MUHC Project: An Investment for Today and the Next Generation

McGill and the MUHC are committed to the creation of a new medical paradigm for this city.
— Bernard Shapiro, Principal & Vice-Chancellor, McGill University
— David Culver, Chairman, McGill University Health Centre (MUHC)

In working towards the creation of a new McGill University Health Centre facility, the MUHC and McGill share a commonality of vision. The goal is a hospital that will deliver the very best quality of patient healthcare imaginable. The byproduct is the ability to attract and retain the brightest and most highly-trained medical talent to staff the hospital, to teach and to conduct research.

(please see MUHC Project, pg. 6)
Dear Editor,

We were saddened to hear of the death of John Gutelius on December 4, 2000. Our sympathies go out to Betty and their children. John was Chief Resident in Surgery when we were junior, middle, or senior assistant residents in 1960-66. He was a junior staff member of the Department of Surgery during the time we were completing the various stages of our training.

John was a role model for us and many other surgical trainees of the nineteen sixty era at the Vic. He was a superb surgeon and gifted teacher. He had integrated the best qualities of his mentors Luke and McCorriston, his experience at Hopkins as a surgical fellow and his interpretation of a rapidly expanding surgical literature. He was always up to date. In retrospect, it is clear that he inherently understood and practiced “evidence based surgery” long before the concept had a name and became fashionable. We can say the same about “surgical outcome measurements”. Early in his practice, he reviewed Dr. Luke’s peripheral vascular cases to compare results between Dacon and vein grafts, diabetics and non-diabetics and hypertensives and non-hypertensives. These outcome studies guided his (and Dr. Luke’s) practice accordingly.

He was very conscious of the teaching obligations of all academic staff. We can recall humorous stories of how John, while he was still Chief Resident, delivered a message to staff surgeons who “swiped” ward cases. In a polite but firm strategy, one senior surgeon learned about the power of assistants, John and all senior assistant residents who were free scrubbed in on the case. Junior residents packed the operating room feigning interest. The senior surgeon found hardly any elbow room to do the case. From this time on, staff operated on ward patients only by invitation.

Perhaps the characteristic of John’s that we most respected was his life long loyalty to the colleagues and residents he admired and to the institutions he served. If you needed counsel, you not only had the opportunity to turn to John, he expected you to do so. He in turn expected that his academic colleagues who knew you would also be ready to help. As Chair at another institution, John insisted, despite opposition, that his staff should treat an elder colleague with the respect he deserved from his past performance. John had this type of loyalty ingrained in his personality. As residents and junior staff, we all knew that those deserving of support could count on John Gutelius.

John left McGill to accept prominent positions at two other Canadian Medical Schools. He continued to contribute and his work and leadership benefited many more students, residents and colleagues. Others will write about these years. We wish to remember the life of John Gutelius during the early part of his career and what he meant to us during those years - a superb surgeon, a great teacher and mentor, and a loyal friend.

John Duff, M.D. Peter McLean, M.D.
Jim Mackenzie, M.D. Ed Monaghan, M.D.
Nelson Mitchell, M.D.

(continued on pg. 5)
NURSE ASSISTANTS IN THE OPERATING ROOM: An Old Possibility Becomes a New Reality

Last December, the Quebec Government passed a resolution modifying certain aspects of The Medical Act, thereby allowing nurses to act as First Assistants in Operating Rooms. Henceforth, they will be allowed to do skin sutures, hold retractors, ligate vessels, manipulate laparoscopes and accomplish any technical or clinical act according to the type of intervention under the supervision of the Surgeon.

Editorial

By E.D. Monaghan, M.D.

There is ample evidence in the surgical literature that these nurses can become quite proficient. The President of the Quebec Order of Nurses, Mme. Gyslaine Desrosiers bemoans the fact that it took the government 8 years to adopt this regulation. She affirms that, at present, there are 2,217 nurses who work in peri-operative care in the Province and 50 have obtained their certificates in OR assistance from the Université du Québec in Three Rivers. There are currently 40 more in training in this program, which has been in place since 1996.

There is, however, concern from the Federation of Medical Residents of Quebec that this new law will adversely affect their training. Dr. Jean-François Calher, President of the FMRO, worries that these nurses will essentially, by replacing them, dilute their operative experience. In other words, perhaps nursing First Assistants should be concentrated in non-University Health Centres leaving Residents to do the assisting in University Teaching Hospitals. In addition, Residents do more than first assist in the OR. They are integral members of the Surgical Team throughout the entire course of the patient in and out of the hospital.

"Not to worry!" affirms Dr. Adrien Dandavino, Director of Medical Studies of the Quebec College of Physicians and Surgeons. The College has asked the four Post-Grad Deans to ensure that Residents have priority in the OR. Even though resident numbers have decreased markedly in the past decade (there are now approximately 337 registered in Post-Graduate Surgical Specialty Programs) in the four Faculties of Medicine in Quebec, we must assure that the advent of these OR nurse assistants does not diminish the quality of the learning experiences of our Residents.

To achieve this end, a new committee has been set up at McGill to plan this co-ordination. The committee consists of Surgeons and Nurses from all our hospitals.

Upcoming Events

February 21-22, 2001
McGill General Surgery Day
Dr. Andre Duranceau, Visiting Professor
The debate format will be used to discuss controversial subjects in General Surgery with prizes going to the winners.

March 14-15, 2001
Cedars Cancer Institute Visiting Professor in Surgical Oncology
Dr. Stimson Shantz, Head and Neck Service, Memorial Sloan-Kettering Cancer Institute

May 10, 2001
Fraser Gurd Day

May 31 - June 1, 2001
Stikeman Visiting Professorship
Dr. Peter K. Smith, Professor of Surgery, Duke University

September 6-9, 2001
Canadian Surgery Forum, Quebec City
- Canadian Association of General Surgeons
- Canadian Society of Colon and Rectal Surgeons
- Canadian Association of Thoracic Surgeons

We have certainly seen progress in the evolution of capabilities and responsibilities of the nursing profession in the past 25 years. Just think of Neonatology, Critical Care, the SICU and the Recovery Room, Triage in the ER, and in Obstetrics. So the specialization of nurses as First Assistants in the OR should be welcome news as long as there can be proper integration with our residents. ✧
Chairman's Message
— By Jonathan L. Meakins, M.D., D.Sc., F.R.C.S.C., F.A.C.S.

WE NEED THE NEW FACILITY TO ENSURE EXCELLENT TEACHING AND CLINICAL CARE

Two of the most compelling reasons for us to embrace the MUHC Glen project are teaching and clinical care. We must ensure that they remain, not just at their current exceptional standard, but that their levels of excellence continue to expand.

Clinically, of course, we already do very well. Our medicine is highly sub-specialized and delivered exceptionally every day in the face of enormous human, fiscal, physical and medical resource limitations and challenges. Indeed, these specializations and restrictions have forced us to avoid duplication of manpower and services by locating some intellectual expertise on one site, equipment on another and client base on still another. It gets to be confusing for the whole medical team - people who are not ill or incapacitated. Imagine how disorienting it could be for patients. And imagine how much more effective our services will be on one site when doctors can confer easily together, patients don't have to travel between clinics and assessments and technology is also nearby.

Let me illustrate this point even more clearly. Recently, the highly-skilled surgical team at the Montreal General Hospital site — after practising the procedure for more than four months — removed a kidney from one patient using the most unusual and non-invasive technique of laparoscopy (surgery via very small incisions). The organ was then flushed, packed in ice and carted unceremoniously through Montreal streets to a waiting patient at the Royal Victoria Hospital site, where it was inserted most successfully. The donor and recipient, by the way, are husband and wife. What a success. What a tribute to collaboration. What a complex and exhausting exercise that will be immeasurably reduced when we all are on one site.

From a teaching point of view also, this move is a must. It is imperative to maintain McGill's superior standing as a medical school. Our graduating residents are in high demand exactly because we have designed their education to integrate clinical excellence and to develop doctors who can truly look after patients. We are in the enviable - and fun - position of having other institutions chasing our "product" precisely because we know what makes a first-rate physician. Equally important is our need to recruit and retain our own students. The idea of a first-rate facility, modern equipment, large operating rooms, wide corridors, top quality research labs and fertile professional stimulation are all tremendous drawing cards when the graduates are choosing where to settle. I have complete confidence that we have the resources within the next generation of MUHC practitioners to sustain a new plant. I just want to make sure they are enticed enough to stay.

We are already in the transition phase of merging a variety of units. It has required, and will continue to require the goodwill and intellectual energy of all concerned to harness multiple medical cultures, skillsets, visions and protocols. But if this difficult period has taught us nothing else, it has reinforced how important it is to design a final facility from the ground up. Renovation is no good. Trying to reshape an old space is an exercise in frustration; just ask the MGH people who are living through the ICU 'upgrade' and the nightmare of structural incompatibilities. The positive side, of course, is that once we are finished this difficult period we will have an improved area and that having made these changes, we know exactly what we want in the new building. And we will be even less willing to continue under compromised conditions in the future. As part of the planning task forces, I have visited other medical facilities that have gone through — or are going through — similar architectural experiences and the consensus is unanimous: don't renovate.....build afresh. No matter which prism you examine it from — patient flow, infection control, cost, anticipated clinical needs, medical standards, technology, education, human ambience.....the answer is always: "design from square one".

It would be a lot easier to stay put. Although I have supported the idea of this reorganization for more than fifteen years now, I am a creature of habit just like most people and I certainly understand the resistance to the merger. I would have been more comfortable staying only at the Royal Victoria among the people and systems where I was known. But it has been
important to split my time between the two sites of the RVH and the Montreal General in order to assess the surgical management issues and to expedite some of the more difficult transition details. And now I would be happy to avoid another move in a few years. Of course it's easier to do nothing. But to relocate on the Glen site is definitely the right thing to do. So I'll do it. It sounds dramatic but I think it's simple; if we stay put we're going to die. We must always strive not just to maintain the status quo but to pursue the very highest levels excellence in delivering patient care, teaching and research. The planning projections describe the new and ultra modern facility as a place where we can do that. The rest will be up to the next generation; but let's leave them in good shape for the future.

MUHC Surgical Services Management Committee

This is a new Committee which Dr. Meakins has set up to deal with surgical issues across sites. It will not replace the current committees established on each site: The Pavilion Management Committee at the RVH and the Surgical Advisory Committee at the MGH. These will continue to deal with site-specific issues, but will meet quarterly instead of monthly.

Committee members include:

Dr. J.L. Meakins, Chair
Dr. S. Backman
Dr. H. Brown
Dr. M. Burnier/Dr. F. Codère
Dr. F. Carli
Dr. N. Christou
Ms. C. Doray, R.N.

Dr. M. Elhilali
Dr. G. Fried
Dr. E. Harvey
Dr. A. Katsarkas
Ms. S. Lanctôt, R.N.
Dr. R. Lewis
Dr. P. Metrakos

Dr. J.-E. Morin
Dr. D. Mulder
Dr. D. Roy
Dr. T. Tulandi
Dr. M. Tanzer
Dr. B. Williams

Dear Editor,
Here's a voice from your dim dark distant past! It's been 25 years since I finished my orthopaedic residency at RVH.

I enjoy reading the Square Knot although the familiar names get fewer and fewer. On a whim, I looked up your missing orthopaedic alumni in the directory of the American Academy of Orthopaedic surgeons and found Dr. Irwin Enker.

Dr. Colin F. Moseley, Los Angeles, CA

Letter received from Dr. Humberto Sangiovanni of Santo Domingo in the Dominican Republic. Humberto was a chief resident in General Surgery in 1963-1964 along with Drs. Rube Zemel, Vince Piccone, R. Baird and Henry Shibata.

The SK thanks him for his generous gift of $100.00.

Marvin J. Wexler, M.D., FRCS(C)

My sincere condolences to Betty and his many offspring. May they gain some comfort in knowing what a profound influence he had on those of us who were fortunate to train under and with him.

Marvin J. Wexler, M.D., FRCS(C)
The relationship between the hospital and McGill's Faculty of Education is so close as to be symbiotic; one needs the other to succeed and each other's strengths are celebrated in unison.

Of course, no one ever thought the task before us would be easy. How could it be? We are talking about a major project that covers a plot of land more than forty-three acres large, that has integrated four distinct establishments and that will only take on a new physical shape in a few years to come. But, simply stated, it needs to be done and we know that together we are going to make this happen.

Indeed, the very scope of the project is one of its strongest points. In the process of blending these individual sites, cultures and personnel, a more vital entity is being created; one that is extremely rich in talent, brainpower and diversity, all of which are focussed on enriching patient care.

For a city as cosmopolitan, as sophisticated and as unique as Montreal, we are unusually passive when it comes to demanding high standards in medical facilities. Perhaps that is because the services, in spite of outrageous limitations and diminishing resources, have still been distinguished. The structures, however, even to the untrained eye, are substandard. And an ageing plant cannot sustain the new model of cutting-edge, high-technology medicine, which is what our health providers are committed to delivering.

Given this extraordinary effort by Montreal's medical personnel, it makes sense that people don't want to let their old institutions go; they are tremendously loyal.

Actually, much of our confidence in the future is based on our rich and successful historical past; Montreal has always been a leader in healthcare and we still have the largest talent pool in Canada. McGill University's Faculty of Medicine alone is among the finest in North America, and its achievements flow through to support many of the University's accomplishments in other fields.

Certainly, the list of innovations and innovators at both McGill and all its teaching hospitals, has always been impressive. Furthermore, our excellence has always attracted excellence.

However, successes built on over-extended human resources will not be available indefinitely. To produce superior research one needs to attract superior researchers. To attract superior researchers and top-flight clinicians one needs to offer libraries, labs, equipment and spaces that support their activities.

So it's fine to mourn for the passing of those older organizations; but then to recognize the benefits of a new reality. It is equally important, as well, to remember the very real flaws that our familiar and comforting institutions have.

McGill and the MUHC are committed to the creation of a new medical paradigm for this city. Some would refer to this as the establishment of a superhospital. This term can be in positive or negative lights. It is certainly understandable that some people are afraid that such an ambitious project will result in a greater feeling of alienation. But super doesn't have to mean mega, it can just mean great; as in great staff, great equipment, great medical care. People, though, are concerned that the money going into this undertaking is well spent and they want to be reassured that all aspects of healthcare in our city — homecare as well as ambulatory services — are strengthened in any reorganization. The MUHC agrees; it is part of our ongoing dialogue with the government.

Most people are impatient to see the new hospital built, to enjoy the benefits of a freshly-designed state-of-the-art medical facility. For some, that impatience translates itself into a pessimism; will it ever really happen?

It will and it must. Many of us who are working hard on the organization and transition of the MUHC won't even still be working in the system when the doors open around 2005, but that doesn't dampen our enthusiasm for, or commitment to the vision. Like planting an orchard, this endeavor is an investment in the future of generations to come. It is our responsibility, whether we personally are here to reap the rewards or not. Our children and grandchildren will be.

This column is made available by the McGill University Health Centre (MUHC) Foundation. Please visit us at:

www.muhcfoundation.com

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The EXIT Procedure

By Jean-Martin Laberge, M.D.

On December 21st, 2000, a team of surgeons, anesthetists, nurses and other specialists and technicians achieved a first in Quebec. At 18 weeks gestation, a fetus was discovered to have a large neck mass. After referral to the McGill Fetal Diagnosis and Treatment Program, further detailed ultrasound examinations and other tests showed this mass to be a teratoma. There were no other malformations. After several meetings with pediatric surgeons (Drs. Flageole and Laberge), the obstetrician (Dr. Samir Khalife) and the genetic counsellor (Ms. Lola Cartier, also coordinator of the Fetal Program), the mother decided to carry on with the pregnancy. The teratoma was partly solid, partly cystic, and was so large (more than 3 times the size of the head) as to prevent fetal swallowing, leading to severe polyhydramnios. Because of maternal discomfort and the risk of premature labor, six amnioreductions were required during the course of the pregnancy (from 500 cc up to 3,000 cc each time). The larger cysts in the teratoma were also aspirated six times, for amounts varying between 300 and 800 cc. With such a large mass causing neck distortion, there would have been a high risk of respiratory distress at birth with inability to intubate the baby. Therefore, the team planned for an EXIT procedure, or EX-utero Intrapartum Treatment. This consists of a cesarean delivery under deep maternal anesthesia to afford complete uterine relaxation and maintenance of the placenta-fetal circulation while the airway is secured. Meetings were held between all obstetrical specialists (surgeons, anesthesiologists, nurses) and their pediatric counterparts. It became obvious early on that delivering the baby at the RVH would be risky, even in the presence of the pediatric team; bleeding within the teratoma could occur at the time of delivery, necessitating emergency resection; even if the newborn was stable, the airway would be precarious, making transport to the MCH dangerous. The decision was unanimous. The EXIT procedure would occur at the MCH, with RVH obstetricians (Drs. Khalife, Gregory and Jean), anesthesiologists (Drs. Hemmings and Kaufman) and nurses (Julie Goudreau for coordination, Francine Asswad, scrub nurse, and Jane Heaton, circulating nurse and postpartum care). We obtained the necessary permissions for privileges at the MCH, for which Dr. Dupont (Associate-DPS) and Mrs. Borisov (MCH Director of Nursing) were most helpful.

The date was set for Thursday, Dec. 21st. Even though the fetus would only be 32 4/7 weeks gestation, we felt that the severe polyhydramnios, combined with the short cervix, was likely to result in premature delivery; the massive size of the teratoma could also result in cardiac failure with hydrops foetalis, necessitating an urgent delivery with a fetus in worse condition. We were proven correct: the mother had to be admitted to the RVH because of decreased fetal movements on Dec. 19. She was kept under constant monitoring until transfer to the MCH on the morning of Dec. 21st. Maternal steroids had been given and pulmonary maturity established.

In early December there were more meetings between all involved to discuss planning and coordination. One of these was attended by Dr. Sarah Bouchard (McGill graduate in General Surgery, U. of M. in Pediatric Surgery), who is currently doing a Research Fellowship at the Fetal Center in Philadelphia. She summarized the Children’s of Philadelphia experience with EXIT procedures, but would not be present for our case since she delivered her own first baby in mid-December (congratulations Sarah and Felix!). Special uterine staplers had to be ordered from USSC. This instrument, shaped like a TA-55, places 2 double rows of resorbable staples (metal staples could act as an IUD) and cuts in-between, like a GIA does. This is essential to prevent bleeding from the uterine edges. Since this instrument is not stocked in Canada, it had to come from the U.S.; it finally arrived on Dec. 20!

Another component that arrived Dec. 20 was the software that would allow the ultrasound machine used for fetal echocardiography at the MCH to also provide obstetrical ultrasound at the beginning of the procedure (see below). The rest of the equipment was all available at the MCH and RVH; it was just a matter of getting it ready. The position of each piece of equipment and each person in the O.R. was determined, and a list of all those who would be allowed access inside the room was made.

Here was the plan:

1. Bring mom to the MCH by car, then up to the ACM* by wheelchair to change, fit antiembolic stockings and gather the charts for both mother and her unborn child. If she had to be admitted to the RVH ahead of time, then she would be accompanied during transport to the MCH by the obstetric head nurse, Marie-France Noël.

   (*ACM: Alternative Care Module — a place on the in-patient surgical ward where we can treat out-patients to avoid overnight admissions.)

2. Go into the O.R. at 7:45 a.m., start I-V, then, under I-V sedation, place arterial and central venous lines, perform ultrasound to check fetal position and insert a...
After successful intubation, the tube would be secured, and when everyone was ready, the obstetrical anesthesiologist (Dr. G. Hemmings) would stop the isoflurane and give I-V syntocinon, the cord would be clamped, the baby placed on a radiant warmer and brought to the adjacent operating room. A cross-match and blood gas would be sent from the cord blood.

The obstetric team (Drs. Khalife, Gregory and Jean) would finish this most unusual C-section, while next door the team of neonatologists (Drs. Louis Beaumier and Geneviève Piuze) pediatric anesthesiologists and pediatric surgeons would stabilize the newborn baby and establish umbilical venous and arterial lines. The plan was to wait one to two hours and have cross-matched blood available before starting resection of the teratoma, unless hemorrhage occurred from the tumor. Going down one floor to the NICU for stabilization was dismissed because of the precarious airway.

Post-operatively, the mother would be kept overnight in the PACU at the MCH, attended by postpartum nurses from the RVH (Jane Heaton initially, then Carmen Holness). Because of our chronic lack of beds at the MCH, mom would be returned by ambulance to the RVH the next day, accompanied by Louisa Ciafoni, RVH clinician nurse specialist. (We can't wait until the MUHC is on a single site!!!). So was the plan, and it functioned as smoothly as can be, despite having more than 20 people inside the operating theater. Four staplers were required to ensure an atraumatic delivery. This resulted in a 20+ cm hysterotomy (and an even bigger hole in the MCH O.R. budget). After the fetus was exposed and monitored, the mouth was suctioned and Dr. Goujard intubated nasotracheally without problems. However, flexible bronchoscopy through the tube demonstrated no tracheal lumen at the end of the tube, likely because of the tracheal compression and deviation by the teratoma. Therefore, the tube was advanced just above the carina under guidance with the flexible scope, which was hooked to the Storz video camera so that everyone could see on the monitor. At this level the tracheal lumen was adequate. We could then take our time to suction the baby and suture the tube to the upper lip while she was still being oxygenated by the placenta.

Thirty-seven minutes after the head was out of the uterus, the maternal anesthesia was modified to allow uterine contraction. Two minutes later, the cord was clamped and divided, and the baby was born! The baby was hand-bagged and transferred on the radiant warmer and out into the adjacent O.R. without problems. There was no difficulty with placental extraction and uterine closure. On the baby's side, the mass was just as huge as expected. It had to be lifted off her chest to allow adequate ventilation. The neonatology
team then took over. Drs. Beaumier and Piuze, assisted by nurses Patricia Leroux and Danielle Lecavalier, stabilized the baby and inserted umbilical arterial and venous lines. The father was even dressed up in O.R. clothes to visit his daughter, and mother was informed that the EXIT procedure had been a success.

About three hours after birth, we started the excision under general anesthesia given by Dr. Reyes. The 2 pediatric surgery fellows (Drs. Emil and Kay) helped resecting this rare tumor. It involved the whole left side of the neck, distorting the normal anatomy (see picture). It was intimately adherent to the left side of the larynx and pharynx, where we ended up with two small mucosal tears. While teratomas are usually benign at birth, complete excision is essential because they may contain malignant elements, and benign ones can recur and degenerate into a malignant yolk sac tumor. The left carotid and jugular entered into the tumor and were totally absent cephalad to the mass. We never saw a left vagus nerve and obviously even less of a recurrent nerve on that side. The left lobe of the thyroid gland was widely exposed and the left parathyroids potentially damaged (or resected with the mass), but the tumor did not extend to the right side of the trachea. When we were finished, there were no strap muscles left, the flimsy ends of the left sternomastoid were re-approximated, but the scalene muscles and the left phrenic nerve appeared intact. The tumor had been adjacent to or displacing the left ear, parotid and mandible, but these structures were also intact at the end of resection.

The tumor weighed 1,085g in pathology. Adding 300 cc of fluid that was removed under ultrasound guidance at the beginning of the EXIT procedure, it gives us a 1.4 kg tumor in a 1.6 Kg baby. The heart was really pumping for two!

The initial post-operative course was uncomplicated, given this type of surgery in a premature baby. On POD 6, we extubated her in the O.R. under flexible bronchoscopy. There was no tracheomalacia. Extubation was successful, but over the course of the following week there were episodes of desaturation and aspirations, especially after nasogastric feedings were begun. Direct laryngoscopy showed a left vocal cord paralysis, as well as poor sensation and motricity of the pharynx. This is complicated by the presence of gastroesophageal reflux. Other current problems/sequelae include a paresis of the mandible, with an excess of skin further laterally. The nerve, likely the IXth and XIth, and surely the Xth, including the recurrent laryngeal. She currently tolerates nasojejunal feedings and her lung function is adequate despite aspiration of saliva. Her right cord should compensate for the left palsy, but we do not know when she will be able to feed by mouth. Neck movements are already quite good and physiotherapy is following her for passive exercises. Despite the large scar, her looks are much improved (see picture).

The parents were remarkable during the whole process. The mother was especially courageous to submit herself to multiple uterine punctures during the course of the pregnancy, bed rest for the last 2 months and a very large laparotomy for the C-section. She did recover very well and is now hoping that the current problems will improve with time.

This experience also brought closer all the members of the Fetal Diagnosis and Treatment Program, including physicians, nurses and other personnel from the RVH and MCH. It was definitely a first in Quebec. Even though the EXIT procedure has been used a few times in Toronto and in several centers in the U.S., this may be the baby with the largest cervical teratoma in relation to body weight to be delivered successfully. Our thanks to all those who contributed to this success. We are appending the names of the ones who were directly involved on the day of delivery, but many others contributed, ranging from blood bank specialists to head nurses, who helped coordinate things between the RVH and MCH sites, and including Mr. Riopel from Material Installations, who was able to bring up the temperature of both operating theaters to a comfortable 260 Celsius. We now feel ready more than ever to handle other fetal malformations that may require an operation before birth.

List of personnel inside the Operating Theater at one time or another during the EXIT procedure: (alphabetically):

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Institution</th>
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<tr>
<td>Asswad, Francine</td>
<td>RVH nurse</td>
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<td>Neonatologist</td>
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<td>Bellerore, Gaby</td>
<td>Anesth. Tech</td>
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<td>(Ped. Anesth.)</td>
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<td>Anesth. Technical Assistant</td>
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<td>Flageole, Dr. Hélène</td>
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<td>Goudreau, Julie</td>
<td>(RVH nurse)</td>
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<td>Goujard, Dr. Étienne</td>
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THE SQUARE
News Items
— By E.D. Monaghan, M.D.

DR. PAUL BELLIVEAU GOES TO QUEENS
As of January 7th, 2001, Dr. Paul Belliveau has left the MUHC to take a position in colorectal surgery in the Department of Surgery at Queens University in Kingston, Ontario.

Paul graduated from McGill in 1974 and was a member of the McGill Postgraduate Training Program in General Surgery. He was a chief resident with Dr. Dominique Cheung in 1978-79. Subsequently, he did Fellowships in colorectal surgery in Minnesota as well as at the London Hospital with the late Sir Alan Parks. Dr. Lloyd D. MacLean took him on staff at the RVH in 1981.

Paul is a very well respected and capable clinical surgeon. He has developed a special interest in inflammatory bowel disease where his services are much in demand.

He has also become a renowned Educator and his C.V. is repeat with awards and responsibilities in this area.

The McGill University Health Centre is very sorry to lose him and we wish him well in his new and challenging career.

JACK WHITE RETIRES
As of November 2000, Jack White and his wife Andy have moved to Tantallon in Nova Scotia at the head of St. Margaret's Bay. At this location, Jack and Andy are very close to the home of Betty Lou and Dr. Bernard Perey. Andy is originally a Maritimer and they have two grown children. They are about to become grandparents for the first time.

Jack graduated from McGill in 1957, trained in General Surgery at the RVH and was a chief resident in 1964-1965 along with Drs. Jim Mackenzie, Peter McLean, and the late Dr. Ed Charette. After a Fellowship at Johns Hopkins University in Pediatric Surgery, he went to settle in Albany, New York where he was Professor of Pediatric Surgery for eleven years. Then he went to Loma Linda in California in the same capacity until 1993. He moved to Long Island, NY in private practice, after which time he went to Mercer University in Macon, Georgia.

Jack goes in to teach once or twice a week at the IWK Children's Hospital in Dalhousie University, Halifax.

ANTOINE LOUTFI IS BACK
Everyone was delighted to welcome the return of Dr. Antoine Loutfi in January after a Sick Leave since last July.

He will resume all his duties including Co-Director of the Breast Centre (RVH site) along with Dr. David Fleisser. Also, he has been appointed as Head of the General Surgery Service at the RVH.

JOE MEAKINS TAKES A L.O.A.
In December, the Chairman announced that he is taking a mini-sabbatical from June 1st until Labour Day, 2001. He is going to Oxford University to work in the Nuffield Departments of Medicine and Surgery to gain expertise in Technology Assessment, which is one of the priorities of the Department and to improve his understanding of this approach to Evidence Based Medicine. The opportunity to study at the Wellcome Institute for the History of Medicine has been established. Dr. Mostafa Elhilali will be Acting Chair during this time and the Associate Clinical Heads of Surgery, Dr. Gerald Fried, at the MGH site with Dr. Jean-E. Morin at the RVH site will also handle the administrative workload. We wish him well during this “sabbatical leave.”

HOCKEY
Staff/Residents Hockey Match to win the coveted Rea Brown Cup was held February 19th at 10:15 P.M. at the McGill arena.

“This is a serious hole. You might want to try a different hat.”
— The Humanitarian
Update From The McGill Division of Surgical Research
— By Lawrence Rosenberg, M.D., Ph.D.

The Division held its 3rd Annual Graduate Studies Lecture and reception on December 4, 2000. Our featured keynote speaker this year was Dr. Marsha Moses, Associate Professor of Surgery, Harvard Medical School, who spoke on The Regulation of Angiogenesis by Metalloproteinases: Therapeutic and Diagnostic Implications. Dr. Moses is an independent investigator in the Angiogenesis Programme directed by Dr. Judah Folkman. This highly successful night was co-ordinated by Dr. Eunice Lee and was hosted at the Shriner's Hospital For Children. Dr. Lee deserves our congratulations for organizing an excellent event that was attended by our students, faculty and guests.

**THE DIVISION WEBSITE** is now fully functional and has attracted graduate studies applications from around the world. Faculty members of the Division were provided last Fall with a logon i.d. and password. These were sent individually by e-mail. You are all highly encouraged to upload your research projects to this site as soon as possible. If you need to re-obtain your logon i.d. and password, please contact me at:

lawrence.rosenberg@mcgill.ca

This site was designed not only as a showcase of research talent to attract graduate students, but also as a means of collecting and collating research-related information that can then be used to generate an accurate and up-to-date annual report of research activities. For this to work, faculty members must supply the required information. I thank you all in advance for your co-operation and support.

Lt. to Rt.: Dr. John S. Mort, Dr. Marsha Moses (guest speaker) and Dr. Eunice R. Lee
McGill Transplant Patient Wins Gold Medal at First Canadian Transplant Games

Elizabeth Ingram who received a combined kidney/pancreas transplant by Dr. Peter Metrakos won a gold medal at the First Canadian Transplant Games held in Sherbrooke, Quebec last August.

Were You There?
Cedar Cancer Research Fund - 1972

Dr. Paul Farrer (left) Director of Nuclear Medicine, RVH shows the total body scanner to Danny Thomas, and Joseph Chamandy, Chairman Cedars Cancer Research Fund. Dr. Edward Tabah (extreme right), Director of the Tumour Registry, RVH, shows his delight at the gift from the Fund.

Team Quebec

Front row Lt. to Rt.: Jean-Marie Tremblay (heart recipient), Daniel Boudreau (heart recipient), Carmen Boudreau (kidney recipient), Gordon Denison (kidney recipient), Laureen Bureau (kidney recipient).

Back row Lt. to Rt.: Jan-O Brosseau (lung recipient), Elizabeth Ingram (kidney-pancreas recipient), Caroline Dube (heart-lungs recipient), Pierre Lazard (heart recipient).

Missing from photo: Diane Hébert (heart-lung recipient), Nadine Ogromski (kidney recipient), Mathieu Plourde-Turcotte (kidney recipient), Danny Labonté and Jacques Forest (kidney recipient).
Dr. Rea A. Brown Day
Thursday November 9, 2000
The Montreal General Hospital
Osler Amphitheatre

On November 9th, 2000, the Division of General Surgery celebrated Rea Brown Day to mark Rea's retirement after 31 years of service to the Department of Surgery. Invited Visiting Professor, Dr. C. William Schwab, Chief of the Division of Traumatology at the University of Pennsylvania spoke at Grand Rounds of the impact of Trauma Systems. For the remainder of the day, we were treated to a series of scientific presentations from Rea's colleagues and former residents.

Rea received some moving and some humorous testimonials from friends, colleagues, former residents and his family. All in all, Rea Brown Day proved to be a huge success and a fitting way to pay tribute to a man who has given so much of himself to McGill and the Department of Surgery.

Roger Tabah, M.D.

Moderator:
Dr. Dr. Liane Feldman

Introduction:
Dr. Tarek Razek

07:45
Surgical Grand Rounds
Dr. C. William Schwab
Chief, Division of Traumatology
University of Pennsylvania Medical Center
Trauma Systems

09:00
Dr. Tarek Razek
Mentors in Medicine

09:15
Dr. Kashif Irshad
Operative Management of Hockey Groin Syndrome: 12 Years of Experience in National Hockey League Players

09:30
Dr. Hélène Flageole
Evolution of the Detachable Balloon in the Fetal Treatment of Congenital Diaphragmatic Hernia

09:45
Dr. Danny Marelli
Donor Hearts Preserved with University of Wisconsin Solution

10:00
Coffee Break

10:15
Donna Stanbridge, R.N.
Minimally Invasive Suite

10:30
Dr. David Sloan
Improving Surgical Education: Cloning Rea Brown and Other Strategies

10:45
Dr. Lawrence Rosenberg
From Cigarettes to Insulin

11:00
Dr. Salim Ratnani
Trauma: Two Interesting Cases

11:15
Dr. Robert M. Ford
Praise of Older Surgeons

11:30
Lunch - Board Room (E6-112)

13:30
Dr. Viney Badhwar
Failure Surgery - An Emerging Specialty

13:45
Diane Borisov, R.N.
Many Sides of Dr. Rea Brown*

14:00
Dr. David Fleischer
Innovations in the Management of Breast Disease

14:15
Dr. Ray C.-J. Chiu
and the Lab

14:30
Dr. James Sullivan
Aging Knee: What You Need to Know

14:45
Dr. Andrew Hill
Submucosal Small Intestine Vascular Bypass Grafts

15:00
Dr. Doug Kinneear
Most Famous Case
Dr. Prina Brodt was promoted to Full Professor as of January 1st, 2001.

The first pediatric retroperitoneal laparoscopic nephrectomy in Canada was performed November 28th, 2000 at the Montreal Children’s Hospital. The team of Drs. J.P. Capolicchio and Maurice Anidjar of the Division of Urology performed the surgery as part of the pre-transplant preparation of a patient with high output renal failure and a solitary hydronephrotic kidney. The retroperitoneal approach, although limited by the amount of exposure, obviates violation of the peritoneum and the attendant risk of adhesions. Furthermore, maintenance of peritoneal integrity allows for continued peritoneal dialysis, an important advantage in the end stage renal disease patient.

Mario Chevrette, Ph.D., Urology Research, has been elected President of the Medical Board of the Canadian Research Society.

McGill University has compiled a list of its top ten research stories of 2000. The top spot for the researcher who attracted the most ink overall goes to Dr. Ray C.-J. Chiu, Professor in the Division of Cardiothoracic Surgery, who made 56 appearances in different media. Dr. Chiu and his colleagues studied the possible use of immature bone marrow tissue called marrow stromal cells as an approach for tending to damaged hearts. These cells are unique in that, once injected into different parts of the body, they transform themselves into new tissue that’s appropriate to their new surroundings. The reason why that’s important is that damaged hearts can’t create new tissue to replace what’s been lost as a result of a heart attack or heart disease. The New York Times, the Los Angeles Times and CBC Radio’s “As It Happens” all covered the story. Dr. Chiu told the McGill Reporter that he is anxious to see the new therapy, done successfully in mice, tried on human subjects. “I believe it will take at least two years for this procedure to come into clinical practice. But if patients exert pressure to speed up the process, that could speed things up. I know that lots of patients with nothing to lose will volunteer for the trials.”

Dr. Claude Gagnon, Director of the Urology Research Laboratory at the RVH, gave a plenary lecture at the British Andrology Meeting in Bristol, UK last October. The title was The Role of Reactive Oxygen Species (ROS) in the Capacitation of Human Spermatozoa. Last September, he also gave a lecture in Berlin at a Workshop on The Beneficial Effect of ROS on Sperm Function.

Dr. Philip H. Gordon continues to bring honors to his Colon and Rectal Surgery Service at the JGH. He recently received four appointments: first of all, he was appointed to the Executive Committee of the Division of General Surgery of the MUHC. He also was appointed reviewer to the British Journal of Surgery as well as to the Surgical Laparoscopy, Endoscopy and Percutaneous Techniques group. Finally, he was appointed member of the Scientific Advisory Board of the McGill Inflammatory Bowel Disease Group. In November, Philip accumulated some air miles. He was invited to be Visiting Professor at the Cleveland Clinic Foundation from November 9th to 11th where he discussed Perianal and Anal Canal Neoplasms in one seminar and Total Mesorectal Excision – Is It Necessary for Carcinoma of the Rectum? in another. He also gave a paper entitled Awareness, Prevention, and Early Detection of Colorectal Neoplasia. At the end of November, he travelled to Marbella in Malaga, Spain where he was an Invited Guest at the Congreso Iberolatinoamericano de Coloproctologia. Here he gave four papers. On December 1st, he was an Invited Guest at a seminar entitled “New Perspective in Colorectal and Pancreatic Cancers” at the Ottawa Regional Cancer Centre. His address was entitled Colorectal Cancer Prevention: Its’ Simple. Why is No One Listening?

Dr. Jean-Martin Laberge accompanied his wife, Dr. Louise Cauquette-Laberge (Head of Plastic Surgery at Ste-Justine), on a mission to Cuenca, Ecuador with Operation Smile. He served as a surgical educator, giving lectures and conferences in Pediatric Surgery, while his wife was operating on children with cleft lip and palate and various other problems. Dr. Laberge has been awarded the Teaching Award for Surgery.

Dr. Peter McKinney of Chicago is a Director and Historian of the...
American Board of Plastic Surgery, and was an examiner in Houston, Texas last September. Dr. McKinney has published extensively on rhinoplasty recently.

Dr. Patrice Nault, Assistant Professor in the Division of Vascular Surgery, recently presented at the International Angiography Conference held in January in Paris, France. His talk entitled "Use of Perioperative Dopplers for Carotid Endarterectomy" was well received by the European surgical community.

Dr. Lawrence Rosenberg is a Section Editor for Tissue Engineering for the newly launched Journal New Surgery: Molecular Basis of Surgical Disease and New Technology. He has been appointed to the College of Reviewers for the Canada Chairs; and appointed to the CIHR Salary Awards Committee. He was instrumental in the establishment of an endowed diabetes lectureship at McGill to be called the "Collip Diabetes Lectureship." Dr. Rosenberg has been awarded a grant from the Juvenile Diabetes Research Foundation to study Prevention of B-cell Loss by Apoptosis During Islet Isolation: Signal Transduction Events and Targeted Pharmacologic Intervention. He also is an invited speaker at the upcoming NCI sponsored symposium on Mouse Models of Pancreatic Cancer, to be held in Nashville, TN.

Dr. Stephane Schwartz received the award for "Distinction pour services Eméitus" presented by the Canadian Dental Association for her exceptional work in the care of children.

Dr. Hani Shennib was promoted to Full Professor as of January 1, 2001.

Dr. Oren Steinmetz was honored by being an invited member of the faculty at the 2000 Canadian Endovascular Strategy Workshop in Banff, Alberta last September.

Dr. Joseph G. Stratford retired as neurosurgeon member of the Pain Centre at the MGH as of the end of August 2000. He was presented with the Award of Merit of the The Montreal General Hospital of the MUHC in Livingston Hall on December 11th. Dr. Michael Churchill-Smith gave the presentation.

Orthopedic surgeon, Dr. Jim Sullivan, has enrolled in the six month course in Insurance Medicine given by the Université de Montréal - "Cours de médecine d’assurance et d’expertise." This is in line with his continued interest in medicolegal evaluations. The course is chaired by Dr. François Sestier, Medical Director of Blue Cross Insurance in Montreal.

Achievements
Residents
and Fellows

Dr. Badr Al-Jabri presented two abstracts at the Canadian Society for Vascular Surgery at the annual meeting in Banff last September. The first was entitled "Incidence of Major Venous and Renal Anomalies Relevant to Aorto-Iliac Surgery" co-authored with MacDonald PS, Satin R, Stein LS, Obrand DI and Steinmetz OK. The second one which was also well received was called "Early Vascular Complications after Repair of Aorto-Iliac Aneurysms" co-authored with OBrand DI, Montreuil B and Steinmetz OK.

This year's academic half-day will alternate between the Royal Victoria Hospital and the Montreal General Hospital, commencing at the MGH on January 10.

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**Royal Victoria Hospital (beginning January 17)**

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<td>SRP Rounds</td>
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<td>2:00 - 3:00 p.m.</td>
<td>General Surgery Lecture*</td>
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<td>March 7</td>
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**Montreal General Hospital (beginning January 10)**

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<td>2:00 - 3:00 p.m.</td>
<td>General Surgery Lecture</td>
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<td>March 7</td>
<td>3:00 - 4:00 p.m.</td>
<td>Morbidity and Mortality Rounds</td>
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**LECTURES**

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<th>Speaker</th>
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<tr>
<td>January 10</td>
<td>Cirrhosis and Portal Hypertension</td>
<td>Dr. J. Tchervenkov</td>
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<td>January 17</td>
<td>Hepatic Infection &amp; Acute Hepatic Failure</td>
<td>Dr. A. Sherker</td>
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<td>January 24</td>
<td>Anorectal disorder</td>
<td>Dr. J. Trudel</td>
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<td>January 31</td>
<td>Hepatic Neoplasms</td>
<td>Dr. P. Metrakos</td>
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<td>February 7</td>
<td>Calculous Biliary Disease</td>
<td>Dr. G. Fried</td>
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<td>February 14</td>
<td>Melanoma</td>
<td>Dr. S. Meterissian</td>
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<td>February 21</td>
<td>Colonic Polyps/Polyposis Syndromes</td>
<td>Dr. B. Stein</td>
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<tr>
<td>February 28</td>
<td>Biliary Neoplasms</td>
<td>Dr. J. Barkun</td>
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<td>Colorectal Cancer</td>
<td>Dr. P. Gordon</td>
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<td>Diverticular Disease</td>
<td>Dr. D. Owen</td>
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<td>April 4*</td>
<td>Anal Cancer</td>
<td>Dr. S. Meterissian</td>
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<td>April 11</td>
<td>Breast Cancer - In situ</td>
<td>Dr. D. Fleiszer</td>
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<td>April 18*</td>
<td>Breast Cancer - Invasive</td>
<td>Dr. A. Loutfi</td>
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<td>April 25</td>
<td>Ulcerative Colitis</td>
<td>Dr. C. Vasilevsky</td>
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<td>May 2*</td>
<td>Thyroid Cancer</td>
<td>Dr. M. Wexler</td>
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<td>May 9</td>
<td>Parathyroid Diseases</td>
<td>Dr. R. Tabah</td>
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<td>May 16*</td>
<td>Soft Tissue Sarcomas</td>
<td>Dr. S. Meterissian</td>
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<td>May 23</td>
<td>Spleen</td>
<td>Dr. R. Salasidis</td>
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<td>May 30*</td>
<td>Acute Upper GI Bleeding</td>
<td>Dr. T. Razek</td>
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<tr>
<td>June 6</td>
<td>Acute Lower GI Bleeding</td>
<td>Dr. D. Evans</td>
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</tbody>
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* = Royal Victoria Hospital
The 6th Annual H. Rocke Robertson Visiting Professor-ship took place on February 15th, 2001 with Dr. David B. Hoyt as this year's Visiting Professor. Dr. Hoyt is presently the Monroe E. Trout Professor of Surgery at UC San Diego School of Medicine, California, where he serves as Vice Chairman in the Department of Surgery and Chief of the Division of Trauma, Burn and Surgical Critical Care. His talk during Surgical Grand Rounds at the MGH was entitled Trauma Systems: Evidence and Ongoing Assessment. Later that day, he also gave the Residents' Lecture which was entitled Vascular Exposure of Penetrating Injuries.

Ineffably diligent and productive, Dr. Hoyt has become a respected leader in trauma care throughout the world. He is currently one of an elite group of accomplished academic surgical traumatologists whose opinions mould our delivery of clinical trauma care and impact cogently on the future development of trauma systems. It was an honour to welcome him to McGill University as the 6th annual H. Rocke Robertson Visiting Professor in Trauma.

"He is the best physician who is the most ingenious inspirer of hope"
—Samuel Taylor Coleridge
McGill Alumni Prominent in CAGS

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<tr>
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<tr>
<td>Dr. John MacFarlane</td>
<td>President (Vancouver)</td>
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<tr>
<td>Dr. Jeff Barkun</td>
<td>Member of Research Committee</td>
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<tr>
<td>Dr. Gerald Fried</td>
<td>Member of Committee on Endoscopic and Laparoscopic Surgery &amp; Member of the Computer Committee</td>
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<tr>
<td>Dr. Antoine Loutfi</td>
<td>Members of the Liaison Committee for the Advancement of Surgical Services in the Developing World</td>
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<tr>
<td>Dr. Peter McLean</td>
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<tr>
<td>Dr. Peter Metrakos</td>
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<tr>
<td>Dr. Roger Tabah</td>
<td>Chair of the Head and Neck Committee</td>
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<tr>
<td>Dr. Carol Ann Vasilevsky</td>
<td>Chair of the Committee on Colorectal Surgery</td>
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Welcome Aboard

Dr. Maurice Anidjar joined the Division of Urology in July 2000 and is based at the MUHC. He did his medical training at the Université de Paris (France) and has a Ph.D. in Surgical Sciences. In addition, he trained in laparoscopic surgery in Strasbourg. He continues to be involved in research at McGill in the area of gene therapy to treat benign urologic strictures (ureter, urethra). He is presently involved clinically in endourology and stone disease and in laparoscopic surgery for upper and lower urinary tracts.

Dr. Brian Buchler joined the Division of General Surgery at St. Mary's Hospital in September 2000. Dr. Buchler is a graduate of Laval (M.D. 1988) and did his residency at the University of Toronto. Before coming to St. Mary's, he was on staff at the Centre Hospitalier des Vallées de l'Outaouais in Gatineau.

Dr. Mark Burman joined the Division of Orthopaedic Surgery at the Montreal General Hospital in July 2000. After graduating from the McGill program, Dr. Burman stayed on for a one-year fellowship in Orthopaedic Sports Medicine and Arthroscopy. This was followed by two further years of training in Sports Medicine, first at the University of Oklahoma, then at the University of Toronto under Dr. Anthony Maniaci.

Dr. Liane Feldman joined the Division of General Surgery MUHC, Montreal General site in July 2000. After graduating from the McGill program, Dr. Feldman stayed on at McGill to complete a two-year fellowship in Laparoscopic Surgery under Dr. Gerald Fried. She is involved in developing minimally invasive surgery at McGill, and is enrolled in the M.Sc. Program in Epidemiology and Biostatistics.

Dr. Tarek Razek joined the Division of General Surgery MUHC, Montreal General site, in July 2000. A graduate of the McGill program (1998), Dr. Razek did a two-year fellowship in trauma and surgical critical care at the University of Pennsylvania. He is presently active in the trauma program and critical care at the MUHC.

Dr. Rudolf Reindl joined the Orthopaedic Surgery staff at the Montreal General in January 2001 where he rounds out the Orthopaedic Trauma Group. After completing his Orthopaedic residency at McGill in June 1998, Dr. Reindl did a fellowship in Orthopaedic Trauma at Der Humboldt University, Berlin, which is one of the three largest trauma centers in Europe, followed by another year at Sunnybrook in Toronto.

Dr. Francine Tremblay joined the Division of General Surgery (Oncology) at the Jewish General Hospital in July 2000. Her area of particular interest is breast cancer. Dr. Tremblay completed her residency in general surgery at the Université de Montréal in 1989, then practiced in Sept-Iles and Joliette. From July 1998 to June 2000, she was a fellow in Surgical Oncology at McGill under the supervision of Dr. Sarkis Meterissian.
McGill University Department of Surgery
Christmas Party

Dr. Marvin and Randy Wexler

Dr. Nick and Katina Christou

Dr. Peter and Amalia Metrakos

Dr. Patrick Charlebois and guest

Dr. Kashid Irshad and Dr. Kristina Zakhary

Dr. Shannon Fraser and Dr. Jose Pascual

Dr. Madeleine Poirier and Dr. Marc Zerey

Dr. Kashid Irshad and Dr. Kristina Zakhary
Maria Monaghan, Mary Bouldadakis, Line Dessureault

MGH SICU nurses

Mary Bouldadakis, Lorenzo Ferri, Betty Giannis, Andrew Seely, Prosanto Chaudhury, Jose Pascual

Lorenzo Ferri and spouse

Janice Hazarian, Lynn Milburn, Rita Piccioni, Ennia Mulfati, Line Dessureault, Ita Symth, Mary Bouldadakis, Diane Cunningham.
## O.R. Allocation RVH Site
### January to March 2001

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**CAPITAL LETTER** = Room to 6 pm  
**Lower Case Letter** = Room to 3:30 pm  
N.V. Christou (Division Head) December 1, 2000
UNIVERSITY SURGICAL CLINIC RESEARCH DIRECTORS AND FELLOWS


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Gutelius, Dr. John Robert peacefully at Kingston General Hospital on December 4th, 2000. Beloved husband of Betty (Timmins – a graduate nurse from the RVH School of Nursing), brother of Bill and Kitty, dear father, father-in-law and grandfather of a very large family.

After graduating from Loyola College in 1949, John went to McGill Medical School from which he graduated in 1955. He trained in General Surgery at the RVH and went on a McLaughlin Scholarship to Johns Hopkins University from 1959 to 1960. He was the chief resident in the Department of Surgery with Dr. Art Freedman in 1961. He was appointed to the Surgical Staff at the RVH and was soon involved in Surgical Teaching. He became the Program Director in the General Surgery Residency Training Program and was a Markle Scholar from 1963 to 1968.

He left McGill in 1969 to become the Head of Surgery at the University of Saskatchewan and was Dean of that Faculty of Medicine from 1970 to 1973. In 1973, he moved to Queens where he was Head of the Department of Surgery until 1983.

John was qualified in General Surgery, Thoracic Surgery and Vascular Surgery. In latter years, he was mainly involved in Vascular Surgery.

However, his main interest throughout his entire career was that of TEACHING. He has many publications under this topic and will be remembered fondly by his many residents and students. At the time of his death, he was Emeritus Professor of Surgery at Queens. He will be missed.

McDougall, Charles W. on November 30th, 2000 surrounded by his family in his home in Edmonton, Alberta after a courageous year-long battle with cancer. The Royal Victoria Hospital and MUHC employees will fondly remember Charles for his fifteen years of loyal and dedicated service. He leaves to mourn his wife Sandy and three children. The Charles W. McDougall Memorial Fund has been created in his memory. ♦
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Contributions of $50.00 are appreciated in ensuring the continued publication of "The Square Knot" and supporting McGill Surgery Alumni activities. Please make cheque payable to the McGill Department of Surgery and forward to Maria Bikas, McGill Surgery Alumni & Friends, The Montreal General Hospital, 1650 Cedar Avenue, Room: D6-136, Montreal (Quebec) Canada H3G 1A4 Telephone: (514) 937-6011, ext.: 2028 Fax: (514) 934-8418.

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