# Moments in surgery

Many of our readers are the guardians of lore, amusing or illuminating, about our surgical heritage. This oral history will be lost unless it is captured now. The Editors invite you to submit anecdotes, vignettes, stories of your mentors (great and small), or simply the tall tales you tell your residents about the way it once was.

## M & M with George Block

**David I. Soybel, MD** *West Roxbury and Boston, Mass*

*From the Department of Surgery, Boston VA Healthcare System and Brigham and Women's Hospital, Harvard Medical School, Boston and West Roxbury, Mass*

FOR MORE THAN 30 years, any resident or student who ever had the opportunity to rotate through the Surgical Service at the University of Chicago found the encounter "up close and personal." This was largely because of George Block. In no arena was Dr Block as effective a teacher as in the weekly Morbidity and Mortality conference.

As a third-year student at the University of Chicago, my first clinical clerkship was in Surgery. In the very first week of that clerkship, I recall being dragged by my residents and senior students to the Morbidity and Mortality conference. The conference room was small and crowded, the air was thick with anticipation—this was the first teaching conference of the new academic year. In retrospect, it was apparent to everyone in the room (except to us junior students) that there would be a show. The most senior professors sat in the front. Dr Block sat on the side opposite the presenting residents, imperious, in a swivel-chair. From here, he would survey the whole room. His wandering eye seemed to land on each of us individually.

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Reprint requests: David I. Soybel, MD, Department of Surgery, 112 Boston VA Healthcare System, West Roxbury Division, 1400 VFW Parkway, West Roxbury, MA 02132.

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There were a number of complications to discuss. In each case, the senior or chief resident recounted the circumstances, the complication, and the outcome. In the first few presentations, Dr Block said nothing. Some of the other members of the staff asked a few questions, then nodded, and allowed the chief resident to sit down. When this happened, the chief resident's relief was palpable. In other cases, the chief resident was held for several minutes to the case, responding to questions of anatomy, physiology, history, and anything the staff cared to ask. If the answer was unsatisfactory, the interrogation continued until the chief resident had redeemed himself or had proven his ignorance beyond a shadow of a doubt. At one point, Dr Block asked my junior resident to name the institution at which a particular moment in surgical history had occurred. Hapless, he said, "I don't know, sir, but if I had to guess, I would say 'Michigan.'" The room broke out in laughter, acknowledging the "inside" joke that Dr Block was still considered a local deity in Ann Arbor. It didn't hurt that my resident had also gone there to school.

Of course, as junior students, we didn't know this, and we sat, mystified at the humor. Dr Block then smiled. "After a year here you still don't know much, but at least that was a good guess." Again, laughter. My resident was off the hook.

Then, the last presentation began. A patient was admitted to one of the Surgical Services with a lower GI bleed. One of the less senior attending staff had been involved. A nasogastric tube had

been placed, with negative results. A rigid proctoscopy had also not been helpful. The patient had undergone angiography, but the bleeding could not be localized. With continued evidence of bleeding, the patient had been taken emergently to the operating room. Faced with a GI tract full of blood, the staff member and chief resident had chosen to perform a right colectomy. This had been performed, with an ileotransverse colon anastomosis. The next day, however, the bleeding resumed, and the patient was taken back to the operating room. The remainder of the colon was removed, and an ileostomy was performed. Later that evening, the bleeding recurred yet again, this time through the ileostomy. At this point, the gastroenterologists had been called into the operating room, where esophagogastroduodenoscopy demonstrated an actively bleeding ulcer in the duodenum. The ulcer was oversewn, and the patient underwent vagotomy and pyloroplasty.

Midway through the presentation, Dr Block was on his feet. Looking out at the room, he asked individual residents about the resuscitation and the differential diagnosis of lower GI bleeding. He asked the chief residents about the indications for right colectomy and "blind" total colectomy. He asked about the likelihood that a bleeding duodenal ulcer would be associated with failure to detect blood in the stomach after placement of a nasogastric tube. Still looking at the room, he said, "Now let me get this straight: You took this man to the OR three times to make a diagnosis and take care of a bleeding duodenal ulcer?"

"Yes, sir," responded the chief resident.

Dr Block spoke again, this time focusing on the chief resident and attending. He said something like this:

"When you review everything that's known about GI bleeding... when you acknowledge the likelihood that an upper source is not always going to be detected by a placement of a nasogastric tube...when you consider how easy it would have been to perform an upper endoscopy to look for that kind of lesion... when you consider just how uncertain this diagnosis was...when you look at the consequences of taking a patient to the operating room with the wrong diagnosis and even then failing to perform the definitive procedure for that diagnosis..... when you put all of this into perspective..... well, all I can say is this was pretty dumb."

The room was silent. The chief resident just stared at Dr Block. The younger attending was red. And then: "And what makes this especially hard to understand is that I made the same mistake several months ago. You didn't learn from *my* mistake. You should be ashamed of yourselves."

I don't remember how the conference ended, just that it ended. But I think most of us junior students were now aware that Dr Block had much to teach.