The Surgeon's Surgeon

R. Burton Lilly '64

Glenn Allen was the surgeon's surgeon. Gentle, strong, unperturbed and quiet, Dr. Allen assumed his daily duties in a smooth undramatic fashion, typifying the type of surgeon that the public never construes and, for that matter, is not commonly found in most surgical suites. His master reputation among medical men cast aside the need for an air of debonair casualness at and about the table, or for the constant rumble of raw humor between the Chief Surgeon and carefully graded echelons of assistants and nurses. In truth, there were no assistants and nurses for Glenn, there were only instruments; some were metal, bright, strong and accurate; others were human, perhaps not so accurate, but nevertheless, flexible and dubiously useful.

Although known internationally for the development of the Allen Perfusion Technique for internal organs, he was better known locally for the "Veni, Vidi, Vici Approach" to all surgical problems in the G-I Division, Municipal Tumor Institute.

Glenn regarded the charts as something less than a necessary evil. He trusted them only for localization of the lesion to the abdomen, the rest he considered in the realm of slightly above the level of the "educated guess". His earlier experience had borne out this viewpoint, for where the surgical judgment of his hand and eye had never failed him, roentgenographic and clinical evaluations could not have the same claim. He had grown to mistrust and later to disregard them. He was "the surgeon's surgeon" and soon the G-I Division, Section of Medicine, Municipal Tumor Institute, frustratingly threw up their hands and spared Dr. Allen's patients the wasteful day of medical work up.

This was indeed unorthodox, and, in fact, unheard of at MTI, but Glenn got away with it, as he had always gotten away with things quite similar and no less unorthodox. As a medical student, Glenn never did lead the class, and rarely came close to it. He had surgery on and in his mind. He studied anatomy with his hands and eyes, turning to the books only for the nomenclature and the anomalies. He modified this attitude somewhat for histology and embryology, accepted physiology for the evil that it was, and flunked biochemistry twice, only to be saved by the "special". His anatomical appetite was next transferred to pathology, and thence to the final step as calculated by Glenn's logic, to surgery itself.

By third year, he considered himself not a medical student, but a student of surgery. He bore the burden of medicine seminars and the variegate droppings of the infinite parade of medical subspecialties (which were claimed to comprise approximately 135% of the student's future practice) with none of the grace, but with all of the misery, of those of least ability in his class. (With surgery, nothing was too trite). In medicine, he learned quickly to summarize and generalize, eventually developing his own therapeutic approach. Take the smear, hit the patient with penicillin, sulfa, and chloramphenicol, and then have the lab report sent to Epidemiology, who would have more use for it than he did.

Glenn was inconspicuous; he was neither tall nor short and his facial features marked him only as another anxious member of the group of students shuffling from class to class. He was usually alone in the throng, or he was not there. His first A-P resection, acting as second assistant, took place while his classmates were designing a program for tuberculosis prevention with the Professor of Preventive Medicine. He had done his second A-P resection, and had observed and performed a bronchoscopic examination before his inconspicuous nature became conspicuous forever, and the

Dean denuded him of his premature green. Quite inadvertantly, however, he had made his point with the surgeons and not so many months later became a most welcome surgical interne.

The Allen family always had a warm place for Glenn since they appreciated professional rather than academic achievement. In medical school, Glenn showed promise of bringing the family some local glory. He would fall well into place, for one brother was in Public Relations and a brother-in-law in Real Estate with a highly regarded suburban position. Glenn's apparent disregard for the solemnity of financial solvency was accepted as proper humility for a "dedicated" medical student. Not until a few months after Glenn's surgical residency began, did they realize that whatever it was they considered humility, it was there to stay. The lack of understanding grew as Glenn insisted on explaining the need for the development of new surgical approaches, approaches that might be less crippling, less scarring or perhaps even bring about less adverse sequelae. The dinner table became his "soapbox" for a tirade on surgical complications and complications of the complications. When the lack of reception became obvious, Glenn tried to explain himself with detailed description of how useless it must be to live an entire lifetime just selling shaving cream to a willing public and to foist houses with questionable foundations on starry-eyed newly-weds.

Not long after this, Glenn decided that his evenings would be spent better in Animal Surgery perfecting old techniques and perhaps developing new ones. It was here that Glenn learned to use his two hands as three, developed an instinctive fluid replacement judgement, and cultivated a respect for the problems of the anesthesiologist. Assistants were scarce since research after 5 p.m. was as unheard of as a union man working on Sunday, but there was one nurse who took advantage of this rare

opportunity to work with dogs and to have her ambitions realized. Glenn and Robin were married the month after he was appointed Associate Professor of Surgery.

Being some years away from his student days, Glenn mistook his students' frantic note taking as a rapid interest in surgery. He added to the professor's well calculated notes with thoughts of his own and in many lectures replaced the professor's notes altogether. This caused a more than moderate confusion amongst the student body which had spent more than time and effort in arranging a printed compendium from the lectures of previous years. After a mild adminstrative squabble over the "limits of responsibility" of the students in surgery, Glenn, disillusioned in his ability to teach, and in student motivation, asked to be given more time for his research and was relieved of didactic teaching duties.

As Glenn's achievements developed and the admiration and respect for his work grew among his confreres, so did the distance between them. There was no need to shake the hand of Dr. Glenn Allen or to pat him on the back, for he knew that his work was good, and it was, but it was not good enough. There was always something taking out too much, not being able to take enough, poor lymphatic drainage, inadequate post-operative circulation, even the scars were too noticeable at times. He often caught the awesome look in the eyes of the assistants, the observers, and the students; something must be wrong, he would think, something must be missing.

He found Robin's early interest in his research work waning. He tried harder and harder to revitalize it by projecting into it things that were far from being realized. He could see her slipping from useful ambitions to wasteful social tendencies His own inadequacy in the complete development of his work appeared to be at fault.

His marriage was strained, he was tense, his stomach was bothering him and he couldn't sleep. He knew that his work was slipping because of it; day by day he was becoming more inadequate. He had to do something about it, something to snap him out of this slump; he could then go on to things that had to be done.

It came to him early one morning as he crisscrossed the bedroom floor. It was 3.00 a.m., but it had to , and could be done now; the most unique operation of all, an operation undocumented in surgical history. Now that he thought of it, the time was ideal, since he must do it alone with no interference. Now he could call on all the resources of his superior skill and knowledge and demonstrate to all, even to himself his true ability. There is usually no activity in the O.R. suite of the M.T.I. until early morning due to the elective nature of their work. At no time, however, is access facilities denied the Chief of Surgery, nor are his motives ever questioned. So at 3.30 a.m. on April 28, 1964, O.R. 1, always equipped for abdominal surgery, was prepared by Dr. Glenn Allen, M.D., F.R.C.S.(C), F.I.C.S., Chief of Surgery of M.T.I.

The patient was properly prepared with an I. V. in both ankles, saline on the right and dextran on the left. The abdomen was scrubbed thoroughly and then swabbed down with zephiran. The entire abdominal wall was then completely infiltrated with a procaine solution and the saline drip was started.

The knife made its familiar course through a pale skin made tauter with the surgeon's hand. The sight of the blood, from tiny spurts, rolling over the glistening yellow fat globules straining at their connective tissue barrier was familiar. Clamping and tying the bleeders was fundamental. Dissecting the rectus sheath clear, Glenn decided to use more local and smiled as he recalled the basic nerve distribution with each injection; T-8, both sides . . . . T-9, both sides . . . . T-10, both sides. With no muscle relaxation, things might be a litte more trying than usual, but not impossible.

The lights were getting unbearably hot and sweat began pouring over Glenn's face and eyes. He was too involved to stop and mop his brow now. This was a time that Robin would be handy as she had been in Animal Surgery. He went on. He had placed a warm pan of saline by the table and began preparing the lap pads and bringing out some of the intestine in something other than the orthodox manner. His stomach was bothering him worse than ever and his head was beginning to throb. He looked up at the clock, it was 4.45 p.m. and he was to know that it was exactly one hour after the initial incision that he vomited for the first time in his surgical career.

He was rushing, the scrubs would be in by 6.30. He had to be through by then. The dextran was turned in. A second brief bout of vomiting did not relieve his nausea. He tied off the exposed vessels as he had done a hundred, even a thousand times and