David C. Sabiston Oral History Project

Interview with Worthington "Sandy" G. Schenk III, MD

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Justin: Good morning. This is the 17th of April 2021. I'm interviewing Dr. Worthington Sandy Schenk in his office at the University of Virginia. My name is Justin Barr. Thanks so much for joining us for this history product. I really appreciate it. If you don't mind just starting a little bit with some of your background, where you grew up, where you went to school, how you got interested in the field of medicine.

Dr. Schenk: I grew up in Kenmore, NY, which is a suburb of Buffalo. My dad was a surgeon. He became the Chief at University of Buffalo. I, growing up, developed a very distorted view of what a chairman of surgery was like. That was because my dad spent most of his time actively in a lab with his sleeves rolled up and was very congenial. His research fellows would be invited over for a Saturday morning barbecue. He did have a Saturday morning conference, early; it was from seven to eight or something. As soon as that was over, he came back home, everybody got together, and we went out to this little bungalow that he had on Lake Erie, and we spent the weekends together as a family. He took every Thursday off. He had to work Saturdays, so he took at least Thursday afternoon. He went in for rounds and so forth, but every Thursday he and my mother would do something together. In the summertime, they would play golf together. In the winter, they would go to one of the nearby ski resorts together. It was not exactly the Sabiston model if you will.

Justin: What kind of surgeon was he? Your dad.

Dr. Schenk: He was a vascular surgeon. He did the first Fem-Pop bypass in New York State. It was non-reversed, and he didn't cut the valves out. He just believed it was not possible that that flimsy little piece of cellophane could stop arterial pressure. Well, guess what. It was a big lesson there. He learned how to reverse the saphenous vein bypass. Useful information.

Lab-wise, he developed the first operational electromagnetic flowmeter in conjunction with-- I forget the company. It wasn't Medtronic, but it had a commercial association with it. I can't remember the company. One of the fellows in his lab actually developed the first caval filter, which at the time was considered a ridiculous

idea. It wasn't developed commercially. When I arrived at Duke, it was a rude awakening about the character and the work ethic of what the Chairman of the Department was like.

Justin: Did you go to undergraduate planning on becoming a surgeon?

Dr. Schenk: Yes I did. Probably from high school on. In high school, I thought I was going to be a chemist. I was a chemistry major.

Justin: Where did you go to undergrad, sir?

Dr. Schenk: I went to University of Rochester. The only time my father and I were in the same operating room, he was watching me operate. I never saw him operate. I went in with him once. We peeked through the window, and the Chief Resident held up the diseased appendix. It was a little bit of an awakening about how Sabiston ran things. A few of us did a rotation at Womack Army Hospital at Fort Bragg, and they always referred to us as the Duke Marines. They said our basic training was tougher than theirs.

Justin: You went to undergrad at Rochester, then went to medical school at…

Dr. Schenk: Duke

Justin: So you had some notion of what Duke surgery was going to be like from the medical student perspective?

Dr. Schenk: I did, yes. Before that, I had met Dr. Sabiston. I think it was at Southern Surgical. My mom and dad would occasionally take me along, because it was nearby, to the Southern, I had met Dr. Sabiston. I remember as a second-year medical student when he did an introductory talk about: "this is what your surgery rotation will be like," I remember I went down and I sat in the front row right next to him, and I said, "Hi. Remember me?". I got kind of a dirty look. I didn't quite understand that. I must say, one of Dr. Sabiston's most remarkable traits was, it didn't matter if you were a student, resident, chairman of the department somewhere else, head of an organization in Europe -- if he met you once, the next time he met you, he would remember your name, your wife's name, your dog's name, how many kids you had, what their names were. He would introduce himself by saying, "How old is Gloria now?" It was very disarming for someone to have an encyclopedic knowledge of you when you didn't think he'd remember who the heck you were. It was a disarming thing that, I'm sure, he learned to do intentionally to establish the relationship to whoever he was talking to.

Justin: Your dad and Dr. Sabiston knew each other?

Dr. Schenk: Yes. My dad was head of one of the study sections at NIH. The one where John Hanks spent some time, as it turns out. Because of national meetings. As I said, he remembered anybody he ever met once. Yes, they knew each other.

Justin: What did your dad think when you told him you're going to go to Duke for surgery residency?

Dr. Schenk: He thought that was terrific. I talked to him about different places. I looked at a number of places. I considered a bunch of places, and I met with Dr. Sabiston to say, "I don't to be too inbred. I love this place, but I think it would be better, overall, for my surgical education, if I did my training somewhere else". I can't remember specifically what his words were, but it was along the lines, if you want to be a loser, that's your problem.

I went and interviewed at five other places. I came back and met with Dr. Sabiston. I said, "You know what? This really is a better place for surgical education". Which apparently didn't come as a big surprise to him. In those days, even though there sort of was a Match, by and large, it was the smoked-filled back room type of thing where new residents were going to be decided. He basically told me I had a job at that point.

Justin: What year did you start at Duke? Do you remember who was in your intern class?

Dr. Schenk: Oh my goodness. My intern class was-- there were either 17 or 19 of us.

Justin: Just the general surgery.

Dr. Schenk: We didn't know. We were all one group. There wasn't any designation ahead of time of who was going to be eventually going into orthopedics, ENT, whatever. The initial assumption was that if you came here for your residency, you were going to be a cardiac surgeon. And it was one of the few combined programs. It was a single combined general and thoracic program. There were only a couple at the time, MGH Hopkins I think might've been the only other two.

Justin: Is that what you wanted to do at the time?

Dr. Schenk: I didn't know that at the time. That was another conversation I had with Dr. Sabiston. But let's see. Hanks was actually a year ahead of me. I got a year ahead of him in the middle, then we ended neck and neck.

Justin: What year did you begin?

Dr. Schenk: Let's see, I did my undergrad in three years, and I did medical school for three years, and it was a little odd because I actually got my diploma, if you will, for my BA in chemistry, after my MD. Because my first year of medical school was treated as a senior year *in absentia* from The University of Rochester. I actually graduated from The University of Rochester in '72 and from medical school in '74. It looked like I went through medical school two years, but it was actually three and three. Then in July of '74? I was an intern.

Justin: What was internship at Duke like in 1974?

Dr. Schenk: Well. My initial second-year resident, which we referred to as a JAR in those days was Jim Lowe. That was an eye-opener. He did not expect me to sleep at all on your day on, and of course it was 36 on, 12 off in those days, which was rough enough, but to have somebody who would want you to come round with them at two o'clock in the morning was a little peculiar.

He was an interesting taskmaster. I do remember that one time that, oh, it was four o'clock in the morning and I was hoping to get an hour of sleep. I actually fell asleep on one of the stretchers that was in the hallway on Halsted ward. I don't know if that's still there? No, I don't think any of those are still there. Halsted is not there anymore, Olser is not there anymore.

Justin: Nothing's in Duke South anymore.

Dr. Schenk: Anyway, it was Halsted, which at the time we separated, which were the "Public" Wards, which were the private ones. None of us at the time realized what an advantage that was to be able to run your own service. But I fell asleep, and I vaguely remember doing this [mimics chest jerking] while somebody was doing CPR on me. Jim Lowe was going, "Oh my God, he's arresting! Get him intubated, you put his foley in, I'll keep doing CPR." I opened one eye. I saw Jim Lowe, and I was like "What the hell?" I just went back to sleep. I was still getting my chest pumped on. With a laryngoscope in my mouth, I was still fuzzy, but when I opened one eye and saw the charge nurse swinging around a foley catheter in her hand, I said, "I guess I better get up. That's enough." I wasn't really prepared for the sleeplessness aspect of it; that came a little later.

Justin: You all were pretty well-protected as medical students rotating on the service?

Dr. Schenk: Oh yes. As I learned later as the so-called teaching resident, they were granted special courtesy, as it were, which we do now, but it's gone through a couple of phases in between. But when I did a rotation at the VA -- and I had made it known that I was interested in surgery -- I hung around a lot. I stayed late. If there were cases going late, I would stay with them, and finally the chief there basically let me do a case as a second-year medical student, which was a little unusual.

Justin: What case did they let you do?

Dr. Schenk: I wish I could remember what that was. Something pretty small, but it wasn't appendectomy, but I think it was something like putting in a peritoneal dialysis catheter or something of that sort. I was being rewarded for hanging around a lot. I tried to be helpful, not just a shithead student that was trying to make points. I tried to do stuff that was actually helpful for the group and the team. While I was there Dr. Sabiston would occasionally round at the VA. That was the famous NG tube incident. I don't know if you've heard of that one?

Justin: Is that the bathroom story?

Dr. Schenk: That's the bathroom story!

Justin: So you were the medical student when this happened?. Because every resident claims it was his patients who had the NG tube. Who was the actual chief resident?

Dr. Schenk: Jim Alexander. The story is basically the Dr. Sabiston was not a big fan of NG tubes. He thought they were unpleasant form of torture for the patient and that in most cases, they were unnecessary.

What that meant was, when Dr. Sabiston rounded everybody got their NG to be taken out. Then about 45 minutes later, they got their NG tube put back in. One guy who just positively needed his NG tube was not in his bed. Walking down the hall, Dr. Sabiston makes a right turn and goes into the men's room. As he's taking a leak, there's a guy sitting in a chair reading a newspaper with an NG tube in, and Sabiston looks at him and asks," Well what are you doing here?" The guy's answer was something on the order of, "They got some big shot that's coming around, and they wanted me to stay in here until he was gone." Of course, everybody is waiting for the firing squad to come out. Just lined up like the firing squad, and of course, the chief resident was sweating.

Justin: What did he say when he got out of the bathroom?

Dr. Schenk: He comes out, stands there for a minute, looks at Jim, nods his head, and they moved along.

I don't know if you've heard that story differently, but that's the way I remember it. "Oh my God we're all going to be shot." He didn't say a word, but that was what my second year surgery rotation looked like as a student.

Justin: As an intern, I hear you all were responsible for part of Monday afternoon conferences.

Dr. Schenk: Sabiston rounds. That was an all hands on deck. He would take mental note of anybody that wasn't there, and they would hear about it, not from him of course. No. The chief resident on that service would get the 2831 as soon as the conference was, over and he would get beat on: "Why wasn't Dr. Schenk at conference today? What did you think was more important than my conference?" That kind of thing.

It was a Socratic style where he taught by asking questions, not in a very benign manner, but that was basically his style. He had questions that were designed for the first year, SAR, chief resident level. He had an absolutely uncanny ability to know which one of us didn't know the answer to his question. It was unbelievable. They'd be simple questions like "how do you spell appendix?" or something like that, and

people would get so frazzled. It was because, I guess, by their body language or something -- "Please don't ask me!" – that he would know.

I hadn't thought about this until just now, but there was one time when I knew the answer to the question, but I decided I was going to act sheepish. He called on me, of course. He was pissed because I knew the answer. [chuckles] He was looking at me like, "Did you do that on purpose?" I didn't do that anymore.

Justin: Any particularly fun stories from intern year?

Dr. Schenk: From intern year? Well, I told you the one about being resuscitated.

Justin: That's pretty remarkable.

Dr. Schenk: Getting the CPR done on me.

Justin: You had to be pretty exhausted to sleep through chest compressions.

Dr. Schenk: That's just Jim Lowe.

Justin: Those are pretty weak chest compressions!

Dr. Schenk: I went back to sleep. From my intern year. It was a while ago after all. I think most of the stories that I know are from middle to later years.

Justin: Did everyone in your intern class progress to JAR year, or was there a pyramidal windowing of the residents?

Dr. Schenk: It was an unusual thing because although it wasn't exactly advertised as a pyramidal system, it clearly was. You didn't know what your future was going to be from one year to the next really. Hanks can tell you how his life went. At one week's notice, he was going to NIH. While he was there, at one week's notice, he was coming back. Because he didn't think he was going to come back. I don't know if he told you that. He was very unsure that he actually had a job back in Durham when he was doing his two years at the NIH.

There's one story that I remember pretty vividly. Bill DeVries was a cardiac super chief at that time. He was a cardiac fellow, is what we would call him today. Of course, one of Dr. Sabiston's favorite cases was tetralogy. Bill DeVries isn't exactly some slacker. He was on the cover of Time Magazine for doing the first artificial heart implant in Salt Lake City. He was a Mormon, so that makes sense. Of course, Dr. Sabiston liked to see everybody happy after his operation and tended round on the thoracic side pretty late in the afternoon. Bill DeVries had this kid who was, I don't know, maybe eight extubated, N.G. tube out, of course, lines were out, Just sitting up happy. I think he was sedated enough he was sleeping through it, but they rounded on him and Bill said, "He's doing great. We got all his lines out."

Dr. Sabiston said, "And you did get a pullback gradient on the pressure when you took the PA line out, didn't you?" silence. "Did you forget what a tetralogy flow involves? Pulmonic outflow obstructions and you didn't get a pullback? Well, I expect to see that first thing in the morning."

It's after midnight now, and he's floating the swan back in this eight-year-old kid. It took forever. It had to come from the groin. It's rather difficult, but he got it out into the right main PA and got a pressure tracing and a pullback gradient that was very little and had it recorded. They come in, they round the next day. Bill hands Dr. Sabiston the tracing of the pullback. He throws it in the trash and doesn't even look at it. Now, that was a memorable occasion, all right. I thought, "Why did you make him put the kid through that?"

Justin: You were the intern on service at that time?

Dr. Schenk: Yes. Just to make a point, and your point-making was more important than that kid's comfort and safety. Okay. I guess I know what I'm up against. That was probably the meanest thing that I saw him do. Most of the time, the stuff that he did was more or less appropriate, or at least indicated. If he saw one of the residents walking through the hall with a cup of coffee in his hand, his chief resident was going to hear about it. He never would call you in personally and tell you that that was unprofessional. He would make your chief do it to make him responsible, basically, for everything that was going on. "This is our job to enforce the professionalism on your service, and we don't expect anything less."

Justin: How was the JAR year different from your intern year?

Dr. Schenk: Well, as things progressed, it became clear that the surgery trainees were becoming the most senior people in the hospital. There were certainly no attendings there after five or six o'clock in the afternoon unless Newland Oldham was doing a case that took 24 hours. He'd still be there, but he wasn't exactly available.

That was a concept that Dr. Sabiston promoted that as the years progressed, and it really started in the JAR year, that you were viewed as the most senior person who was physically in the hospital, which wasn't necessarily exactly true because there are other surgery residents, they didn't get to go home either.

It started at a JAR level, I guess more so at the VA than in the big house. The medicine residents were just a different genre than the surgery residents. They [surgery residents] engendered a certain level of respect from the staff and the nursing staff and so forth, whether it was really justified or not.

Justin: Is there was a trauma, did an attending come in, or did the residents just took care of that case?

Dr. Schenk: Residents would take care of the case. Until the later years, there wasn't a separate trauma service. Moylan was hired to come there. I actually did my research time after the JAR year with Joe Moylan, so I got to know him a little bit. We didn't have trauma care protocols set up in detail like we do now, where we have separate trauma service, so yes, that's what the trauma attendings are expected to do. That's become more of a national paradigm now anyway, but it certainly wasn't then.

Depending on the situation, an attending might meet them in the operating room, but a lot of times they didn't. One case, when a ruptured aneurysm came in, the chief resident hastily got things moving to the OR and got things under control. The attending did come in for that. As it turned out, that the patient was a fairly well-to-do well-known pillar of the community kind of guy. Maybe that's why the attending came in. Oh shoot, I can't remember who the chief was at that time. It was very interesting that the patient knew who actually took care of him. When they made rounds, the attending said, "Hi, how are you doing today? I'm your surgeon." He said, "No, you're not." [laughs] I know who took care of me, he is my surgeon," pointing at the chief resident. When he sent a thank you card, it was to the resident not to the attending, which was interesting. That certainly didn't happen very often. For most things, the attending didn't come in for trauma, not if it was a gunshot wound or a stabbing.

There's more stabbings in Durham than there are in Charlottesville, it's just not fashionable to stab anybody in Charlottesville, apparently, and more blunt trauma than we had in Durham.

Justin: There are still plenty of stabbings in Durham.

Dr. Schenk: I'll bet. I mean, it was just a more common thing. It was about that time that the paper came out from Charity Hospital in New Orleans, about non-operative management in stab wounds, which was not universally hailed. We weren't expected to do that. If somebody came in with a stab wound, you could if you wanted to, prove that it didn't enter the peritoneal cavity, but that was it. Other than that, they would get their negative lap and go home -- five or six days later. That was not a popular treatment at the time, at least not yet.

Justin: Did you pick going into Dr. Moylan's lab, or was that assigned to you from Dr. Sabiston?

Dr. Schenk: No, it wasn't assigned. These things were negotiated. At that time I was interested in trauma. The two things I was interested in was trauma and vascular. Trauma was still not quite recognized as a legitimate intellectual activity. Vascular surgery was, but there was no, at least very few anyway, I guess, vascular fellowships. Initially, when there started to be a vascular board, which was a very controversial thing at that time as well because the thoracic board basically included your competency to do vascular surgery. The separate vascular board was considered a subspecialty of general surgery. That's kind of the way it was treated at Duke. There were surgeons that did vascular and thoracic cases. The same

surgeon would do the vascular case on the general side and the heart case on the thoracic side. It seemed a little peculiar, but that's the way it was. It ended up, I had enough separate rotations of vascular surgery that I actually qualified for the initial couple of board exams. They didn't have anybody, or there were very few people that were qualified to give the board exam. Same thing in trauma, which was actually the surgical critical care certificate. I think I was certificate number 005 or something for the critical care certificate.

Justin: You got boarded, as it were, in both vascular and trauma?

Dr. Schenk: I didn't get to take the vascular board because I was in the hospital, having accomplished an inelastic collision with planet Earth. I missed that opportunity, and I was out long enough that didn't qualify anymore unless I wanted to do a two-year fellowship. I chose not to do that. It didn't affect my life one way or the other, so I didn't do that. At the time, it was not possible to get certified in both trauma and surgical critical care, which made no sense.

It was because one of the rules of surgical critical care was that you weren't an operating surgeon at that time. That's changed now. It didn't make any sense, because of large fraction of people doing surgical critical care are in fact, what's evolving as emergency surgery group or whatever you want to call it. But at that time, because of mutually exclusive rules about what you had to do to qualify, you couldn't do both.

Justin: Between the two, you chose to focus on trauma in the lab?

Dr. Schenk: I focused on trauma, and I was also interested in nutrition. The first paper that I actually produced myself was on calcium balance and trauma patients. That's how I got started, presenting a paper at the surgical forum at the College.

Justin: How did Sabiston interact with you guys when you were in the lab?

Dr. Schenk: Not.

Justin: At all?

Dr. Schenk: Pretty much not, and particularly if you weren't doing something related to cardiac or something like that.

Justin: You never had to present your research or anything like that?

Dr. Schenk: No. Again, if you weren't headed toward cardiac surgery, you were kind of a second-class citizen. I'm sure that the faculty probably felt that a little bit as well, that you didn't have quite as much attention from the boss.

Justin: You were pretty convinced at this point that you were not going to pursue cardiothoracic?

Dr. Schenk: No, I wasn't quite convinced yet. It wasn't until the senior year before becoming a chief resident that I met with him. I said, "I'm really interested in vascular surgery, and I have decided not to pursue cardiac." At that time, quite a few people were doing this cardiac thing and then never used it, a bunch of people that went completely through the program. Now, let's see, about that time it was possible to be a Transplant Super Chief, instead of a Cardiac Super Chief.

Justin: Was Bill Meyers ahead of you or behind you?

Dr. Schenk: He was one year behind me.

Justin: Was there a Transplant Super Chief before him?

Dr. Schenk: Yes, there was. I'm trying to remember who the first Transplant Super Chief was-

Justin: Randall Bollinger?

Dr. Schenk: Might have been. I think there was one before him. Anyway, I told Dr. Sabiston that I've decided that wasn't particularly interested in doing mediastinal fem-pops; I'd rather do them in the lower extremity. His reaction was basically, well I just can't express how disappointed I am in you. Words to that effect. "Thank you, sir, for the encouragement" . That was when it crystallized that clearly cardiac was the premier guiding light of the entire surgical existence at Duke. I decided that wasn't for me. Would have been fine, but I wasn't going to be happy doing that. Although it was a certain degree of high-tech and it was very dramatic, it also seemed rather repetitive. Wasn't sure I'd get very much intellectual stimulation out of doing all that. At the time, maybe they still do, the residents who were going to be cardiac super-chief also spent time in London, at the Great Ormond Street Hospital, specifically to do pediatric hearts, because there wasn't that many pediatric hearts in Durham. There were clearly some. To go do that, do your six months at Great Ormond's Street and come back and finish as a cardiac super-chief like Brad Rodgers did and then never use it…I think he knew from the start that he wanted to do pediatric surgery. Maybe pediatric cardiac was somewhere in his agenda, but it seemed a waste to me.

Justin: Brad Rodgers' portrait is one of the only ones that is not signed in the halls.

Dr. Schenk: Is that right?

Justin: Yes. I was wondering if you knew any reason why.

Dr. Schenk: I knew they didn't get along after he decided he wasn't going to do cardiac surgery, even though he seemed to be in that pathway. I don't know any story about why that picture isn't signed. Is mine signed?

Justin: Yes, sir. His is the only one.

Dr. Schenk: [laughs] Is that right?

Justin: There is only one other from before him but out of the whole wall, it is noticeable that Brad Rodgers…

Dr. Schenk: [chuckles] It is noticeable that there's a blank there.

Justin:. How many years did you spend in the lab total?

Dr. Schenk: Two.

Justin: That was pretty standard? Or was that a variable?

Dr. Schenk: It was pretty standard. Unless you were Steve Rerych, who never came out of the lab, ever. He was an Olympic class swimmer and very interested in exercise physiology. About this time, quantitative cardiac ultrasound was coming along. He became full-time researcher. Every year that went by we're going, "Is Rerych coming out this year?" [chuckles]

Justin: Did you have to worry about funding at all for the research, or was it all taken care of?

Dr. Schenk: It was pretty much taken care of. To a certain extent, you're expected to at least apply for funding. Whether you got it or not was not as important as going through the process of figuring out how to do a grant application. I did that. I got a little bit of funding. I'm sure it didn't completely support me or the lab.

Justin: You came out as an SAR1. Is that the year you went to Womack, or was that later in residency?

Dr. Schenk: I think it was at the year after that.

Justin: Were you guys going to the Asheville VA also?

Dr. Schenk: No. I didn't. People at that time who were designated to become cardiac surgeons went to Asheville. People who were destined to become general surgeons didn't. As it turned out, when I finished and I put all my cases together for my Board application, the one operation I did the most of was pacemaker, which was odd. That was because the Federal Government, in their wisdom, of course, standardized it. Everybody in the whole VA system got the same pacemaker, which was recalled.[chuckles] Everybody who had a pacemaker-- we had to make up the schedules. Some were in the OR. A lot of them were in the cath lab -- everybody's pacemaker had to get replaced.

Justin: That wasn't done by interventional cardiology at the time? Those were surgical?

Dr. Schenk: No. I don't think they did any of them at the time. It's good to learn how and a little bit about the physiology and how if someone was really pacemaker dependent, you had to be careful about it. I re-operated on somebody that one of my colleagues forgot to tighten that screw in where the lead goes into the pacemaker. I had to fix that.

Justin: I'm sure at an ungodly hour.

Dr. Schenk: I don't think so. I think he was put on the schedule for the three people I was going to do that day in the cath lab. We did a lot of pacemakers. Even though cardiology was a pretty upstanding service and intellectual activity with nationally recognized people, nobody was going to go against Dr. Sabiston if there was something he thought was a surgical operation. He was absolutely appalled at the concept of blowing up a balloon in an atherosclerotic lesion.

Justin: Interesting

Dr. Schenk: It was when Grüntzig, who was from Switzerland or Germany, I don't remember. Grüntzig had this idea, "I wonder if we couldn't improve hemodynamically significant atherosclerotic lesions by blowing up a fairly stiff balloon inside it". There was no really good model for atherosclerosis in animal modeling, so he decided he was going to do it in people from the start. Let me see, where is there a good place to start where there's frequently atherosclerotic lesions? Coronary arteries. The first clinical trial of balloon angioplasty was in the coronary arteries. Good luck getting that approved by the IRB these days. It was phenomenal. As those initial publications were coming out, he told us all to be skeptical of any publication that came out of Germany anyway because they were all liars.

Justin: What was his hatred of Germany?

Dr. Schenk: I don't know. I think he was not particularly fond of the publications that came out of Germany. I don't remember if Grüntzig was German or Swiss. We had one of these Monday afternoon conferences where he brought that up and he said, "Can you imagine somebody stupid enough to try to blow up a balloon in an atherosclerotic lesion, that it would either embolize or rupture the vessel, or make it worse and occlude it and clot it 100% of the time?" Angioplasties were not very common at that time at Duke. This was a while ago.

Justin: Did that change over the course of your residency?

Dr. Schenk: I don't think it had changed by the time I had left. That was still considered on the fringe of medical advancement at that time. When I started there, if you can imagine taking care of blunt head trauma without a CT scan, we didn't have CT scans. The first CT scans were only for cranial CT. They were smaller devices. That was a huge step forward. We treated blunt head trauma looking for intracranial lesions by doing carotid arteriograms in the ER by direct stick of the carotid.

Justin: You'd cut down or do it percutaneous?

Dr. Schenk: Percutaneous. That was the good old days of treating head trauma and placement of Burr holes that didn't do much and so forth. Things came a long way from that.

Justin: Were there CT scans by the end of your residency?

Dr. Schenk: Some. I think the first body CTs were being introduced. I remember a conference where the concept of cardiac ultrasound was being put forth. The clinical use of ultrasound was still in its infancy as well. Ultrasound probes was a single revolving probe inside a cylinder instead of having an array of detectors. It was peculiar, but it was very interesting to see mitral valves open and close on ultrasound. That was a very innovative concept at that time. To think that aortic valves are being put in percutaneously now. Sabiston would roll over in his grave. Maybe he is.

Justin: What was his relationship to you when you were in your SAR years?

Dr. Schenk: It was a lot more collegial as things moved along, because Dr. Sabiston was of a lot of things; a national leader, editor of journals, the publications that he wrote, he spent a lot of time with teaching. One thing he was not was a particularly talented operative surgeon. It wasn't really spoken of out loud very much, except what Dr. Hanks told me, but he really relied on his help in the operating room to make things go smoothly.

Justin: What year did you start operating with him?

Dr. Schenk: See, most of the time, there was a barrage of people that were in the operating room with him. There was the chief resident, senior resident, maybe an intern, and of course, there had to be a student all there for pretty much every case that he did. I operated with him when I was the teaching resident, too. He did a session where we did a pretend carotid endarterectomy on a dog, where he demonstrated this for a subgroup of students.

I learned that I had to keep two DeBakey pickups in my hand and put them close to each other, so this is where the next stitch goes. I think he understood what was going on and he appreciated that, that he was being kept out of trouble. Until the first triple-A that I did with him. That would have been as a senior.

Justin: What year were you a teaching resident?

Dr. Schenk: I think that was part of a second-year rotation, JAR year, I think.

Justin: Did you have clinical responsibilities as well?

Dr. Schenk: No. I don't know if they still have that.

Justin: In a modified form.

Dr. Schenk: You had certain select obligations; take care of the students, you ran certain conferences, and so forth.

Justin: Did you get out of Q2 call for that month?

Dr. Schenk: Yes, I think so, because there weren't any clinical responsibilities. That was a break, but there weren't too many breaks. I did this demonstration in the dog lab with him, but I also had to put together his slides when he was giving a talk to a student group. Shoot, what was his lab assistant's name that used to do that stuff? Brad something. Which was just a mirror image of what Blalock had been doing. Blalock had his--

Justin: Vivian Thomas.

Dr. Schenk: Vivian who kept him out of trouble. I don't know if he ever actually operated with him, but he was always there looking over his shoulder when they were doing BT shunts or whatever. He [Sabiston] modeled that after him with Brad. I think maybe we never knew what his last name was, just Brad. Anyway, Brad wasn't around, and the teaching resident had to put slides together.

Justin: Brad was also African American?

Dr. Schenk: Yes, he was. He just mirror-imaged what Blalock was doing. He almost worshiped Blalock. At any rate, I had the slide set for-- he was giving a talk. On aortoiliac occlusive disease. He was going to start a course with René Leriche, and what Leriche syndrome was and blah, blah, blah.

I can't remember exactly how, but I managed to drop the slides out of the carousel. I'm sure I didn't get them back together in the right order. I had about five minutes to get all this done. Got them all back in the carousel. It was really amazing. He would glance at the slide, and without missing a beat, he would go on and say whatever it was that I was showing on the slide. Went from René Leriche to aortic pulse transmission or something and whatever the first aortic prosthesis was and so forth.

I'm sure I had them in the wrong order. He never missed a beat. I got to the end of the slides, and he was still talking. I kept going. The next slides were on, I don't know, breast cancer. I don't know what it was. Whatever it was, he just seamlessly started talking about it, and then he goes, "Well, I think our time is up." Never said anything to me.

Justin: Really?

Dr. Schenk: Apparently, he was just very comfortable being able to talk about anything, and in any order, and make it look like it was all congruous. I was pretty impressed by that. That, and his ability to know everything about everybody.

Amazing. Amazing encyclopedic knowledge of people, which I never had. I still have trouble with names. He had just a remarkable memory for people's names.

Justin: When you were there, did Chase Lottich start as the first female resident?

Dr. Schenk: Yes.

Justin: What was it like integrating her? Because before, it was a bunch of white guys throughout all of Duke's history. What was it like integrating the first female resident to general surgery? She was how many years behind you?

Dr. Schenk: Two or three. It must have been at least three, because I was out of the lab when she started. I think the residency being what it was, the band of brothers sort of thing, we all looked out for each other and stuff. That went to her too, that we wanted to be her big brother sort of thing, make sure things came along. My most vivid memory of Chase Lottich was, at that time, there was a call room in the SICU.

Justin: Which is on 2200? That was in Duke North at the time or still in Duke South?

Dr. Schenk: That was in the new part.

She came out to start morning rounds, started in the ICU, and she came out, and apparently didn't notice that she didn't have her white skirt on. I said, ‘Uh, Chase…”

Justin: Was Dr. Sabiston there at the time?

Dr. Schenk: No. This was just the resident rounds first. I was like, "Don't do that again." I don't even know how she ended up because I would've been gone while she was still in there.

Justin: In private practice surgery; does mostly breast in Raleigh, but still in the area.

Dr. Schenk: She's in Raleigh. My sister still lives in Raleigh. She saw a breast surgeon in Raleigh, but it wasn't Chase Lottich.

Justin: Were there any African Americans there when you were a resident?

Dr. Schenk: No.

Justin: Eddie Hoover was after you or before you?

Dr. Schenk: Yes, after. Except for Brad, who was Dr. Sabiston's boy.

Justin: You progressed to Chief year -- what was chief here like with Dr. Sabiston?

Dr. Schenk: John Hanks was on at the time of Sabiston's service. When you first started chief year, Dr. Sabiston was on what was called Public General to try to get

things off on the right foot. You spent July with Dr. Sabiston on your service if you happened to be assigned to that, and then he took August off. Blalock must have taken August off, for all I know.

I was on Private General as the Chief. Dr. Sabiston had a triple-A that he had posted. Scott Jones had a Whipple that he had posted. John said to me, "Wouldn't you really rather operate with Dr. Sabiston?" "No." Clearly, he would much rather [operate with Jones], because GI was his interest, and he did his laboratory time with Scott Jones. I never did a Whipple during residency.

Anyway, it turned out that he got that concept approved, that I would help Dr. Sabiston, which apparently, Dr. Sabiston was just fine with because by that time, he knew that John was interested in GI general surgery. He wasn't following in his footsteps. John said, "Have your 4-0 prolene already set up, and maybe even in your hand." I said, "What are you talking about?" He said, "When he goes around the aorta, he will put a hole in the vena cava, and you just want to be prepared to fix it." "Are you crazy?" He said, "No, I'm serious. You'll want to be able to do that."

Having been forewarned and knowing already that if things were going well, you would lead the direction of where things were going and keep him out of trouble. We got around the aorta just fine. Got proximal-distal control, and we did it the way you usually do it. Did the upper anastomosis first because you could lift it up, and you could do it circumferentially. That was fine. Then you cut it to the right size for the distal end. He starts going across the front, anterior half of the anastomosis.

Justin: Without doing the back end?

Dr. Schenk: Correct. I think, this will be interesting. Should I say something? That would be insulting. What the heck. Let's see what he does. He's going [mimics attempting to stich behind a vessel]. I'm trying to do this [mimics rolling over the vessel], to rotate a little bit for him now. He passes the suture around to the other side and finishes coming up from the other end. Talk about making an easy problem hard! That was the first human case, I believe, I did with Dr. Sabiston.

Justin: Did it leak?

Dr. Schenk: No, it was fine. He did not like Prolene. He used, I think it was Tevdek or something as his vascular suture because Prolene was kinky. It had a memory. When he set a suture down, he wanted it to stay there. He was not fond of Prolene because of that memory aspect of the Prolene. If you didn't iron it first by stretching that a little, it had lots of kinks in it. Anyway--

Justin: When he was doing these cases with you, was he asking you questions the whole time also or was that what the students are there for?

Dr. Schenk: No. That's pretty much what they were there for, but it was pretty much all business when we had a case to do and trying to limit the amount of blood loss

and stuff by trying to do things right. That case went fine, even though the distal anastomosis was JV error kind of thing.

Justin: What was the main difference between the public general surgery service and the private general surgery service?

Dr. Schenk: The socio-economic class of the patients was the biggest difference. I think it was the same on the medicine service. I'm not sure about that. I think they had a resident's service as well, but it was very sharply defined. At that time, if a patient turned out to be covered by Medicare, which an increasing number were, then they might end up on a public service because of what we referred to as the wallet biopsy. But they had to have an attending assigned because that was one of the rules to comply with Medicare. There would be an attending assigned who may or may not ever see the patient during their hospitalization.

Justin: If they're not covered by Medicare, it was solely resident-run?

Dr. Schenk: Yes. It was still solely resident-run if they have Medicare attending, who, like I said, may or may not have ever even seen them. He just signed their discharge summary, which we could get away with at that time, and actually, we didn't realize that wasn't really the way the world was supposed to operate.

Justin: On the private side, there was always attending involvement?

Dr. Schenk: Yes. You didn't make any independent decisions on the private side. There was a very specific pecking order when it came to OR time on the private side. You had to be very careful about that because you were the one that made up the OR schedule.

Justin: As the Chief Resident?

Dr. Schenk: As the Chief Resident, yes. Whoever was supposed to get a first start on such and such a day, if he's behind somebody else, you're going to hear about it. In fact, you would hear about it that morning. You'd better get this fixed right now. That was your biggest liability on the private service, was making sure all those rules were followed.

Justin: The private service resident made the OR schedule for just the private people or made the whole OR schedule?

Dr. Schenk: For just the private people.

Justin: They were assigned X number of ORs a day?

Dr. Schenk: Yes. So was the public service, had their two ORs, They were responsible for establishing that. In those days, there wasn't quite the emphasis on

total efficiency use of OR time. You could have some unused OR time and nobody was going to beat on you about it.

Justin: On the public service, the resident decided who to take to the operating room, when to take them. They did the whole operation and managed the whole postoperative course?

Dr. Schenk: Yes. They were expected to let the Medicare-assigned attending know about that. I don't remember any cases where they actually came and participated in the operation. Like I said, there was one well-known ruptured aneurysm where it had an interesting outcome.

Justin: What were your morning meetings like with Dr. Sabiston when you were the Chief Resident?

Dr. Schenk: Among other things, you were expected to know everything happening in the hospital on every service. If the chairman of the bank was admitted for angina or something, you were expected to know that.

Justin: Total non-surgical problem, you're expected to know?

Dr. Schenk: Absolutely. You were expected to know everything that was going on in the hospital. Again, you were the senior person that was actually physically in the hospital, because as a Chief Resident, you were every other day, forever. Occasionally, he threw in a, "What did you think about the basketball score?" Or something. He'd throw that in there just to keep you off balance.

When I say everything, you were expected to know everything that was going on, especially with your own patients. He had a philosophy that there was basically one right way to do anything. There's no variation about that. You weren't really expected to insert any individual judgment about whether maybe we'll treat this probable appendicitis with antibiotics or something like that. That was not received very well, even if it was successful. It was his attitude that there's almost always one right answer to every question. That became evident pretty quickly.

Justin: As a chief, you rotate on the public service, the private service, were there other chief rotations that year? The VA?

Dr. Schenk: Yes. You did the VA. Well, there was a cardiac service, but there was also a super chief on that service, but there was a chief. I guess John could probably tell you how warmly he was received when he was on that service. He was not expected to know anything about those patients for some reason. The las was Trauma / transplant.

Those were a combined service because, by and large, neither one of them had schedulable cases, so they fit together. Did not have very many living donor transplants.

Justin: Bollinger did the first liver transplant with Myers and McCann. So that was after you had left Duke?

Dr. Schenk: Yes. That was after I left. McCann was in my intern class; he started with me. He just died recently.

Justin: Did you and he talk about staying for vascular? Because he did sort of like a super chief vascular type year at Duke?

Dr. Schenk: He did, yes. Actually, I was already gone and I've been gone at least one year-

Justin: So he finished after you?

Dr. Schenk: - yes, when McCann was still there.

On our first day of internship, when we had a little introductory welcome to Duke by Dr. Sabiston, McCann went down the aisle and he sat down next to Dr. Sabiston. If you weren't a super chief, you weren't supposed to sit next to Dr. Sabiston. He went down and sat next to Dr. Sabiston. He was sitting there waiting for this little talk to start, and McCann pulls his pipe out of his pocket and puts it in his mouth. Geez! [laughs] I can't remember who it was that calmly went over and took him by the shoulder and pulled him out of his seat. [laughs] We were thinking "Oh my God, you're going to get killed." I don't think Dr. Sabiston saw it, but--

Justin: McCann just had no idea?

Dr. Schenk: Oh, not a clue.

Justin: Because he came from Cornell, I think, for medical school. Right?

Dr. Schenk: I don't remember. But this was not going to be a collegial little picnic. When McCann went and sat down next to him, pulled the pipe out of his pocket…Oh my God! I told him to never do that again.

Justin: I assume Dr. Sabiston was anti-smoking?

Dr. Schenk: Oh, absolutely. He was also very much anti-facial hair. Jim Lowe had a pretty well-trimmed mustache, but any other facial hair was not tolerated. On the first day, one of the things he said was the surgeon starts his day with the application of a blade -- to his face.

Justin: He had no trouble with alcohol?

Dr. Schenk: What do you mean by trouble?

Justin: Or, he was not opposed to it. Because he did have trouble with alcohol. Was that known to the residents at the time?

Dr. Schenk: No. That wasn't really an issue at the time. As chief residents, we would be invited to his house for our farewell dinner. I'm not exactly sure what the scenario was, where I ended up going to that twice, and he had exactly the same dialogue. "Isn't that interesting the way the candlelight flickers on the ceiling," it's exactly the same stuff and fair amount of alcohol. He liked to ply others with alcoholic at meetings and stuff. We weren't aware at that time that he personally had any problem with alcohol.

Justin: How were his Christmas parties?

Dr. Schenk: Let me see. Christmas parties, seems like I was always on call on Christmas, but party, of course, wasn't on Christmas day. They were formal, a little bit rigid as you'd expect them to be. It's not like there was a dance floor and a live band the way there was at some of our earlier Christmas parties here. Certainly, children weren't invited to the Christmas party there. Sometimes somebody would bring their kid, but not often. Good food, though. Pretty good layout. It seemed to me I was always on a call, but then I had about a 50-50 chance for that one. I don't remember a lot of Christmas parties. I don't think I went to very many of them.

Justin: How many years were you at Duke in total for your residency?

Dr. Schenk: 11 years, I guess, if you include medical school.

Justin: Residency was eight?

Dr. Schenk: Yes. Six plus two.

Justin: You did an extra SAR year?

Dr. Schenk: Yes.

Justin: Was the schedule pretty variable? How many years at each individual would do?

Dr. Schenk: Well, Newland Oldham was the guy assigned the task of figuring out what the starting lineup was going to be the following year. You really didn't know until early May what was going to be happening the following year. He was also the axeman. If somebody was going to be told they were not coming back, he was the one that had that-

Justin: Not Sabiston?

Dr. Schenk: -had that duty. That's correct. That was one of those things like beating on the chief resident when your intern was carrying a cup of coffee, that's one of the things he'd delegate, and he delegated that responsibility to Newland. So you didn't

really know. You'd have a meeting with him, with Newland, and either you would be told or have some negotiation over the next year.

My recollection is I wanted to do an extra year specifically for vascular and do as many vascular rotations as possible at the VA and at Duke. Like I said, I had enough time that I could have qualified for those boards. I also had enough time in the ER that I would've qualified for emergency medicine boards at the time. Oh, God. Every year there was a couple of months in the ER--

Justin: That's pretty painful.

Dr. Schenk: Well, but it was run by the house staff. You had a second-year medical resident and you had typically-- Initially, it was just a second year – later it was a second and maybe a fourth SAR, and they ran the ER. The patient would come in with alcoholic gastritis or GI bleed or something that you would negotiate which side this patient was going to go on.

Justin: You guys did all the orthopedic stuff also?

Dr. Schenk: We didn't do a lot of it, but we'd have to call the ortho guy, but I learned a fair amount of orthopedics from being in the ER a lot. I remember when I was here [UVA] as an attending and I broke a toe, I had to show the second year ortho resident how to do a digital block on my toe: "Hold on, let me do it." [laughs] We learned how to take care of some simple fractures, how to relocate a dislocated shoulder, a few other common things.

Justin: Then the graduation ceremony, was that a forced formal affair? Was there any type of emotion that you all are graduating and becoming Duke surgeons?

Dr. Schenk: It was pretty formal. Each of the finishing guys was expected to have a little bit of a prepared thing, mostly about who are you going to thank for your educational progress and so forth. It was pretty formal and followed a standard plot.

Justin: How much influence did Dr. Sabiston have on your next steps when you were leaving residency in terms of getting a job here [UVA] and moving onwards?

Dr. Schenk: Since I wasn't going into cardiac surgery, not a whole lot because clearly at that time, one call from Sabiston would be all it would take for whatever it was that you wanted. Scott Jones had come here a year and a half before that, and one of his expectations taking on the chief role was to establish UVA as a designated trauma center. He needed a trauma chief, and he called me up and asked if I was interested in that job.

Justin: Straight out of residency?

Dr. Schenk: Yes. Which was a sticking point for some of the faculty here [at UVA]. I didn't find this out until later, that they thought I was pretty junior to be taking on that

task. But we had just finished going through that process at Duke while I was in the lab. I was involved with knowing what you had to demonstrate to say that you were qualified as a designated trauma center, a level one trauma center. I managed to get that going and completed. We got designated a year after I got here, but it was still loose at that time in terms of having specific, designated only-trauma faculty attendings. It was almost only me, and I certainly wasn't only trauma. My other love at that point was vascular surgery, and I was more interested in elective carotids and fem pops.

Justin: Who else was pulling trauma call here aside from you?

Dr. Schenk: We had a rotating schedule just like any other general surgery attending call. The call for general surgery were also expected to be the call for trauma. It was at a point where people were expected to show up if it was serious trauma. If it was declared a level one trauma by the ambulance crew bringing them in, then you were notified ahead of time and the attending was expected to be there.

Justin: Did your relationship with Sabiston change after you were on faculty here compared to when you were a chief resident?

Dr. Schenk: I don't think so. I think he would be always very cordial. If you had made it through the program, he was done beating on you. He didn't have to do that anymore because you had survived that gauntlet. It was more collegial, treated more like a colleague than a second-class citizen. I think that's probably true of most of the people who left there, maybe except Brad Rogers. I'm not exactly sure what that relationship was, but it was always strange.

Justin: Any other great stories from residency or from chief year?

Dr. Schenk: I told you the one about the tetralogy. You heard about the plum story. That didn't involve me, but I sure heard about it.

Justin: Because you said you and Dr. Hanks were co-chiefs?

Dr. Schenk: Yes. We were co-chiefs at that time. I certainly heard about that.

The first lady of South Carolina, the governor's wife, came to Duke for her breast cancer surgery. This was a huge feather in the cap, that she didn't go to someplace in South Carolina where they had a couple of medical centers that she might've gone to. He did her mastectomy with John Hanks.

Justin: This is before the days of lumpectomy?

Dr. Schenk: Not entirely, but pretty much. A so-called modified radical was pretty much the standard treatment at that time. Lumpecs, not yet. She had a mastectomy done, and Dr. Sabiston had a habit of leaving the OR as the case was finishing and basically coming back 10 minutes later to make sure you were actually getting the

hell out of the room so he could get his next case started. He does a mastectomy with John Hanks, and he closes the incision with continuous 2-0 silk**.** It was awful. I wasn't there. I had to hear about it from Hanks.

John says to the scrub, "We can't send the first lady of South Carolina back looking like this!" As soon as Dr. Sabiston left the room, Hanks ripped out the closure and redid it and just barely got the dressing on it, when Dr. Sabiston came back, "How are things going, John?" "Oh, just fine, sir!"

Then about a month after that, his secretary of so many years pages me and says, "You better know about this patient who was admitted to Dr. Sabiston today, because I don't think he knows it."

I go, "Oh God, who is that?" This is the sister of the first lady of South Carolina. Since her sister got her breast taken care of there, she's going to go out for that 'well-known breast surgeon' – Oh my god -- to take care of her. This of course was the day when everybody was admitted the day before anything that ordinarily would have been day surgery anyway. His secretary forewarns me about this while I'm sitting next to Dr. Sabiston in a conference, I don't remember which one. So I took him there to go see this woman. She brought her mammogram with her. He introduces himself to her, introduces me to her and so forth. He puts the mammogram film up on the screen. There was a viewing box in the room in those days. He goes, "Hmm, hmm, hmm." I sort of reach over [mimics rotating the film right-side up] [laughs] And there's nothing there. It has circled a very vague density in the left upper outer quadrant. Sabiston says, "You will get her set up to have that biopsy in the morning, first case." I'm thinking, "You got to do a needle localization for this because otherwise there's just no way." My next-door neighbor was the head tech in mammography. I called her, I said, "Look, I will mow your lawn for the next year if you'll help me out with this. We need to do a needle loc and He wants the patient in the OR at 7:30 AM. You get what I'm getting at here?" "You want me to come in at 6:30 AM and do a--?" "Yes. Can you do that for me?" "I will." "I'll mow your lawn for a year if you do that for me."

I can't remember if there was money involved, but anyway, she did agree to do it. The patient got a needle loc done, and we did manage to get her in the OR. The mammography was in the old part still. The OR, of course, was in the new part, and the stretcher wasn't going to fit on the elevator. Anyway, it was a real task getting her up there in time for Dr. Sabiston.

Justin: This is when there was still a train back and forth between them?

Dr. Schenk: Yes, we didn't have to stop the train. We get in there, and the patient is asleep. Dr. Sabiston picks up the knife off the mayo stand, and he puts it back down. He says, "Sandy, how do you know what the interpretation was of this mammogram?" I said, "Dr. Sabiston, it's already got--" "How do you know it wasn't really on the other side?" "That doesn't matter. There's a wire on the--" "No. I want

you to call the hospital where that was done and find out the report of that mammogram."

I still remember. It was the St. Francis Xavier Hospital in Charleston, South Carolina. I got the number, got the medical records, blah, blah, blah, patient such-and-such with this-and-this date of birth. "Is there any way you can read to me over the phone what the mammogram report was?" "Okay. It says, 'Nondescript small density in the left upper outer quadrant. Rule out malignancy. Likelihood malignancy is low'," or something like that. I told Dr. Sabiston. He picks up the knife. Puts the knife back down. You hear a sigh in the room from the second-year resident, first-year resident, student. "Sandy, how do you know they were reading you the report of the correct patient?"

"Sir?" "How do you know they were--?" He was just very paranoid that somehow, somebody would make a fool out of them for screwing this up, and he knew he himself hadn't really prepared for this. He just met the patient yesterday as a surprise, and somebody is going to try to make a fool out of him.

I can't remember – somebody had, I don't know, an amputation on the wrong leg or something. It was in the newspapers, and that surgeon was being ridiculed or whatever. Just suddenly, Sabiston was very paranoid that something was going to turn out bad about this. "Sandy, I want you to call them back. Don't tell them the name of the patient. Give them her social security number and see if they come up with the same report."

"You're serious, aren't you? Okay." By this time, I remembered the number of the St. Francis Xavier Hospital in Charleston, South Carolina. I called them back up and I said, "Hello, and can I have medical records, please? Hi, you remember talking to me a few minutes ago?" "Yes." "Don't tell me the name, and I won't tell you the name. I'm going to give you the social security number. I want you to look it up based on the social security number and then you tell me if it's a-- No, no, I'm serious. It's--"

Justin: [laughs]

Dr. Schenk: "No, really, I need you-- Look, I can't explain why, but look, could you please just do that for me?"

Justin: You're calling from the operating room?

Dr. Schenk: Yes. I'm over in the corner of the operating room. I've still got my gown and gloves on. "Okay, sir, I've found it. Now what do you want?" "Can you read it to me, please?" "Yes, certainly, 'Nondescript density in the left upper outer quadrant. Rule out malignancy. Likelihood malignancy is low'." "Thank you, sir," and I told Dr. Sabiston that. I read it back to him. "Yes, sir, it's the correct patient. They've told me again, in the left upper outer quadrant, nondescript density, and low likelihood of malignancy."

"Okay." He picks up the knife again. Sets it backs down on the mayo stand. You could hear a sigh. He looks over the ether screen. "Do you mind waking the patient up for me, please?" "Are you done?" "No. I want to talk to the patient." "You want to what?" "I said, I want to talk to the patient. I want you to wake her up" "She's not going to make any sense talking to you." "Just wake her up. I want to talk to her." "Whatever you say." He's pushing the drugs and the oxygen, giving her the reversal. He extubates her.

Sabiston reaches over the screen. "Miss _____?" "Hmm?"

"Miss _____, when you had that trouble with your breast, it was never on the right side, was it? Was it always on the left side?" "Hmm"

"Okay, put her back to sleep." "Dr. Sabiston, she's not going to re--" "Never mind." He comes around from the ether screen. Anesthesia has not yet re-intubated the patient, but he's given her some of the Pentothal. Sabiston picks up the knife, picks up the wire, takes the wire out, sets it on the mayo stand, and makes an incision-- "Ah." [patient screaming]. The anesthesiologist said, "Excuse me, Dr. Sabiston, would you mind waiting until she's asleep?"

He's no longer got the wire in and he just does a chunkectomy, and I'm thinking, "Oh, my God, we're going to have to get a specimen mammogram." I'm thinking, "Oh, my God, we're going to be in for it. She's going to end up getting a mastectomy because they can't call it. They're going to say it wasn't included in the specimen or something. Holy shit." About this time, my buddy from next door calls the OR directly. He says, "I just want you to know that the radiologist says this is so indistinct that we won't be able to tell whether or not it's in the body or the specimen by specimen mammography."

Dr. Schenk: "Thank God."

The pathology, of course, was completely benign. I go, "Holy smokes, what a display of…"

Justin: It's remarkable that he expected you all to know every last detail about the patient and then walked into this operating room seemingly knowing next to nothing.

Dr. Schenk: Yes. He was coming in pretty blind. For that reason, I think he was feeling paranoid about it, that he was relying on these underlings to have set him up. That we set up for the wrong operation. Like I said, the best part I remember is when he reached over and took the wire out and set it on the mayo stand.

Justin: That's a lot of lawn mowing for nothing!

Dr. Schenk: A lot of lawn mowing for nothing. [laughs] Clearly, he did not understand what a needle loc biopsy was, and he clearly didn't the day before when I said, "This is going to require a needle loc because it's not palpable and you can't tell

where it is." "Oh, yes. Of course, of course. Have her there at 7:30 AM and I'll be there."

Justin: Remarkable.

Dr. Schenk: St. Francis Xavier Hospital. I remember that from 40 years ago. Yikes.

Justin: We've been talking a little bit over an hour. Is there anything we didn't cover that you want to make sure we include in the interview?

Dr. Schenk: No, I don't think so. Like I said, a remarkable man. A very good teacher in some ways. A very hard taskmaster if you're in that teaching program. Well-known internationally. He was clearly a leader of American surgery with the textbook and so forth, but not a particularly skilled operating surgeon. Do people know that he did the first coronary bypass in America?

Justin: Everyone at Duke knows that. I assume most cardiac surgeons are aware

Dr. Schenk: I think they are, but because it wasn't successful…

Justin: He never published it.

Dr. Schenk: …he never did another one after that.

Justin: That's what I heard. It wasn't planned. It was a coronary endarterectomy and then it went down, so he bypassed around it.

Dr. Schenk: The patient had an embolic stroke.

Justin: I didn't know that part.

Dr. Schenk: embolized part of the bypass, probably.

Justin: He never did another CABG?

Dr. Schenk: Never did another one after that. He did do some general surgery operations and fixing hernias and mastectomies, did some GI stuff. He didn't really like that, but he did some of that. And of course, the cardiac. He did some valves and Pediatric. The thing he liked most, of course, was being able to do tetralogy of fallot, which was probably a real challenge for the super-chief. There was the one thing he was completely wrong about, and that was the angioplasty concept.

Justin: I hear he liked pectus cases also?

Dr. Schenk: He did. He liked the pectus cases, of course. On one grand rounds he brought the patient and--

Justin: You would do Ravitch-style?

Dr. Schenk: I don't think he put the rods in the way they usually do for adult pectus.

Anyway, this was a, I don't know, about a 16 or 17-year-old kid, had a pretty bad pectus and he had the preop pictures and he had the patient come in, and he had Dr. DeVries explain what the geometry was of this defect, so how you could plan the incision so that it came out right in the midline. The patient came and he took his shirt off and it was an oblique incision. "Sorry, sir, I should have warned you." Of course, nobody laughed or anything but we were all thinking, "Oh my God, poor Bill, he's going to get it for this one." That was the last time a patient ever came to grand rounds. In years gone by, that was a concept that you'd actually present a patient That's why it was called rounds.

Do you know about the puppy patrol?

Justin: No.

Dr. Schenk: Among the mid-level SARs, one of them would be assigned to the puppy patrol, which was to go and throw a puppy in front of Dr. Sabiston's car on the way into work so that he'd be in a good mood for the rest of the day, all symbolic of course. Oh God, who missed puppy patrol today? He clearly had days when he was in good mood, days when he wasn't.

What was the deal? He was a medical student at UNC?

Justin: Yes, sir.

Dr. Schenk: That was the puppy patrol.

Justin: I've never heard of that before.

Dr. Schenk: Maybe it was just in our year. Obviously, it was all symbolic and for the rest of that year, we'd talk about, "Oh, must have had a good puppy patrol today."

Justin: He does seem like he was a remarkable but complicated man.

Dr. Schenk: What I was about to say was that he was very anti-UNC.

Justin: Interesting. Did he go there for undergrad?

Dr. Schenk: Even though he was there-- It was undergrad? He also did medical school at UNC but at any rate, even though he clearly had an affiliation there.

Justin: He was from North Carolina, too.

Dr. Schenk: He was born in North Carolina. His brother still lives somewhere in North Carolina. At any rate, he saw them as second-class rivals. "We're the real medical center here in this state; why would anyone want to go to UNC?" I looked at

UNC as a potential residency spot. It was pretty well known and I knew some of the surgeons there.

Justin: Was George Sheldon, Chair at the time? Did he and Sheldon have a congenial relationship?

Dr. Schenk: I think so. I don't think he would ever publicly say that patients should not go to UNC. This was just between you guys and me. Why would anybody want to do it? Sheldon was very good to me, even as a resident. He didn't even know me that well. He wrote letters for me to get into associations and stuff, which was unexpected. A really good guy. Apparently, he thought a lot of me for some reason, I'm not sure why. He was very good to me. I think it would have been an enjoyable residency in some other ways, had I gone there. Like I said just from the level of the intensity of the educational process after I had gone around and looked at other places that I came back and said, "There isn't any place that--" I didn't say in comparison. I just said this is the best place of all the places that I have visited and interviewed. He didn't exactly say, "Well, of course, idiot." He said, "Well, you got a job here then."

Justin: Well he must have thought highly of you to hire you.

Dr. Schenk: I guess. It was a different conversation when I said, "I think I owe it to myself to broaden my background." When I came back, I think he appreciated that, that this was a better program than the other places that I looked at. Maybe he brought that program up from a backcountry place. It had a fair amount of money initially from the Dukes, of course, but it wasn't exactly a well-known medical center until he arrived from Hopkins.

Justin: Well, thank you, very much for your time. I really appreciate it. I'll get this transcribed and get you a copy of the transcript.

Dr. Schenk: That's fine.

[01:47:45] [END OF AUDIO]