday I was at the MGH with Eleanor who had endoscopy. The nurse taking care of Eleanor in the recovery room said, "Dr. Hendren, you operated on my son nineteen years ago, and he's fine." Later we were downstairs in the hall and met Hermes [C.] Grillo. Hermes showed the world how to resect a trachea; that was "no man's land" before Hermes developed that surgery. Two other people on the hospital staff said, "Hello, Dr. Hendren." One of them said, "You operated on my daughter with a twisted spleen twenty-five years ago." The other one said, "You operated on my daughter with reflux." So you know it's fun to get these kinds of things. I got a letter last week about a kid who's now 6'4" tall who had renal failure with severe urethral valves when he was a baby.

Young people ask me about the future frequently. I tell them, "Things are different than they were when I started practice. However, a constant which

endures is that a doctor, more than any other profession, will always have the satisfaction of helping others attain life which they're losing." I don't think the banker or the lawyer has that same satisfaction. They may exceed your productivity in terms of income, but not in satisfaction. There's a limit to how much you can take with you when you die. I don't think that most people who become physicians today enter it with the idea of becoming wealthy. If that's the reason an individual chooses a career, it's not a good one.

DR. PEARSON: Someone asked me the same question. I said, "Well, I think perhaps my epitaph should be, 'I can't remember a day that I went to work reluctantly.'"

DR. HENDREN: That's wonderful. I think your philosophy is the same as mine. I say to young people, "Tell me any other areas where a person goes to work eagerly on Monday morning." I looked forward to Monday mornings when I was operating, much more I think than the banker looks forward to getting back behind the teller's cage, so to speak.

DR. PEARSON: Tell me now about the modern, the new surgery – the robotics, the endoscopic surgery, and things of that sort. Do surgeons automatically have a three dimension perspective so that they can work through those telescopes and do the things that they're doing now?

DR. HENDREN: I think it's easily learned.

DR. PEARSON: Is it?

DR. HENDREN: Yes. I don't think that it's too difficult. The team watches a TV monitor above the table instead of through the scope. You're not actually working through the scope.

DR. PEARSON: Does it have three dimensions or must you be able to figure it out?

DR. HENDREN: You can figure it out, particularly if you've got two instruments that are in the field, and you're working one with one hand and the other with the other hand, they're not in the same plane, so you get the third dimension. Of course, there are some scopes that give you stereoscopic vision. That does give you an edge for depth perception. Dr. Gross operated his whole life without depth perception. He had a cataract in one eye. He didn't have it fixed until Dr. Trygve Gunderson did it after Gross retired. Dr. Gross never divulged his monocular vision until Dr. Peter Mansfield in Seattle got an ocular melanoma and lost an eye. Dr. Gross got in touch with Peter, his former resident, and told him, "Don't give up surgery on account of that. I did my whole career with one eye." He'd learned that when he was a little boy at Atlantic City. You know how a little kid will hold a finger up in front of the nose and then close one eye and then the other? You learn

which is your dominant eye. My right eye is the dominant one - when I close it the finger shifts to the right. If I close the left eye, the finger does not shift. Gross learned that he didn't have any vision in one eye when he was looking at a light house across his finger. He had a congenital cataract. So his father gave him a clock to take apart, and then a smaller one, and then an even smaller one. This taught him how to compensate for poor depth perception with only one eye. Gross used short instruments. He would change the position of the instrument to mimic depth perception.

DR. PEARSON: So it's learnable. Well, now incisions are smaller, and patients are elated with smaller incisions. But after abdominal surgery, they're not well immediately, they have to reabsorb that air and they're uncomfortable for twenty-four hours or so.

DR. HENDREN: Many of us were skeptical when the first laparoscopic colecystectomy was demonstrated. The vast majority of gall bladders are done now laprascopically, and most surgeons can learn how to do that without any great troubles. Now that has been extended to many other kinds of surgery.

DR. PEARSON: I've seen laparoscopic splenectomies which are kind of interesting.

DR. HENDREN: Yes. Splenectomy can be done that way. You morselate the spleen and pull it out in a bag. I just don't know that I think that's a great advance.

DR. PEARSON: Well I see people doing baby hernias laparoscopically. You know the incision in usual baby hernia is so small.

DR. HENDREN: It will leave a scar anyway. One of our young urologists was very gung-ho to do a nephrectomy with laparoscopic technique. He had a baby with a multicystic kidney. He was proud that he removed the multicystic kidney in about two hours, and sent the baby home two days later. I perchance had one of those easy, little cases referred two days later. I helped the urology resident do it. Instead of four one-cm incisions for a scope and the manipulators, we made one 3-cm incision and removed the kidney in thirty minutes. I sent the baby home the next morning to New York. So, I'm not sold on the great utility of doing something laparoscopically when it can be done just as easily surgically, for example, pyloric stenosis and inguinal hernia.

DR. PEARSON: What else is new?

DR. HENDREN: Fetal surgery is being done. I'm not so sure that its utility is going to be that important on the overall scene.

DR. PEARSON: It certainly hasn't seemed very good in diaphragmatic hernias, nor in meningomyocele.

DR. HENDREN: I think that if a baby in utero in my own family had a bad malformation, I might advise pregnancy termination. The woman should make the choice. Now at the same time, we make a maximum effort for any little tyke that is born with a major malformation. I mean, here they are and we do our best to correct them.

DR. PEARSON: Yes, and now with fetal ultrasound, these things are diagnosed so early. There's been a tremendous decrease in babies with meningomyocele, and I'm convinced that most of that is because of prenatal diagnosis and termination, not to closing them in utero.

DR. HENDREN: Dr. Claire Fekété of Paris told me of the current practice in France. Ultrasound is commonly used to screen pregnancies. If a major malformation is certain, parents may choose pregnancy interruption. If they wish to have the baby, the best care will be given to the baby and the government will pay all the health care costs, even if some would judge that to be unreasonable.

DR. PEARSON: Catholic France. That's interesting.

DR. HENDREN: It is interesting, isn't it? I think that I've quoted her correctly. The next thing you mentioned is robotic surgery. No question you can do endoscopic surgery using a robot; that's been demonstrated. I don't think it's going to be something that's very widely used. First, there's a big learning curve. Second, it's very expensive equipment. I just don't think it will ever be available in every community hospital for every kind of surgery.

DR. PEARSON: So much is postoperative care and things of that sort.

DR. HENDREN: I believe there's still going to be a role for the well trained general surgeon who can open a patient and do what is necessary. It was interesting to me last month. I was in Taiwan. A young surgeon was showing me around. He was very proud of doing laparoscopic pyloplasties in little babies. The operative time was about the same as doing an open pyeloplasty. The results were nearly as good as open cases. Open pyeloplasty has been very satisfactory in my experience and should be uniformly successful. The young surgeons were showing me laparoscopic pyeloplasty but didn't have a clue how to do a major reconstructive operation. I was asked to scope two of his patients while there. It made me sad because both of those kids needed a major reconstructive operation, and there wasn't anybody willing or able to do it. One of them was a cloaca previously operated on. The vagina was retracted out of sight. So was the rectum. The child had a severe degree of hydronephrosis on one side and nobody's going to be able to do a major reconstructive operation. So that little girl is going to die with entirely fixable pathology.

To be concentrating on a laparoscopic pyeloplasty seems to me to be putting "the wrong emphasis on the wrong syllable." I saw another kid the same day, whom I cystoscoped, with a cloacal exstrophy. The child had a pseudobladder from bowel, but there was no continence mechanism. To me it's sad to see a child I could fix, but not under impossible circumstances where it's an unfamiliar nurse, or series of nurses. The nurse assigned the day of the endoscopy had never seen such a procedure previously! It would literally be foolhardy to undertake a big operation under such conditions. I learned that the hard way several times in my career.

DR. PEARSON: Sad. You've done a lot of work going overseas and operating. What's the organization?

DR. HENDREN: The first country was Malawi; the trip was sponsored by the US Department of State. Physicians for Peace sponsored trips to Syria and Egypt. Dr. Charles Horton was the driving force in Norfolk, Virginia, behind Physicians for Peace. He was a dedicated and highly skilled surgeon, and sadly he died recently. The majority of trips revolved around surgical meetings after which I was asked to do some special cases. When our children had grown up, Eleanor could go with me as well as Dorothy, who would bring our instruments, vascular grafts, good suture material, and all the things necessary to do good surgery elsewhere. Pakistan was one of the most interesting, and dangerous, places we worked – at the Aga Khan University Hospital. We did ten intersex cases in one week, plus a variety of other miscellaneous cases. Other places included China (Beijing, Jinan, and Shanghai together with Dr. Tony [Anthony] Shaw), Japan, Manila (Eleanor came home with salmonella), Hawaii, India, Mexico, Panama, Columbia, Brazil, England, Ireland, Germany, France, Russia, Hungary, Spain, Poland, Holland, Switzerland, Finland, Austria, and Guatemala.

It has been a privilege to be visiting professor to lecture and often to operate in 40 other schools and hospitals in the United States - two or three visits in eleven; and two specialties, general surgery, and urology, at Yale, Hopkins, Virginia, UCLA, and East Virginia Medical School.

DR. PEARSON: Dr. Patricia Donohoe was interested in Müllerian ducts and things of that sort, as I remember.

DR. HENDREN: That's right. Pat came to see me in 1969 about a clinical job on a very strong recommendation from Judah Folkman with whom she had been working in his research lab. We had just acquired some lab space and a fellow, and needed help increasing productivity there. I agreed to help her clinically for six months, and to help her secure a place in Liverpool whose surgeons I knew well.

While she was getting more training in Liverpool, she returned for the APSA meeting, and gave a paper on her research. It was about the changes in the

kidney caused by ischemia over a period of time including microangiographic studies of the kidneys. As we were flying out of The Homestead in Virginia following that meeting, Eleanor, Pat and I were all sitting together in the airplane and I asked Pat what she wanted to do when she finished in Liverpool. She said that she was all set to go into practice in pediatric surgery in Brockton and Randolf, Massachusetts. I said that her capabilities far exceeded that plan and suggested that she join us at the MGH. We then discussed studying the events which occur in sexual differentiation. I emphasized that the great depth of research at MGH would offer advice and collaboration with others with expertise in electron microscopy, biochemistry, genetics, and so forth. So Pat came and started that research at the MGH. Her first grant was for $15,000 from the H. P. Hood Foundation.

DR. PEARSON: Yes. I know, the Hood Foundation. The current senior Hood was one of my classmates at Dartmouth.

DR. HENDREN: And so with that $15,000 grant, along with money from our department to finance the biochemist and others, the first Müllerian duct paper was produced. That first paper was turned down initially. Dr. David [B.] Skinner was the editor of the *Journal of Experimental Surgery*, chief of surgery at the University of Chicago, and a former MGH chief resident. I called him to request he re-review the paper which may have not been read by surgeons with understanding of this field of research. The result was acceptance of the paper.

DR. PEARSON: Tell me about your long-time scrub nurse, Dorothy Enos.

Dr. HENDREN: Dorothy Enos was one of the scrub nurses at the Children's when I was the chief resident. On July the 4th, when I was just starting as chief resident in 1960, we had a horrendous load of cases in that holiday interval. We used all eight ORs. We were so busy the nurses didn't have time to clean up between cases. So they'd just break out another room, then another room, and we went around that way. We had all kinds of cases, intestinal obstructions, and so forth. And the two nurses who were on were Dorothy and her roommate, Maggie Knapp. Dotty would scrub with me periodically when I was a resident. Then two years later, after I finished as chief resident in 1962, I came to the OR one morning and there was Dorothy standing in the hall crying. I said, "Dotty, what's wrong?" She said, "I was scrubbing with Dr. William Green."

DR. PEARSON: The orthopedist?

DR. HENDREN: Yes. He was a mean man. He had bawled her out because she didn't want to hold the X-ray film behind a patient's hip, while the X-ray tech aimed the X-ray tube directly at it. She objected to that, as she should have. So he made her feel ashamed by saying, "If you had any

dedication to the patient, you wouldn't mind doing that." So she left the room, and was standing in the hall crying. I said, "Why don't you come down to the General and scrub with me?" Well I caught her at just the right time and she said okay. And Jean Lootz, a nurse anesthetist said, "You won't like it there. You won't last even a year." So Dorothy decided to try the MGH for a year. She stayed until age 65, over 40 years, and then retired.

Dorothy is the best operating room nurse I ever worked with. She was very dedicated to the patient at hand. It was evident to all at the General what an enormous asset Dorothy was for pediatric surgery. She would be in early in the morning and have everything set up just right. She would be there when the case started, and she would be there until we finished. She didn't take all the usual breaks for coffee, lunch, and so forth, which can disrupt a big case. Her salary level was appropriate for her excellence. But when she was asked why she stayed so long in the same job, she said, "Well, I enjoyed working with Dr. Hendren, and he always thanked me at the end of a case because he truly appreciated my contributions to the case." I would frequently say to her, "Dotty, what do you think about this?" And she would often suggest what we should do. She was intuitive. She was more than the scrub nurse. She was, in fact, my first assistant much of the time. The other nurses at the General accepted her slowly, but then they soon realized that, "This woman is an enormous help," and they began to do what she did, namely get in the field with the suction and work, and stop neatening their instrument tray. You go into an OR, you'll see much of the time the scrub nurse is neatening her instruments. With Dorothy, she was right in the middle of the case. If you look at the photographs in Wayne Miller's book, she's always right in the middle.

Robert Gross worked that way with his scrub nurse, Marie Dresser, too. Marie was also very good. Marie, during an emergency, would sometimes shake and be unable to work. When an emergency occurred, Dorothy was just as cool as the center seed of a cucumber. She would never falter and would never get flustered. She would always keep her poise and her cool, and she was always highly professional. I never heard her tell an off color joke. If somebody did tell an inappropriate joke, she would remain silent.

When she came over to Children's with me, the nursing administration tried to block it. Ann Black, the head of nursing, tried to put a kibosh on it. I said, "If you want me to come to Children's, I bring all of my team - my nurse, my secretaries." I had five ladies who worked with me in the office at the General. They all came.

We were at the Children's just a week when Dorothy got called in by the head of nursing, Mrs. Black. She said she did not approve of a nurse working for a doctor. Dorothy replied, "I don't work <u>for</u> Dr. Hendren, I work <u>with</u> Dr. Hendren. We together have a common interest in doing what is right for the child." Ann Black then said, "Let me tell you that you'll be

the last nurse working with a doctor as long as I'm here." The reason nursing doesn't like it, is that they want complete control of all aspects of nursing.

DR. PEARSON: I'm reminded of the story of Dr. [Alfred] Blalock and Vivien Thomas at Johns Hopkins...

DR. HENDREN: Yes, I know of the close working relationship between Dr. Blalock and his gifted laboratory technician, Mr. Vivien Thomas, who was himself an outstanding surgical technician. There was a program on Nova of their close relationship. I thought it was terrible that he wasn't invited to a retirement dinner for Dr. Blalock. Dr. Mark Ravitch snuck him in the back door.

DR. PEARSON: But they did have a retirement ceremony for him, and his portrait was put up in the Johns Hopkins Hospital, so ultimately they recognized him. The fellows, I think, and former residents sponsored the celebration.

Have you heard the story that Helen Taussig originally went to Boston to ask Dr. Gross whether he would do a shunting operation for blue babies, and he allegedly said, "Young woman I don't make ductuses. I close them!"

DR. HENDREN: Yes. That was a good story. Gross told it often and highlighted that he made a big mistake not listening to Taussig. The Blalock-Taussig shunt made Hopkins the world's capitol for blue baby palliative shunts until the day of complete repair on cardiopulmonary bypass evolved.

Dorothy retired when she was sixty-five in 2003. Her birthday is in mid-March but she graciously agreed to work with me for another six months so I could clean up the backlog of big reconstructive cases that were waiting to be finished. Then she built a house in Bonita Springs, Florida. She had a lovely house in Newton, where she was a great gardener. She later chose to sell her Newton house and become a Florida resident for more than half of each year. She returns to Massachusetts for the summer. She speaks of "the good life" now, in contrast with a very busy and productive one for those 40 years. Dorothy was a singular help in carrying out many of our big reconstructive cases with success. She's scrubbed through all of it – the cloacas, the megaureters, the undiversions, and the complete reconstructions. She had unique talents and she never got upset.

I remember one day we were doing a newborn with a very large hepatic tumor. We had resected much of the right lobe of the liver next to the vena cava and the side biting clamp controlling the cava broke. In many cases such an event is a catastrophe, especially if it's a small baby. I pressed my left thumb and forefinger on the cava, and said quietly, "Dotty I need a clamp and then another clamp." She had both ready already! I said to her after the case, "Where the hell did you get those clamps? I've never seen

them before." She said, "I got them when the American College of Surgeons was here in Boston, because I thought they looked good and I thought someday you'd find a use for them." There they were. We got the hole in the cava sewed up where the clamp had slipped off, and the anesthetist didn't even know it happened. It was just done totally quietly. She was right in there.

I remember another time we were doing a baby ductus. Sometimes the little premie ductuses are very fragile, and can easily be cut by tying a ligature snugly. A small clip is often safer. We used to put those little baby ductuses on between scheduled cases. They would come from the nursery in their incubator, often on short notice, have a 15 to 20 minute ligation, and go back to the nursery. Young Dr. Thomas Peebles, a pediatric intern, you must know his pediatrician father, was rotating through surgery for a month. So he was standing just to my right as I tied the ductus and it cut through. Dorothy saw this. I put a finger on it. Dorothy said, "Excuse me," as she put her hip against Tom Peebles and pushed him out of the way to get right in next to me with suction. So I'm there with a tiny clamp that she handed me, and she had the suction on and the two of us worked and got the ductus clamped, divided, and over-sewn, but there was not a skipped heartbeat because she was there. If anybody else had been there, it could have been curtains. Some surgical residents want to get in the middle of it in an emergency. Things go better with the nurse a surgeon has worked with for many years.

In one month we had three senior surgeons seek our help. First was the otorhinolaryngology service chief. He came into my room and said help was needed in OR 3. When I said, "We are almost finished, so I'll be just a few minutes." He said, "I need it now." I went immediately. Deep in the neck, one of the great vessels was bleeding vigorously. I packed the wound and then asked them to get Dorothy. Meanwhile I apologized to the scrub nurse, whom I did not know. "Ma'am, I'm sorry. I don't know you and you don't know me, and I'm going to ask Dorothy to come in because she knows just what moves work best for this." The nurse was delighted to have that excuse for moving out of the field because they were talking about putting the patient on bypass and things like that because of uncontrollable bleeding. They couldn't control it because they couldn't see where the blood was coming from. Meanwhile we just continued pressure on the pack and waited for Dorothy. When she came in, the first thing I did was to get the two doctor assistants' hands tied up with four retractors. Then we enlarged the incision. When we had the field laid open and well exposed, I starting teasing the pack off, and as it came out I could see where the bleeding was coming from. Dorothy handed me a stitch, and another, and another, and soon we had it controlled. The point was that Dorothy knew intuitively exactly what I needed, including how to provide the proper exposure for each part of an operation, and she always provided it. Nursing administration simply does

not know these subtleties of OR table performance which are so important in some cases.

A few days later, the head of gynecology down the hall got into trouble, making a hole in the vena cava while doing a laparoscopic procedure. When I got the word that he wanted me, I said, "Don't do anything, just press on it until I can get there." He had opened the belly by that time. With Dorothy's help the incision was enlarged to get control of the vena cava above and below the hole. The pack was then removed with good vision of the hole. It was very simple.

A short time later a request came from another senior colleague, the chief of urology, whose room was down the hall. He said, "I'm into vessels in the side wall of the pelvis and I can't get at them to expose them." I said "Please, just press on them and give me a chance to get down there." I always made that request, for once, as I was en route from home at night, another surgeon continued trying to stop bleeding and cut the vena cava in two! That was a dicey thing to deal with, but it ended okay. I learned that the mass being removed was an extra vagina with no egress and tensely distended with blood. It's a big mass. I said, "She doesn't have any cancer?" "No, she doesn't." I said, "Okay, so we don't need to worry about cutting into it." One never can control adjacent vessels with a big mass filling the pelvis, because it doesn't let you get at the vessels. So first of all, I opened the mass with four incisions to allow removing one quarter of it at a time, with a hand inside to guide dissection on the outside. After the first quarter was out it was easy to control the lateral pelvic vessels. We then dropped out, but I suggested not including the little drama in the op note. My colleague expressed his thanks. It was the teamwork with Dorothy that had made the difference. Other nurses soon began to emulate her. When we left the OR, they all were very supportive of her. Mrs. Black was long gone, incidentally. Some of the nurses said, "I was trained by Dorothy." That was a nice thing for them to say.

You asked about medals a while ago. There were a couple of others that were significant. One was the Valentine Medal of the New York Academy of Medicine. The doctors who had gotten it previously were mostly very well known urologists. The person who introduced me at that time was Dr. James Glenn, former head of urology at Duke [University] and then president of Mount Sinai Hospital in New York City. What an interesting evolution of events as compared to our somewhat antagonistic first acquaintance many years earlier, when he had suggested repairing small infants was ill advised and implied that the surgeon who does so must feel he can walk on water. It's better to put out a flame rather than fan it!

DR. PEARSON: Good story.

DR. HENDREN: And we're good friends. He discussed a couple of our papers at a meeting of the American Surgical in very complimentary terms. I tell that story because it shows that a soft answer can indeed turn away wrath, and it did. I value our friendship greatly.

DR. PEARSON: Do you think a generation ago there was more enmity, competition, and that sort of thing between doctors?

DR. HENDREN: I don't think so. It still occurs.

DR. PEARSON: I saw it between Lou Diamond in Boston and Carl Smith in New York - both great pediatric hematologists but they were very competitive and even antagonistic.

DR. HENDREN: Well, you see, it doesn't have to be. I tried to avoid that kind of small stuff. When somebody says something nasty it's better to rise above it.

DR. PEARSON: But within Children's Hospital didn't the fact that Dr. Schuster went and squealed to Gross on a number of occasions bother you?

DR. HENDREN: Yes. Schuster was that way. But also, Gross encouraged it. Gross liked to have people tell him things, and unfortunately then he would act upon them without finding out what the facts were. When he told me to stop doing endoscopy, he gave as his reason that he did not want to offend Dr. Carlyle Flake. But Dr. Flake had told me that he had no interest in suctioning out the tracheo-bronchial tree of a post-op cystic. He was interested in diagnostic bronchoscopies and removing foreign bodies. The order still remained. And that's the way Gross was. He made quick, sometimes cruel judgments. Richard Segnitz, Dick, was a good person. On Good Friday he went to Mass early in the morning. When Gross came into the hospital and learned that Segnitz was not in the hospital because he was at Mass, he fired him. That's the way it was.

Now another medal that I think worthy of note is the Denis Browne Medal of the British Association of Paediatric Surgeons. It was a great honor to receive it. Also of note is the Sulamaa Medal from Dr. Matti Sulamaa, who was the pioneering pediatric surgeon in Finland. A lectureship was started in his name with a medal. He told them to invite me to be the first lecturer, which I did with great pleasure. And we drove up to see him living in northern Finland in the home in which he was born. He died not long after that occasion. That was a nice honor to be asked by him to give that lecture. He was an exceptional surgeon and human being.

DR. PEARSON: It's nice. You know I think we all say that we're often recognized far more out of town than we are in town.

DR. HENDREN: Well, that's right. A prophet is without honor in his own country.

DR. PEARSON: Exactly.

DR. HENDREN: I was very pleased to be given an honorary doctorate Honoris Causa by the Université D'Aix Marseille in France. The only other surgeon who had received it before was Orvar Swenson, whom I admire enormously. The chief in Marseille was Dr. Michel Carcassonne. I helped train their young pediatric urologist who became the outstanding pediatric surgeon-urologist in southern France. The end of his operating career occurred when he was flying over the Pacific and took a sleeping pill. His head bent over and he kinked his carotid, and lost the ability to speak.

DR. PEARSON: Well, what do you think is the future in surgery? I've never been good at predicting the future.

DR. HENDREN: I think surgery will remain a great profession and will continue to attract good people. It can't be hurriedly taught.

DR. PEARSON: And ability is dexterity?

DR. HENDREN: Surgery requires more than dexterity. It requires concern for your patient, honesty with your judgment, willingness to ask for help when needed, and free admission when one has erred in judgment, diagnosis, or operating. Some people are endowed with it and others aren't.

DR. PEARSON: Hardy, this has been a great day talking with you. I'm very impressed that you remember the names of patients that you treated a long, long time ago. I've enjoyed seeing the "Hendren Archives of Pediatric Surgery." Many of these wonderful things should be preserved for future historians. Thank you for taking the time with me, and thanks to Eleanor for letting me monopolize you for an entire day. And thanks to both of you for your hospitality

DR. HENDREN: Thank you, Howard. I'm honored to be asked, and especially to have you as my inquisitor!

And my thanks to Susan Fontaine, BFA, MS, for her excellent editing of this lengthy discourse!

-WHH

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CURRICULUM VITAE

Name: William Hardy Hendren, III, M.D.

Office: The Children's Hospital, 300 Longwood Ave., Boston, MA 02115

Home Address: 247 King Caesar Road, Duxbury, MA 02332

Date of Birth: February 7, 1926

Place of Birth: New Orleans, Louisiana

Married: Eleanor McKenna of Wilmington, Delaware, 1947

Children: Sandra McLeod Hendren (1947-1984); B.S. Education, 1970, and B.S. Nursing, 1980, Boston University.

Douglas Hardy Hendren (1950); A.B. Harvard College '72; M.D., Case Western Reserve '82; Harvard Orthopedic Program, Mass. General Hospital 1982-88; Orthopedic Surgeon: Eureka, California, 1989-1996; Harrisonburg, VA, 1996-present.

William Grant Hendren (1953); A.B. Dartmouth College '75; M.D. Harvard Medical School '79; Surgical Resident, Mass. General Hospital 1979-86; Thoracic Surgical Resident, Emory University 1986-1989; Associate in Cardiac Surgery, Cleveland Clinic, 1989-90; Staff surgeon, Presbyterian Medical Center, Philadelphia, 1990-91; Chief of Cardiac Surgery, Graduate Hospital, Philadelphia, PA 1991-1999; Chief of Cardiac Surgery, Eisenhower Medical Center, Palm Springs, Ca. 1999-2002; MBA University of Southern CA 2004.

Robert Bruce Hendren (1957); A.B. Dartmouth College, '78; M.D. Loyola University School of Medicine '84; Surgical Resident, University of Alabama 1984-87, and 1989-92; Surgical Research Fellow, Children's Hospital-Boston 1987-89; Urology resident, Mass. General Hospital, 1992-1996; Urologist, Evansville, Indiana, 1996-1999; Urologist Louisville, Kentucky 1999-present.

David Fraser Hendren (1960); A.B. Dartmouth College, '83; Northwestern University Law School '86; Attorney in Boston, 1986-1997; President, Catalyst Health and Technology Partners, 1997-present.

EDUCATION:

1943	Woodberry Forest School, Orange, Virginia (Trustee 2001-2007)
1948	Dartmouth College, A.B. (cum laude) Rufus Choate Scholar
1950	Dartmouth Medical School (2 year school at that time)
1952	Harvard Medical School, M.D. (cum laude)

MILITARY:

1943-46	Active duty U.S. Navy (aviator) Qualified as carrier pilot aboard U.S.S. Saipan
1946-54	Naval Aviation Reserve

POSTDOCTORAL TRAINING:

July 1, 1952-June 30, 1953	Intern, Massachusetts General Hospital
July 1, 1953-Dec. 31, 1954	Assistant Resident, Mass. General Hospital
Jan. 1, 1955-Dec. 31, 1956	Senior Resident, Children's Hospital, Boston
Jan. 1, 1957-Dec. 31, 1957	Senior Assistant Resident, Mass. General Hospital
Jan. 1, 1958-Dec. 31, 1958	Chief Surgical Resident, Mass. General Hospital and American Cancer Society Fellow
Jan. 1, 1959-June 30, 1959	Research Fellow, Children's Hospital, Boston
July 1, 1959-June 30, 1960	Chief Surgical Resident, Children's Hospital, Boston
July 1, 1962-Sept. 30,1962	Surgical Assistant, Hosp. for Sick Children, Great Ormond St., London

BOARD CERTIFICATION:

1958	American Board of Surgery
1959	American Board of Thoracic and Cardiovascular Surgery
1975	American Board of Surgery, Pediatric Surgery
1982 & 1999	Recertified, Pediatric Surgery, American Board of Surgery

CURRENT APPOINTMENTS:

2000-	Robert E. Gross, Distinguished Professor of Surgery, Harvard Medical School
1998-	Chief of Surgery, Emeritus, Children's Hospital, Boston
2004-	Honorary Surgeon, Massachusetts General Hospital

PREVIOUS APPOINTMENTS HELD:

Harvard:

1958	Teaching Fellow in Surgery
1959	Instructor in Surgery
1959-1960	Teaching Fellow in Surgery
1960-1965	Instructor in Surgery
1965-1969	Clinical Associate in Surgery
1969-1971	Assistant Clinical Professor of Surgery
1971-1974	Associate Clinical Professor of Surgery
1974-1985	Professor of Surgery
1985-2000	Robert E. Gross Professor of Surgery

Hospital:

1959-1961	Assistant Surgeon, Children's Hospital, Boston
1960-1982	Chief of Pediatric Surgery, Mass. General Hospital
1959-1960	Assistant in Surgery, Mass. General Hospital
1960-1964	Assistant Surgeon, Mass. General Hospital
1964-1973	Associate Visiting Surgeon, Mass. General Hospital
1974-2003	Visiting Surgeon, Mass. General Hospital
1962	(3 mo.) Surgical Assistant, Hosp. for Sick Children, Great Ormond St., London
1968	(2 mo.) Visiting Surgeon, Queen Elizabeth Hospital, Blantyre, Malawi, Africa (sponsored by U.S. Dept. of State)
1968-1982	Associate Surgeon, Shriners Burns Hospital, Boston
1982-1997	Senior Surgeon, Brigham and Women's Hospital, Boston
1982-1998	Chief of Surgery, Children's Hospital, Boston

MEMBERSHIPS:

American Surgical Association 1973
New England Surgical Society (President 1992)
Boston Surgical Society (Vice-President 1993)(President 1998)
American Pediatric Surgical Association (President 1981-1983)
American College of Surgeons (President, Mass. Chapt. 1989)(Governor 1981-86)
American College of Surgeons (Vice President 1998)
British Association of Pediatric Surgeons (Honorary Membership)
New England Pediatric Society
Urological Fellow, American Academy of Pediatrics 1971
Surgical Fellow, American Academy of Pediatrics 1960 (Chairman 1978)
Massachusetts Medical Society
American Medical Association
American Urological Association
Society of Pediatric Urological Surgeons (Europe)
Pan Pacific Surgical Association
Society of Genitourinary Reconstructive Surgeons (Founding Member)(President 1991)
New England Medical Association (President 2000-2002)

HONORARY MEMBERSHIPS:

Fellow, Royal College of Surgeons in Ireland 1990
Fellow, Royal College of Surgeons of England 2000
Fellow, Royal College of Physicians & Surgeons, Glasgow 2004
Kansas City Surgical Society
Texas Pediatric Society
Columbian Society of Surgery
Society of Pediatric Urology
Brazilian Society of Surgery
Swiss Association of Pediatric Surgery
Polish Association of Pediatric Surgeons
Greek Association of Pediatric Surgeons

EDITORIAL ASSIGNMENTS:

Associate Editor, Journal of Pediatric Surgery
Editor, Volume on Pediatric Surgery, Surgical Clinics of North America (1976)
Co-editor, Zeitschrift für Kinderchirurgie – Surgery in Infancy and Childhood
Editorial Reviewer for: New England Journal of Medicine
Archives of Surgery
Pediatrics
Journal of Urology
Journal of Thoracic Surgery
Cancer
Editorial Board, Urology Times (1976-82)
Editor: Volume on Urologic Conditions in Infants and Children, in Seminars in Pediatric Surgery Vol. 5, No. 1, 1996

COMMITTEE ASSIGNMENTS:

Harvard Medical School:

1951-1952	National Student Internship Matching Plan Committee (Establishment of the Matching Plan which is still in use)

Children's Hospital, Philadelphia:

1979	Ad hoc Committee to Review Surgery

American College of Surgeons:

1972	Chairman, Postgraduate course in Pediatric Surgery
1977-1982	Motion Picture Committee
1981-1986	Board of Governors
1981-1986	Advisory Council for Pediatric Surgery
1983	Scholarship Committee
1986	Liability Committee
1986	Nominating Committee
1987	Credentials Committee Mass. Chapter ACS
1989	President, Massachusetts Chapter
1997-1998	Vice-President, American College of Surgeons

American Board of Surgery:

1972	Guest Examiner, Boston
1977	Guest Examiner, Boston
1978	Guest Examiner, Hot Springs, Virginia
1984	Guest Examiner, Kansas City, Mo.

American Academy of Pediatrics:

1960	Fellow, Section on Surgery
1971	Fellow, Section on Urology
1973-1979	Executive Committee, Surgical Section
1974-1977	Secretary, Surgical Section
1978	Chairman, Surgical Section
1978	Development Committee, Surgical Criteria
1976-1977	Program Chairman
1977-1978	Council on Sections

American Pediatric Surgical Association:

1972	Program Committee Chairman
1974-1976	Educational Committee
1974	Chairman of Postgraduate Course in Pediatric Surgery, Boston
1981-1983	President, American Pediatric Surgical Association
1981-1984	Board of Governors

American Urological Association:

1972	Program Committee, New England Section

Society of Genitourinary Reconstructive Surgeons:

1986	Founder Committee
1990	President-Elect
1991	President

The New England Surgical Society:

1992	President

COMMITTEE ASSIGNMENTS- continued

Boston Surgical Society:

1998	President

The New England Medical Association:

2000-2002	President

Massachusetts General Hospital:

1975-1982	Surgical Coordinating Committee
1976-1982	Research Committee
1974-1975	Utilization Review Committee
1975	Bicentennial Committee
1974	Audio-visual Committee
1973-1974	Operating Room Committee
1960-1995	Intern Selection Committee

Children's Hospital, Boston:

1982-1987	Steering Committee
1982-1998	Staff Executive Committee
1982-1987	Operating Room Committee (Chairman)
1982-1998	Surgical Executive Committee (Harvard)
1983-1984	Finance Committee
1982-1998	Multiple Ad Hoc Committees
1998-	Archives Committee

AWARDS AND HONORS:

1941	Eagle Scout
1948	**Rufus Choate Scholar,** Dartmouth College
1949	U.S. Navy Commendation Letter for Performance as Aviator in Naval Reserve
1970	First Prize Motion Picture Award of American Urological Association
1972	Second Prize Award for Biological Photographers Association
1973	Second Prize Award for Clinical Research, American Urological Assoc.
1974	Second Prize Award for Clinical Research, American Urological Assoc.
1975	Third Prize Award for Clinical Research, American Urological Assoc.
1977	**Lou Leavitt Humanitarian Award**
1978	**William P. Burpeau Award** of New Jersey Academy of Medicine
1979	American Academy of Pediatrics Commendation of Service as Chairman of Surgical Section
1981	**William R. Smart** Film Grand Prize, American Urological Association
1981	Second Prize Award for Exhibit for Educational Purposes, American Urological Section
1981	First Prize for Exhibit, South Central Section, American Urological Assoc.
1982	Docteur Honoris Causa, de L'Université D'Aix-Marseille, France
1983	**William E. Ladd Medal** of the American Academy of Pediatrics, Surgical Section
1984	President, Aesculapian Club, Harvard Medical School
1985	**Ferdinand C. Valentine Medal** of The New York Academy of Medicine, Urology Section
1988	**Matti Sulamaa Medal** of the Finnish Association of Pediatric Surgery
1991	**Denis Browne Medal** of the British Association of Pediatric Surgeons
1993	Urology Medal of the Urologic Section of the American Academy of Pediatrics

AWARDS AND HONORS – continued

1998	**Harry Andler Memorial Award** Society ROFEH International, New England Chassidic Center, Boston, Ma.
1999	Certificate of Achievement, American Urological Association
2001	**Henry Jacob Bigelow Medal** of Boston Surgical Society
2003	**Arnold M. Salzberg Mentorship Award**, by the Surg. Section of the Am. Acad. Pediatr.
2004	Doctor of Medical Science, Honoris Causa, Drexel University College of Medicine, Philadelphia
2007	Distinguished Service Award by American Pediatric Surgical Association
2007	Dedication of W. Hardy Hendren Pediatric Surgical Conference Room at Massachusetts General Hospital
2008	Establishment of W.Hardy Hendren Professorship of Surgery at Harvard. First Incumbent Dr.Tom Jaksic.

INVITED LECTURESHIPS - (excluding local talks and those given as Professor):

Hugh Hampton Young Memorial Lecture, Mid Atlantic Section, AUA
Hepburn Memorial Lecture, Hartford
Willis H. Potts Memorial Lecture, New York (2x)
Wm. P. Burpeau Memorial Lecture, Newark
J. Warner Duckett Memorial Lecture, Dallas
Carl T. Bunts Memorial Lecture, Richmond
American Urological Association (Postgraduate courses in New York, New Haven, Boston, New Orleans, Denver, Los Angeles, Chicago, Minneapolis, Dallas)
Canadian Urological Association
Mexican Urological Association
Orange County Urological, California
Brazilian Urological, Rio de Janerio
Venezuelan Urological Association
Brooklyn Urological Association
Cleveland Clinic Surgical Symposium
Albany Medical College
Pan Pacific Surgical Association (General, Thoracic, and Urologic)
University of Miami
Variety Children's Hospital, Miami (2x)
Kansas City Surgical Association (2x)
Houston Surgical Association (2x)
Pediatric Surgical Symposium, Munich, Germany
University of Indiana (3x)
Albert Einstein College of Medicine, New York
Henry Ford Hospital, Detroit
Michigan Surgical Society
Wyland F. Leadbetter Symposium, Minneapolis (2x)
University of Missouri
Tennessee Pediatric Association
University of Cincinnati
Children's Hospital, Dayton, Ohio
University of New York, Syracuse
Maine Medical Center, Portland
Dartmouth Medical School, Hanover (2x)

INVITED LECTURESHIPS – continued

Carlo Erba Foundation, Milan, Italy
Italian Pediatric Surgical Association, Messina
Polish Surgical Association
San Salvador Pediatric Association, El Salvador
Brazilian Association of Pediatric Surgeons
Third David Vervart Lecture, Sophia Children Hospital, Rotterdam
Niles Wishard Memorial Lectureship, Univ. of Indiana
Max Grob Memorial Lectureship to Swiss Association of Pediatric Surgeons
Australasian Urological Association
Japanese Association of Pediatric Surgeons (2x)
Asian Society of Pediatric Surgery
University of Manila, The Philippines
Dartmouth Medical School, Hanover, New Hampshire
Merideth Campbell Lecture, AUA Annual meeting, 1992
Ronald Cooke Lectureship, Hartford, Ct., 1993
Methodist Hospital, Houston
Boston Surgical Society-Pediatric Surgery Program, 1968 & 1994
Northeast Medical Association, 1990, 1992, 1993
Merrill Davis Lecture, University of Indiana
5th Loren Chandler Lectureship, Stanford University Medical Center
University of Thessaloniki, Greece, 1994
Hungarian Association of Pediatric Surgeons, 1991
Wyland F. Leadbetter Lecturer, American Urologic Association, New England Section
Polish Association of Surgery, 100th Anniversary, Kracow, 1989
Los Angeles Urological Association, 1989
Cleveland Urological Association, 1990
First Imre Pilasonavich Memorial Lecture, Pecs, Hungry, 1991
Mexican Association of Pediatric Surgery, Torreon, Mexico, 1991
American Association of Neurological Surgeons, Boston, 1991
Graduate Hospital, Philadelphia, PA, 1992
Keio University, Tokyo, Japan, 1994
Children's Hospital, Pittsburgh, Pa., 1994 (2x)
Harry Spence Memorial Lecture, North and South Texas Chapters of Am. Coll. Surg., 1995
Genitourinary Reconstructive Surgeons (4x)
Society of Pediatric Urologic Surgeons, annually since 1971
University of Salzburg, Austria, 1993
Pediatric Urology Symposium, Varese, Italy, 1994
Brazilian Society of Pediatric Urology, 1995
Anesthesia postgraduate Course, Boston, 1994
Japanese Society of Pediatric Urology, Tokyo, 1994
William Richardson Lecture, University of Tampa, 1995
New England Surgical Society, 1995
Denver Urological Society, 1996
Arnold Colodny Lecture, University of Vermont, 1996
Downstate New York College of Medicine, 1996
New York Pediatric Surgical, 1996
Medical Grand Rounds, Children's Hospital, Boston, 1996
Lecture as visiting faculty, Long Island Jewish Hospital, 1996
Templeton Lecture, Medical College of Virginia, 1996
McCluskey Memorial Lecture, University of Pittsburgh, 1996
United Ostomy National Conference, Boston, 1996

Historical Lecture to American Academy of Pediatrics, 1996
Raymond Sackler Lecture, Cornell University
Thomas V. Ballantine Lecture, Hersey, Pa
The Sir John Dewhurst Lectureship, The N. Amer. Society for Pediatric & Adolescent Gyn.
Will C. Moore Lecturer, Dept. of Surgery, Indiana University School of Medicine
Thomas Santulli Lecture, Babies and Children's Hospital of New York
Invited Lecturer, 5th Annual Pediatr. Urology Winter Forum. Children's Hospital, Phila.
Theodore C. Jewett Lectureship, University of Buffalo, State University of New York
Blackfan Lecturer, Children's Hospital, 2002
R. J. White Lectureship, Fort Worth Surgical Society, 2007

VISITING PROFESSORSHIPS in USA - (*included operating):

USA: *Philadelphia Children's Hospital (3x)
*Pittsburgh Children's Hospital (3x)
*Columbus Children's Hospital
*Primary Children's Hospital, Salt Lake City
*Children's Hospital, Seattle
Oakland Children's Hospital
*National Children's Hospital, Washington, D.C. (2x)
*Babies Hospital, Columbia Univ., New York
*Children's Mercy Hospital, Kansas City
*Washington University, St. Louis
Yale University (2x) in surgery and in urology
*Johns Hopkins University (2x) in surgery and in urology
*Univ. of Kansas
Univ. of Missouri
Univ. of Virginia, Charlottesville (2x) in surgery and in urology
*Univ. of Texas, Dallas
*Medical College of Virginia, Richmond
*Univ. of California, Los Angeles (2x)
Univ. of Minnesota
Univ. of Illinois, Chicago
*University of Chicago
*Univ. of Alabama, Mobile
*Univ. of Alabama, Birmingham
Univ. of Oregon
*East Virginia Medical School, Norfolk (3x)
*Univ. of Hawaii, Honolulu (2x)
*Univ. of Mississippi
The Orvar Swenson Visiting Professorship, Tufts Univ., Boston
*Long Island Jewish Hospital, New York (2x)
Dartmouth Medical School (2x)
Baylor Univ., Houston
***The Ronald Pfister Visiting Professorship**, The Univ. of Colorado
Faculty at Pediatric Surgical Residency Conference, Temple University, Philadelphia
Cornell University
*San Diego Children's Hospital (3x)
*Visiting Professor, Dept. of Surg. University of Wisconsin-Madison Medical School
W. Dean Warren Visiting Professor, Emory Univ. School of Medicine, Atlanta
***Thomas S. Parrott Visiting Professorship**, Scottish Rite Children's Hospital, Atlanta
Judson Randolph Visiting Professor, Children's Hospital, Washington D.C.

VISTING PROFESSORSHIPS Abroad - (*included operating):

Abroad:

*Adler Hey Children's Hospital, Liverpool, England (2x)
*University of Marseille, France (member of Ph.d.Jury) (3x)
*University of Lyons, France
*Children's Hospital, Munich, Germany
*University of Warsaw, Poland (2x)
*Central Surgical Institute, Moscow, Russia
*Our Lady's Children's Hospital, Dublin, Ireland (5x)
*Queen Elizabeth Hospital, Blantyre, Malawi, 1968 (for six weeks per US Depart. of State)
*University of San Paulo, Brazil (2x)
*Antiocha University, Medellin, Columbia (3x)
*Children's Hospital, Bogota, Columbia
Children's Hospital, Melbourne, Australia
*American Univ. in Kracow, Poland
*Children's Hospital, Pecs, Hungry
*Christian Medical College, Vellore, India
Children's Hospital, Jutendo University, Tokyo, Japan
*University of Barcelona, Spain
*Sophia Children's Hospital, Rotterdam, Netherlands
*Beijing Children's Hospital, Beijing, China
*Shandong Medical College, Jinan, China
*Shanghai Children's Hospital, China
*University of Berne, Switzerland (3x)
*Tohoku University, Sendai, Japan
University of Freiberg, Germany
*University of Helsinki, Finland, 1988
Hong Kong University (2x)
*University Children's Hospital, Damascus, Syria (with physicians for peace)
*Panama First Pan American Conference Pediatric Urology
*Kinderspital Salzburg, Austria (2x)
*Kinderspital, Bern, Switzerland (3x)
***First Imre Pilazanovich Professorship**, Pecs, Hungary
University of Athens, Greece
*Hospital for Sick Children, Great Ormond Street, London, England
*Aga Khan University, Karachi, Pakistan
University of Brasilia, Brazil
*Three Universities in Egypt, 1996, Tanta, Mansoura, and Cairo with Physicians for Peace
*Universitatesklink Fur Urologie, Innesbruck, Austria
*University of Cologne, Germany (2x)

PUBLICATIONS

ORIGINAL ARTICLES:

1. Hendren WH, Haggerty RJ: Staphylococcic Pneumonia in Infancy and Childhood: Analysis of Seventy-Five Cases. *JAMA* 168:6-16, 1958.

2. Green TH Jr, Hendren WH: Subtotal Gastrectomy for Bleeding Duodenal Ulcer in Childhood: Report of Three Cases with Six-Year Follow-up Study in One. *New Engl J Med* 262:118-122, 1960.

3. Ulfelder H, Hendren WH: Vaginal and Uterine Tumors in Children. *Clin Obstet and Gynecol* 3:175-186, 1960.

4. Elian E, Shwachman H, Hendren WH: Intestinal Obstruction of the Newborn Infant Usefulness of the Sweat Electrolyte Test in Differential Diagnosis. *New Engl J Med* 264:13-16, 1961.

5. Longino LA, Hendren WH, Owings RS: Congenital Hypertrophic Pyloric Stenosis. *Am J Surg* 101:605-609, 1961.

6. Hendren WH: Treatment of the Severely Burned Child. *Pediatr Clin North Am* 9:277-296, 1962.

7. Hendren WH: Esophageal Atresia and Tracheo-esophageal Fistula Principles of Management. *Clin Pediatr* 3:30-41, 1964. (This paper described use of sump suction tube.)

8. Hendren WH: Abdominal Masses in the Newborn. *Am J Surg* 107:502-510, 1964.

9. Spence HM, Murphy JJ, McGovern JH, Hendren WH, Pryles, CV: Urinary Tract Infections in Infants and Children. *J Urol* 91:623-638, 1964.

10. Hendren WH, Greep JM, Patton AS: Pancreatitis in Childhood: Experience with 15 Cases. *Brit Arch Dis Child* 40:132-145, 1965.

11. Hendren WH: Vesicoureteral Reflux and Pyelonephritis in Childhood. *Postgraduate Med* 37:529-538, 1965.

12. Hendren WH, McKee DM: Lobar Emphysema of Infancy. *J Pediatr Surg* 1:24-39, 1966.

13. Austen WG, Goldblatt A, Buckley MJ, Hendren WH: Cardiopulmonary Bypass: Correction of Congenital Anomalies in Infancy. *The Heart Bulletin*, p. 94-97, September, 1968.

14. Talamo R, Hendren WH: Prolonged Obstructive Jaundice. *Am J of Dis Child* 115:74-79, 1968.

15. Hendren WH, Constable JD, Zawacki BE: Partial Primary Excision of Major Burns in Children. *J Pediatr Surg* 3:445-464, 1968.

16. Hendren WH, Henderson BM: Immediate Esopagectomy for Instrumental Perforation of the Thoracic Esophagus. *Ann Surg* 168:997-1003, 1968.

17. Hendren WH: Ureteral Reimplantation in Children. *J Pediatr Surg* 3:649-664, 1968.

18. Rosenberg B, Hendren WH, Crawford JD: Posterior Urethrovaginal Communication in Apparent Males with Congenital Adrenocortical Hyperplasia. *New Engl J Med* 280:131-134, 1969.

19. Hendren WH, Crawford JD: Adrenogenital Syndrome: The Anatomy of the Anomaly and Its Repair. Some New Concepts. *J Pediatr Surg* 4:49-58, 1969.

20. Hendren WH: Operative Correction of Megaureter in Children. *J Urol* 101:491-507, 1969.

21. Hendren WH, Crawford JD: Surgical Treatment of Endocrine Disorders in Children. *Proceedings Meeting of German Surg Soc and Am Coll Surg*, Munich, 1968, p. 273-282. Berlin: Springer-Verlag, 1969.

22. Hendren WH, Henderson BM: Recent Advances in Pediatric Surgery. *Am J Surg* 118:338-355, 1969.

23. Dretler SP, Pfister RC, Hendren WH: Extrarenal Calyces in the Ectopic Kidney. *J Urol* 103:406-410, 1970.

24. Hendren WH, Henderson BM: The Surgical Management of Sacrococcygeal Teratomas with Intrapelvic Extension. *Ann Surg* 171:77-84, 1970.

25. Hendren WH: Functional Restoration of Decompensated Ureters in Children. *Am J Surg* 119:477-482, 1970.

26. James AE, Greenfield JC, Pfister RC, Weber AL, Hendren WH, Neuhauser EBD: Roentgenological Appearance of Postoperative Congenital Megacolon (Hirschsprung's Disease). *Am J Roentgenology, Radium Therapy & Nuclear Med* 109:351-367, 1970.

27. Hendren WH: A New Approach to Infants with Severe Obstructive Uropathy: Early Complete Reconstruction. *J Pediatr Surg* 5:184-199, 1970.

28. Bode HH, Hendren WH: Healing of Faecal Fistula Initiated by Synthetic Low-Residue Diet. *Lancet* 1:954, 1970.

29. Abel RM, Fisher JE, Hendren WH: Penetration of the Alimentary Tract by a Foreign Body with Migration to the Liver. *Arch Surg* 102:227-228, 1971.

30. Williams WH, Hendren WH: Intrapancreatic Duodenal Duplication Causing Pancreatitis in a Child. *Surgery* 69:708-715, 1971.

31. Hendren WH: Posterior Urethral Valves in Boys. A Broad Clinical Spectrum. *J Urol* 106:298-307, 1971.

32. Hendren WH, Monfort GJ: Surgical Correction of Ureteroceles in Childhood. *J Pediatr Surg* 6:235-244, 1971.

33. Weber AL, Pfister RC, James AE, Hendren WH: Megaureter in Infants and Children: Roentogenologic, Clinical, and Surgical Aspects. *Am J of Roentgenology, Radium Therapy, and Nuclear Medicine* 112:170-177, 1971.

34. Hayek A, Riccardi V, Atkins L, Hendren WH: 49,XXXXY Chromosomal Anomaly in a Neonate. *J Med Genetics* 8:220-221, 1971.

35. Hendren WH, Warshaw AL, Fleischli DJ, Bartlett MK: Traumatic Hemobilia: Non-Operative Management with Healing Documented by Serial Angiography. *Ann Surg* 174:991-993, 1971.

36. Donahoe PK, Hendren WH: The Surgical Management of Laryngotracheoesophageal Cleft with Tracheoesophageal Fistula and Esophageal Atresia. *Surgery* 71:363-368, 1972.

37. Oparil S, Goldblatt A, Hendren WH: Left Superior Vena Cava Steal Syndrome. *New Engl J Med* 286:303-304, 1972.

38. Donahoe PK, Stewart D, Osmond JD, Hendren WH: Pneumoperitoneum Secondary to Pulmonary Air Leak: A Clinical Case and Laboratory Study in the Rat. *J Ped* 81:797-800, 1972.

39. Allen TD, Glenn JF, Hendren WH, King LR, McGovern JH, Perlmutter AD, Thompson IM: Management of the Severely Obstructed Urinary Tract in the Pediatric Patient-A panel discussion. *J Pediatr Surg* 7:706-714, 1972.

40. Hendren WH: Reconstruction of Previously Diverted Urinary Tracts in Children. *J Pediatr Surg* 8:135-150, 1973.

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42. Dretler SP, Hendren WH, Leadbetter WF: Urinary Tract Reconstruction Following Ileal Conduit Diversion. *J Urol* 109:217-224, 1973.

43. Donahoe PK, Osmond JD, Stewart DR, Hendren WH: Renal Parenchymal Tolerance to Artery Occlusion: A Time and Damage Study in Rats Developing Collateral Circulation. *Ann Surg* 178:138-142, 1973.

44. Hendren WH: Medical Progress Pediatric Surgery. *New Engl J Med* 289:456-462, 507-515, 562-568 (Aug. 30), (Sept. 6), (Sept 13), 1973.

45. Soper RT, Hendren WH, Johnson DG, Randolph JG: Symposium on Hernia Management in Infants and Children. Part. I, Congenital Diaphragmatic Problems. *Contemporary Surgery* 2:90-118, 1973.

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47. Hendren WH: Reoperation for the Failed Ureteral Reimplantation. *J Urol* 111:403-411, 1974.

48. Hendren WH, Kim SH: Abdominal Surgical Emergencies of the Newborn. *Surgical Clinics of N America* 54:489-527, 1974.

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50. Hendren WH: Urinary Tract Refunctionalization After Prior Diversion in Children. *Ann Surg* 180:494-510, 1974.

51. Hendren WH: Evaluation of the Child Who Wets. *Paediatrician* 3:251-270, 1974.

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54. Hendren WH, Kim SH: Trauma of the Spleen and Liver in Children. *Pediatr Clin North Am* 22:349-364, 1975.

55. Hendren WH, Hale JR: Electromagnetic Bougienage to Lengthen Esophageal Segments in Congenital Esophageal Atresia. *New Engl J Med* 293:428-432, 1975.

56. Marfatia S, Donahoe PK, Hendren WH: Effect Of Dry and Humidified Gases on the Respiratory Epithelium in Rabbits. *J Pediatr Surg* 10:583-592, 1975.

57. Canty TG, Hendren WH: Upper Airway Obstruction From Foregut Cysts of the Hypopharynx. *J Pediatr Surg* 10:807-812, 1975.

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59. Harrison MR, Hendren WH: Agenesis of the Lung Complicated by Vascular Compression and Bronchomalacia. *J Pediatr Surg* 10:813-817, 1975.

60. Hendren WH: Exstrophy of the Bladder- An Alternate Method of Management. *J Urol* 115:195-202, 1976.

61. Kim SH, Hendren WH: Endoscopic Resection of Obstructing Airway Lesions in Children. *J Pediatr Surg* 11:431-441, 1976.

62. Hendren WH: Repair of Laryngotracheoesophageal Cleft Using Interposition of a Strap Muscle. *J Pediatr Surg* 11:425-429, 1976.

63. Hendren WH, Donahoe PK, Pfister RC: Crossed Renal Ectopia in Children. *Urology* 7:135-144, 1976.

64. Middleton AW Jr, Hendren WH: Ileal Conduits in Children at the Massachusetts General Hospital from 1955 to 1970. *J Urol* 115:591-595, 1976.

65. Hendren WH: Reconstruction of the Diverted Urinary Tract. *Hospital Practice* 11:70-79, 1976.

66. Hendren WH, Hale JR: Esophageal Atresia Treated by Electromagnetic Bougienage and Subsequent Repair. *J Pediatr Surg* 11:713-722, 1976.

67. Hendren WH, Hale JR: High-Pouch Imperforate Anus Treated by Electromagnetic Bougienage and Subsequent Perineal Repair. *J Pediatr Surg* 11:723-733, 1976.

68. Donahoe PK, Hendren WH: Bile Duct Perforation in a Newborn with Stenosis of the Ampulla of Vater. *J Pediatr Surg* 11:823-825, 1976.

69. Hendren WH: Urinary Diversion and Undiversion in Children. *Surg Clin North Am* 56:425-449, 1976.

70. Donahoe PK, Hendren WH: Evaluation of Newborn with Ambiguous Genitalia. *Pediatr Clin North Am* 23:361-370, 1976.

71. Donahoe PK, Ito Y, Marfatia S, Hendren WH: The Production of Mullerian Inhibiting Substance by Fetal, Neonatal and Adult Rat. *Biology of Reproduction* 15:329-334, 1976.

72. Fagenholz SA, Hendren WH: Occult Rupture of a Main Stem Bronchus. *J Pediatr Surg* 12:509-512, 1977.

73. Donahoe PK, Ito Y, Hendren WH: The Preservation of Mullerian Inhibiting Substance During Long Term Freezing of Testicular Fragments. *Cryobiology* 14:534-542, 1977.

74. Donahoe PK, Ito Y, Price JM, Hendren WH: Mullerian Inhibiting Substance Activity in Bovine Fetal, Newborn and Prepubertal Testes. *Biology of Reproduction* 16:238-243, 1977.

75. Ito Y, Donahoe PK, Hendren WH: Maturation of the Rectoanal Response in Premature and Perinatal Infants. *J Pediatr Surg* 12:477-482, 1977.

76. Hendren WH: Surgical Management of Urogenital Sinus Abnormalities. *J Pediatr Surg* 12:339-357, 1977.

77. Price JM, Donahoe PK, Ito Y, Hendren WH: Programmed Cell Death in the Mullerian Duct Induced by Mullerian Inhibiting Substance. *Am J Anat* 149:353-376, 1977.

78. Donahoe PK, Ito Y, Hendren WH: A Graded Organ Culture Assay for the Detection of Mullerian Inhibiting Substance. *J Surg Res* 23:141-148, 1977.

79. Donahoe PK, Ito Y, Morikawa Y, Hendren WH: Mullerian Inhibiting Substance in Human Testes After Birth. *J Pediatr Surg* 12:323-330, 1977.

80. Ito Y, Donahoe PK, Hendren WH: Differentiation of Intramural Ganglia in the Dissociated Rectosigmoid of the Rat: An Organ Culture Study. *J Pediatr Surg* 12:969-975, 1977.

81. Marshall FF, Hendren WH, Nason HO: Severe Blunt Trauma of Upper Urinary and Intestinal Tracts in a Child. *J Urol* 118:315-318, 1977.

82. Donahoe PK, Crawford JD, Hendren WH: Management of Neonates and Children with Male Pseudohermaphroditism. *J Pediatr Surg* 12:1045-1057, 1977.

83. Pfister RC, Hendren WH: Primary Megaureter in Children and Adults Clinical and Pathophysiologic Features of 150 Ureters. *Urology* 12:160-176, 1978.

84. Althausen AF, Cook KH, Hendren WH: Non-Refluxing Colon Conduit: Experience with 70 Cases. *J Urol* 120:35-39, 1978.

85. Donahoe PK, Crawford JD, Hendren WH: True Hermaphroditism: A Clinical Description and a Proposed Function for the Long Arm of the Y Chromosome. *J Pediatr Surg* 13:293-301, 1978.

86. Hendren WH: Tapered Bowel Segment for Ureteral Replacement. *Urol Clin North Am* 5:607-616, 1978.

87. Hendren WH: Some Alternatives to Urinary Diversion in Children. *J Urol* 119:652-660, 1978.

88. Morikawa Y, Donahoe PK, Hendren WH: Cholinergic Nerve Development in Fetal Lung. *Dev Biol* 65:541-546, 1978.

89. Hendren WH: Constipation Caused by Anterior Location of the Anus and its Surgical Correction. *J Pediatr Surg* 13:505-512, 1978.

90. Hendren WH: Complications of Ureterostomy. *J Urol* 120:269-281, 1978.

91. Morikawa Y, Donahoe PK, Hendren WH: Cholinergic Nerve Development of Fetal Lung in Vitro. *J Pediatr Surg* 13:653-661, 1978.

92. Hendren WH: Penile Lengthening after Previous Repair of Epispadias. *J Urol* 121:527-534, 1979.

93. Hendren WH, Mitchell ME: Surgical Correction of Ureteroceles. *J Urol* 121:590-597, 1979.

94. Nieh PT, Hendren WH: Obstructing Posterior Urethral Valves in Octogenarian. *Urology* 13:412-413, 1979.

95. Morikawa Y, Donahoe PK, Hendren WH: Manometry and Histochemistry in the Diagnosis of Hirschsprung's Disease. *Pediatrics* 63:865-871, 1979.

96. Donahoe PK, Crawford JD, Hendren WH: Mixed Gonadal Dysgenesis, Pathogensis, and Management. *J Pediatr Surg* 14:287-300, 1979.

97. Radhakrishnan J, Morikawa Y, Donahoe PK, Hendren WH: Observations on the Gubernaculum During Descent of the Testis. *Investigative Urology* 16:365-368, 1979.

98. Swann DA, Donahoe PK, Ito Y, Morikawa Y, Hendren WH: Extraction of Mullerian Inhibiting Substance from Newborn Calf Testis. *Dev Biol* 69:73-84, 1979.

99. Crooks KK, Hendren WH, Pfister RC: Giant Hydronephrosis in Children. *J Pediatr Surg* 14:844-850, 1979.

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101. Hendren WH, Radhakrishnan J, Middleton AW Jr: Pediatric Pyeloplasty. *J Pediatr Surg* 15:133-144, 1980.

102. Donahoe PK, Hendren WH: Pelvic Kidney in Infants and Children: Experience with 16 Cases. *J Pediatr Surg* 15:486-495, 1980.

103. Hendren WH, Hensle TW: Transureteroureterostomy: Experience with 75 Cases. *J Urol* 123:826-833, 1980.

104. Hendren WH: Urogenital Sinus and Anorectal Malformations: Experience with 22 Cases. *J Pediatr Surg* 15:628-641, 1980.

105. Hendren WH, Crooks KK: Tubed Free Skin Graft for Construction of Male Urethra. *J Urol* 123:858-861, 1980.

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107. Kim SH, Hendren WH, Donahoe PK: Gastroesophageal Reflux and Hiatus Hernia in Children: Experience with 70 Cases. *J Pediatr Surg* 15:443-451, 1980.

108. Hendren WH: Reconstructive Problems of the Vagina and the Female Urethra. *Clin in Plastic Surg* 7:207-34, 1980.

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110. Hendren WH, Donahoe PK: Correction of Congenital Abnormalities of the Vagina and Perineum. *J Pediatr Surg* 15:751-763, 1980.

111. Hendren WH: Reoperative Ureteral Reimplantation: Management of the Difficult Case. *J Pediatr Surg* 15:770-786, 1980.

112. Hendren WH: Congenital Female Epispadias with Incontinence. *J Urol* 125:558-564, 1981.

113. Amis ES Jr, Pfister RC, Hendren WH: Radiology of Urinary Undiversion. *Urol Radiol* 3:161-169, 1981.

114. Kim SH, Hendren WH: Repair of Mild Hypospadias. *J Pediatr Surg* 16:806-811, 1981.

115. Newhouse JH, Pfister RC, Hendren WH, Yoder IC: Whitaker Test After Pyeloplasty: Establishment of Normal Ureteral Perfusion Pressures. *Am J Radiol* 137:223-226, 1981.

116. Hendren WH: The Belt-Fuqua Technique for Repair of Hypospadias. *Urol Clin North Am* 8:431-450, 1981.

117. Hendren WH, Kim SH, Herrin JT, Crawford JD: Surgically Correctable Hypertension of Renal Origin in Childhood. *Am J Surg* 143:432-442, 1982.

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119. Hendren WH: Further Experience in Reconstructive Surgery for Cloacal Anomalies. *J Pediatr Surg* 17:695-717, 1982.

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121. Hendren WH: Pediatric Surgery. *American College Surgeons Bulletin.* p. 43-48, January, 1983.

122. Hendren WH: Ureterocolic Diversion of Urine: Management of Some Difficult Problems. *J Urol* 129:719-729, 1983.

123. Hendren WH, McLorie GA: Late Stricture of Intestinal Ureter. *J Urol* 129:584-590, 1983.

124. Hendren WH, Radopoulos D: Complications of Ileal Loop and Colon Conduit Urinary Diversion. *Urol Clin North Am* 10:451-471, 1983.

125. Donahoe PK, Hendren WH: Roux-en-Y On-line Intussusception to Avoid Ascending Cholangitis in Biliary Atresia. *Arch Surg* 118:1091-1094, 1983.

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127. Hendren WH: Presidential Address to American Pediatric Surgical Association: Some Reflections on the Cost of Health Care. *J Pediatr Surg* 18:659-669, 1983.

128. Donahoe PK, Hendren WH: Perineal Reconstruction in Ambiguous Genitalia Infants Raised as Females. *Ann Surg* 200:363-372, 1984.

129. Vacanti JP, Crone RK, Murphy JD, Smith SD, Black PR, Reid L, Hendren WH: The Pulmonary Hemodynamic Response to Perioperative Anesthesia in the Treatment of High-risk Infants With Congenital Diaphragmatic Hernia. *J Pediatr Surg* 19:672-9, 1984.

130. Hendren WH, Hendren WG: Colon Interposition for Esophagus in Children. *J Pediatr Surg* 20:829-839, 1985.

131. Hendren WH, Reda EF: Bladder Mucosa Graft for Construction of Male Urethra. *J Pediatr Surg* 21:189-192, 1986.

132. Ikawa H, Kim SH, Hendren WH, Donahoe PK: Acetylcholinesterase and Manometry in the Diagnosis of the Constipated Child. *Arch Surg*. 121:435-438, 1986.

133. Hendren WH: Repair of Cloacal Anomalies: Current Techniques. *J Pediatr Surg* 21:1159-1176, 1986.

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