PREFACE

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

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

Historical Archives Advisory Committee, 2005/2006

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ABOUT THE INTERVIEWER

Jay L. Grosfeld, MD, FACS, FAAP

Dr. Jay L. Grosfeld is the Lafayette Page Professor of Pediatric Surgery at the Indiana University School of Medicine in Indianapolis, Indiana. He attended both undergraduate school and medical school at New York University [NYU], graduating from the latter in 1961. He trained in general surgery at NYU under Dr. Frank C. Spencer from 1961-1966. After two years as a captain in the US Army Medical Corps (1966-1968), he obtained postgraduate training in pediatric surgery at the Columbus Children’s Hospital, Ohio State University (1968-1970) under the direction of Dr. H. William Clatworthy, Jr. At the conclusion of training, Dr. Grosfeld’s first full-time academic position was assistant professor of surgery at NYU School of Medicine from 1970-1972. In 1972 Dr. Grosfeld was appointed professor of pediatric surgery at Indiana University School of Medicine and the first surgeon-in-chief of the Riley Children’s Hospital in Indianapolis. He has remained at Indiana in that position for the past 32 years.

From 1985-2003, Dr. Grosfeld served as chairman of the Department of Surgery at Indiana University School of Medicine and training program director of the general and pediatric surgical residencies. He was chairman of the American Board of Surgery in 1997 and also served as vice-chair of the ACGME-Residency Review Committee for Surgery. In 1995 Dr. Grosfeld was elected president of the American Pediatric Surgical Association and was secretary and then chairman of the Section on Surgery of the American Academy of Pediatrics [AAP]. He has been a member of the AAP for 30 years and is a previous William E. Ladd Medical recipient.
Interview of Harvey E. Beardmore, MD

DR. BEARDMORE: Since my stroke, things have changed. I had been smart in arithmetic and all of a sudden I am not smart in arithmetic. There is a certain period during which there is recovery, but it is never complete. And of course it works for a little bit

DR. GROSFELD: Well, I think you are doing fine. We’ve gotten a great deal of information and fortunately we do have information from your records that demonstrates a lot of things.

DR. BEARDMORE: Yes, I was impressed with how much information you referred to yesterday.

DR. GROSFELD: The history really is what you remember and sometimes we have to corroborate some things and fortunately we can do that. Your records may fill any gaps that you might have, so I wouldn’t be very concerned about that.

DR. BEARDMORE: Well, I enjoyed every minute of my career and I seem to have been blessed by being in a position where I was assuming areas of responsibility and for some reason it just advanced until I was on the executive committee of everything I belonged to and president of all those societies.

DR. GROSFELD: Well sometimes if you want a job done you go to the busiest people, because you know they’ll do it.

DR. BEARDMORE: Well, I think that’s true.

DR. GROSFELD: Were your efforts in pediatric surgery well supported by the hospital administration?

DR. BEARDMORE: Oh yes, it was a children’s hospital.

DR. GROSFELD: How about your pediatric colleagues? Was there a good interchange? Mutual respect?
DR. BEARDMORE: Pediatric colleagues? Yes, no question about it. I also had a great deal of support from surgeons in adult hospitals by referral. And some support in looking after the children of the adult surgeons.

DR. GROSFELD: You took care of many of the children who required surgical interventions?

DR. BEARDMORE: That belonged to the faculty, yes, I did.

DR. GROSFELD: Good care

DR. BEARDMORE: Well, I hope so. You know if you want to make a lot of money, you don’t go into pediatric surgery. You know. Unless there is a wealthy uncle or grandfather or something, you don’t like to charge what you feel your work is worth. On the other hand, you get involved in Medicare and that means that everybody is the same.

[Brief interruption]

DR. GROSFELD: Tell us about your family.

DR. BEARDMORE: My father was a businessman and customs officer. He emigrated to Canada from Scotland. He met my mother at a hospital because she was having her appendix out. A romance blossomed and it resulted in me.

My mother was interested in the Imperial Order Daughters of the Empire. That was a group of Canadian women. That was her main work, to be a member of that group.

I grew up in Windsor, Ontario and went to McGill [University]. I joined the army as sergeant and then I went to the officers training center. Then I went overseas. Somebody had made a mistake on the number of artillery officers they needed, so I volunteered to go infantry. Since I volunteered to go infantry, I had to choose a regiment. The Essex Scottish regiment that my father had been in had a non-regular army commander. The reinforcements for the Canadian Infantry overseas were from McGill University. So I elected to go with the [Princess Patricia’s] Canadian Light Infantry as opposed to accepting a position with the Essex Scottish. The latter group was practically wiped out to a man in the invasion of Europe. I was with the infantry and I went to Italy. I had a ball. I was very lucky. When I came
back from overseas and was discharged, I took a job as a medical officer to the Victoria Rifles of Canada. I worked for a little while because it was a source of remuneration to me while I was going to school. Medical officers were better paid. When I was in the service, Frances joined the Wrens [Women’s Royal Canadian Naval Service or WRCNS] of the [Royal] Canadian Navy. We were married at the conclusion of the war.

DR. GROSFELD: Dr. Beardmore, tell me about your home in Morin Heights [Quebec].

DR. BEARDMORE: I have a sizable property. It is 2200 acres, four square miles, not four miles square. So my interest has been in forestry and I cut logs. The wood here is mostly soft wood, which is spruce and I sell them. I have foresters choose areas that should be carefully cut. You don’t clear cut anywhere. You just cut to improve what’s left. When my farm was active, I had 22 cows and I used to sell milk and send cream to a butter factory.

DR. GROSFELD: How did you balance your interest at the [Montreal] Children’s Hospital and these other ventures?

DR. BEARDMORE: I used to sell eggs too. I used to collect, wash, clean, weigh and box those eggs. When I’d come into the Children’s Hospital in the morning there would be a lineup of people waiting to get these fresh eggs. I sold eggs into the village and to every store that handled eggs. I used to make two trips a week with a Jewish friend who was in business. I remember complaining to him about the fact that the price of the egg cartons had gone up.

DR. GROSFELD: Do you think that the system of care for the children in Canada is adequate? Do you think it is well funded?

DR. BEARDMORE: No, not yet. Not yet. I don’t think there is any child who can’t be looked after, because we have a Medicare system, you know. Any time you go to the doctor you present the card. Sort of paying what they could afford. Everybody can afford a basic amount with the Medicare system. There was a lot of complaining on the part of practitioners when it first came out. So you may get less money, but you get paid for everybody. It took a little while for the doctors at the head of their profession to realize that their income was practically the same if they were paid less for everybody than nothing for somebody.
DR. GROSFELD: With doctors, like other people, it is hard to adapt to change sometimes.

DR. BEARDMORE: Yes, it is. But I think that there was a certain code amongst doctors because I know that I never charged another physician. It was a personal thing, but it was satisfactory as far as I was concerned.

DR. GROSFELD: Do you think the views of the young physicians today differ from your views?

DR. BEARDMORE: Oh, yes. Because they are paid on a running scale. You get paid so much for an appendectomy, so much for a cholecystectomy, and that’s a set fee. People were very upset when that came, but I think they soon realized that is was about the same for getting less for everybody than more for some and none for the other.

DR. GROSFELD: Do you think care is provided in an expeditious way on elective cases? Or is there a long wait, is there a long list for elective work?

DR. BEARDMORE: Well, there didn’t used to be. There might be a long wait before a hernia was repaired. There would be a list. But pediatric surgery has adapted well under these conditions.

DR. GROSFELD: Do you think there has been improvement in the care for children who are injured, the trauma patient?

DR. BEARDMORE: Well, I think every children’s hospital certainly is aware of the special requirements of the injured patient. No question about that.

DR. GROSFELD: Do you think there have been a lot of changes in the management of children who have abdominal injuries?

DR. BEARDMORE: Yes. The change to an observation policy so you do nothing surgical for the situation was a big change. You don’t have to invade. Like splenectomies, for example—today we rarely need to remove injured spleens.

DR. GROSFELD: Dr Beardmore, when we discussed the beginning of your experience as a baby surgeon, you had indicated that Dr. Dudley Ross was your mentor. Tell us a little bit about him.
DR. BEARDMORE: Well, you see Dudley Ross sort of stayed on at Montreal Children’s Hospital [formerly Children’s Memorial Hospital] past his retirement, in order to facilitate my acceptance into the Children’s Hospital. When I joined the staff of the Children’s Hospital he retired.

DR. GROSFELD: Was Dr. Ross a general surgeon? Was he a self-taught pediatric surgeon?

DR. BEARDMORE: Oh, I think so. Because there was nowhere someone like him could go and learn to be a pediatric surgeon. There wasn’t a big scope of pediatric surgery at the time he trained either. There were a few operations that were done periodically, but the scope of pediatric surgery in the early years was not huge.

DR. GROSFELD: Was this because many premature infants died or there was no pediatric anesthesia in those days?

DR. BEARDMORE: No. I think in one way it was because most patients were admitted to Children’s Hospital under the pediatrics department and it was the pediatric surgeons who were called by the pediatricians eventually to consult.

Well, I think that’s true that there were some delays except if it was something obvious. I mean, if there were something that obviously required surgery, you’d go right to the surgeon. But if it were a matter of an unclear differential diagnosis sometimes there would be delays. But once the surgeon was given a patient, it was his patient. There were many pediatric specialists in the hospital and you could get consultation by just asking.

PAUSE

DR. GROSFELD: Now Dr. Beardmore, you’ve traveled extensively as a professional and lectured in many parts of the world.

DR. BEARDMORE: Yes. That’s right.

DR. GROSFELD: Are there any special moments in time that you recall where you had a most unusual experience that you’d like to tell us about?
DR. BEARDMORE: Well, I’ve had some interesting experiences. I remember once being in a European city and saw a child that wouldn’t feed properly. It would start to feed and then it would choke. It had been on intravenous fluids. They asked me to come and see the child. I took the child by the ankles and held it up like this and a spherical piece of tissue on a stump came up into its throat. Its problem was that every time it went to eat this ball of tissue went down and blocked the esophagus. This child had been a problem in this European hospital for quite a while. I held him up by the heels and this spherical myoma came out on a pedicle and I asked for a pair of scissors and snipped it. They’d been trying to feed this child for a long time. Why it wasn’t diagnosed, I don’t know.

When we had neurosurgery in the hospital, I used to look after all of the pediatric neurosurgical patients that we had. A lot of them had head trauma. I recall a little girl was brought to the Children’s Hospital. She had been sent to a delicatessen to get a hot smoked Greek sandwich to take home and of course she was hit by a car and rendered unconscious. After about 10 days she woke up and asked for a smoked Greek sandwich. Just crazy. [Laughs]

DR. GROSFELD: Were there any disappointments along the way during your career as a pediatric surgeon?

DR. BEARDMORE: You mean patient-wise, or any way?

DR. GROSFELD: Any way.

DR. BEARDMORE: Well, I think I was a very difficult person to be around sometimes because of my insistence on super care for my patients. As a result, I used to spend many hours at a child’s bedside. It was so hard if a child did not do well, and then afterwards you realize that probably all the work you did was not helpful.

DR. GROSFELD: Would you do anything different today than you did in the past?

DR. BEARDMORE: I don’t think so. Do you mean in surgical techniques?

DR. GROSFELD: Yes.
DR. BEARDMORE: Well, I think you have to keep pace with current events. And I think that’s one reason why you should keep up with the literature and be experienced enough to evaluate it in a worthwhile fashion and also spend time with the patient because I think your physical presence is something that’s important.

Pediatric surgery isn’t a specialty that is overcrowded with a multitude of diagnoses. The patients you see are huddled together in an age group. For the pediatric surgeon, it doesn’t take him very long to get control of everything he is going to see because he doesn’t see that broad a differential diagnosis. Particularly now, because there are subspecialties in pediatric surgery.

DR. GROSFELD: When you trained you were basically the man for all seasons, though, weren’t you? You did everything.

DR. BEARDMORE: That’s right. And I just gave up some areas of care one at a time as more competent people (pediatric orthopedists, neurosurgeons, etc.) arrived on the scene. Which, I must say, was a satisfactory situation as far as I was concerned.

DR. GROSFELD: Do you think that specialization improved the level of care?

DR. BEARDMORE: Oh, I think so. Because a lot of the surgical specialties had had a good grounding in the adult work so that when it came time to do the pediatric part they had sound experience, albeit in the adult.

Occasionally we had specialties that collaborated in the care of one patient and there would be part of a procedure that was done by someone who was a specialist in one area and another part of the procedure done by someone else. In most instances, children had the best of both worlds.

DR. GROSFELD: Of all your colleagues in pediatric surgery, who were your favorite people?

DR. BEARDMORE: I am not sure that I have favorite people. But I know that in centers like Toronto, for example, there are three or four pediatric surgeons there. And here in Montreal I had a number of colleagues in pediatric surgery.
DR. GROSFELD: You are credited for developing the CAPS (Canadian Association of Paediatric Surgeons). Did you have a lot of support from your colleagues?

DR. BEARDMORE: Yes and no. It took me two full years to do it. In those two years, it allowed me to align surgeons who were doing pediatric surgery that were looking for a place where they could congregate and meet and discuss things. So that allowed us to form the CAPS over a two-year period where there was little opposition from the pure pediatric surgeons to form a specialist organization.

DR. GROSFELD: The CAPS actually preceded the development of the American Pediatric Surgical Association [APSA] by four years.

DR. BEARDMORE: Yes, but not the surgical section [Section on Surgery] of the American Academy of Pediatrics.

DR. GROSFELD: That is quite accurate; the AAP was the first group. That was in 1948. CAPS was formed in 1967 and APSA in 1971.

DR. BEARDMORE: Many pediatric surgeons belong to more than one organization. I belong to three: CAPS, the surgical section of the AAP, and APSA.

DR. GROSFELD: You also are a member of the British Association of Paediatric Surgeons, an overseas member.

DR. BEARDMORE: BAPS, right. The others, I think, were the three major thrusts to pediatric surgery in North America.

DR. GROSFELD: Canada at one time had been part of the British Empire. Did any of your trainees spend time in the British Isles?

DR. BEARDMORE: No, not to my knowledge.

DR. GROSFELD: How about at St. Justine’s Children’s Hospital [Hôpital Sainte-Justine] here in Montreal? Did those young people spend time in France or Belgium?

DR. BEARDMORE: They couldn’t wait to get out of France and get some North American training. For a long time, you know, they were French-
trained and therefore because of that they were held back a little bit. With time they organized themselves and developed some consolidation in training.

DR. GROSFELD: What do you think is the main value of meetings like the surgical section of the American Academy, CAPS or APSA?

DR. BEARDMORE: Well, I think that those meetings are at different times of the year and they can be attended by different people. Having more meetings available meant you didn’t go to “THE” pediatric surgical meeting since your exposure to information was available at all three. You couldn’t always go to all the meetings. However, I usually attended most and it was a rare few meetings where I wasn’t a participant somewhere on the program.

DR. GROSFELD: Did that help establish a certain level of camaraderie between yourself and many of the other children’s surgeons in the United States?

DR. BEARDMORE: Oh, I think so. You know, it was a nesting area for the pediatric surgeons to come together. Actually, I think early in the history of the surgical section of the American Academy there were really quite a few surgeons there who weren’t pure pediatric surgeons. Pediatric surgeons, as I said, we don’t spread very widely. The conditions which require a pediatric surgeon, I think, are relatively few.

DR. GROSFELD: Did that help influence the American Board of Surgery to establish certification in pediatric surgery?

DR. BEARDMORE: Well, there were very few pediatric surgeons. There were very few. You see, the American Board of Surgery wasn’t really interested in being anything else than the American Board of Surgery. You could never tell them that they should have an “American Board of Pediatric Surgery.” They didn’t like that. So, there were times somebody asked for that recognition and they said, “No.” So I decided that I should backtrack and instead of having a board of pediatric surgery, I should ask for a subdivision of the Board that would advance the importance and the recognition of the certification in pediatric surgery to a point where the Board would now fully accept pediatric surgery as a specialty.

DR. GROSFELD: Was it a tough battle?
DR. BEARDMORE: It was in a way, and in a way it wasn’t. Early on they were just cold to the idea—it was a tough battle. But as time went on and there was more pediatric surgery being done it became easier to convince the American Board of Surgery that we should be separate from the general surgeons.

DR. GROSFELD: That occurred in 1974, is that correct?

DR. BEARDMORE: If you say it is correct, I’ll say it is correct.

DR. GROSFELD: Did you have to take an exam to get certified?

DR. BEARDMORE: Yes, that was one of the things they demanded. There were going to be no grandfathers. Everybody that became a pediatric surgeon had to take an exam. I took an exam. And we were examined by adult surgeons who were becoming interested in pediatric surgery.

DR. GROSFELD: Where was the first exam given?

DR. BEARDMORE: Well, I can’t name it. There were a few of us and we sort of examined each other and then we had an examination to which surgeons could apply.

DR. GROSFELD: That was a real milestone in the history of pediatric surgery and you were given great recognition for accomplishing that because at the time the pediatric surgeons, as you alluded to, had previously been turned down by the American Board of Surgery three or four times.

DR. BEARDMORE: There were some that did not favor Board recognition. Especially by people like Orvar Swenson. He was a bugger. He didn’t like it.

DR. GROSFELD: What was your relationship with the American Pediatric Surgical Association?

DR. BEARDMORE: I guess I was there at the beginning.

DR. GROSFELD: Did you serve as president of that organization?

DR. BEARDMORE: Yes. Somebody said that I had been the president of every organization and until they had a society on the moon there wouldn’t be a vacancy for me.
Some people think my being Canadian was an advantage. Because I’ve heard people say that there were others (from the United States) that approached the American Board of Surgery to permit certification in pediatric surgery, but it was the presence of a Canadian who had no real axe to grind who pulled it off. Perhaps it wouldn’t have come about as quickly as it did without my help.

DR. GROSFELD: You actually served on the American Board of Surgery for a period of time after that occurred. What kind of experience was that?

DR. BEARDMORE: I found it very interesting because you made acquaintance and had socialization with all of American surgery.

DR. GROSFELD: Did you examine other people who wanted to acquire their Boards?

DR. BEARDMORE: Yes.

DR. GROSFELD: You were the first Canadian to be president of the American Pediatric Surgical Association. I also note that in 1974 you were the first president of the World Federation of Associations of Pediatric Surgeons. What role did that group play in promoting children’s surgical care?

DR. BEARDMORE: Well, there were Italians, and the English were very prominent, and the French. They were all in line.

DR. GROSFELD: Do you think that was a worthwhile effort?

DR. BEARDMORE: Oh, yes. It brought a lot of pediatric surgeons together, internationally.

DR. GROSFELD: Looking at your clinical practice, there were a few areas of pediatric surgery that seemed to be of more interest to you than others; including the management of babies that had esophageal atresia. I think you were one of the first surgeons to employ a slightly different technique in repairing esophageal atresia.

DR. BEARDMORE: One of the first. Not the first.

DR. GROSFELD: Can you tell us a little bit about the operation you used?
DR. BEARDMORE: Well, it was an operation in which you tied off the fistula and joined up the esophagus.

DR. GROSFELD: So you joined the esophagus from the blind proximal point to the side of the lower part.

DR. BEARDMORE: No, it was sometimes to the end.

DR. GROSFELD: Did that work as well as the end-to-end anastomosis?

DR. BEARDMORE: Oh, no. The end-to-end was better.

DR. GROSFELD: Another condition that you had great interest in was babies with congenital diaphragmatic hernia. What do you remember best about the care of those babies?

DR. BEARDMORE: Congenital diaphragmatic hernia. Outcome depended on the severity of the lesion. I think they had gastrostomies. Does that answer that question?

DR. GROSFELD: I think that’s OK. In 1984, you spent five weeks in China as a consultant. Tell us about that.

DR. BEARDMORE: Well, I never saw a girl baby operated on. I never saw any surgery done on a female infant. The male infants were operated on and nobody had very much to say about the females. How long did you say I spent in China?

DR. GROSFELD: Five weeks. You spent most of your time in Chunking [Chongqing].

DR. BEARDMORE: That was where the big hospital was. At that time, they weren’t very advanced in pediatric surgery. They did a lot of minor surgery on male infants and I don’t think they ever saw a female infant operated on.

DR. GROSFELD: Did you provide any education or workshops in emergency care of the babies while you were there?

DR. BEARDMORE: I guess I did, but I don’t recall any specific cases.
DR. GROSFELD: Dr. Beardmore, in 1986 you received one of the highest awards that a pediatric surgeon can receive in the United States, the William E. Ladd Medal from the Section on Surgery of the American Academy of Pediatrics. What did that mean to you?

DR. BEARDMORE: Well, I thought it meant a lot to me because it was the culmination of my experience with the Academy and that the Academy appreciated what I had done through the years.

DR. GROSFELD: Did your family attend that event?

DR. BEARDMORE: No.

DR. GROSFELD: Did that occur in Washington, DC?

DR. BEARDMORE: I think so.

DR. GROSFELD: Well, that is a very special event in the life of a pediatric surgeon and certainly it was recognition for all the contributions that you made to the field.

DR. BEARDMORE: Well, that was nice of them, but I have a more recent one than that.

DR. GROSFELD: Tell us about that.

DR. BEARDMORE: Well, there’s a picture hanging on the wall on the way downstairs and it’s from the American Pediatric Surgical Association.

DR. GROSFELD: That was in 2004, when you were the recipient of the Distinguished Service Award by the American Pediatric Surgical Association at their meeting in Florida. Tell us a little bit about that.

DR. BEARDMORE: Well, I couldn’t go to Florida. I can’t remember why. I guess it was sometime after I’d had a cardiac arrest or something. At any rate, I couldn’t go to Florida. So they did a video and they presented that to me in Florida and then Bradley Rodgers came up here with that and presented it to me here.
DR. GROSFELD: Wasn’t that a nice thing to do? Dr. Rodgers had trained with you in Montreal, didn’t he?

DR. BEARDMORE: Yes.

DR. GROSFELD: He was one of your disciples.

DR. BEARDMORE: Unfortunately at the time of his interview here, he had trouble with his previous appointment. He came into my office and I said, “Well, Bradley, if you go across the hall and tell Dr. [Herbert] Owen who you are and come back here, you’ve got a job.” Because he needed one more year to become qualified in pediatric surgery and he’s gone like firecrackers since then.

DR. GROSFELD: I believe he was president of APSA at the time, when he gave you the award?

DR. BEARDMORE: Well, maybe.

DR. GROSFELD: I think that was the case. Well, that is a wonderful thing and another feather in your cap in regard to distinction as a pediatric surgeon. Now, you actually retired from clinical practice in the early 1990s, is that correct?

DR. BEARDMORE: Yes, that’s right. My wife wasn’t very well and so I retired from my practice to look after her.

DR. GROSFELD: You did that for three years until she passed on, is that correct?

DR. BEARDMORE: Yes.

DR. GROSFELD: What was the cause of Mrs. Beardmore’s death?

DR. BEARDMORE: Frances had one hip operated on and it went very well, and the pain was gone. But after that she developed severe pain in the other hip. So she decided instead of going through all that pain again that she should have the other hip repaired. So it was during that operation for the other hip that she expired.

DR. GROSFELD: That must have been a difficult experience. I know you have a large family.
DR. BEARDMORE: We have six kids. Well, we only have five now; one passed away.

DR. GROSFELD: And how many grandchildren?

DR. BEARDMORE: I don’t know, wait.

DR. GROSFELD: I think you said ten.

DR. BEARDMORE: My children have their children’s families in different places and I can’t keep up with them. Mrs. King, my nurse’s aide, will know. I just had the first great-grandchild in Vancouver.

DR. GROSFELD: Tell me about your hobbies. I notice that you were the vice president of a fish and game club here in Quebec.

DR. BEARDMORE: The cabin is over there [pointing across the meadow], and I think we are members.

DR. GROSFELD: Do you like fishing?

DR. BEARDMORE: I’d stay on the water forever. I like fly fishing.

DR. GROSFELD: You were also a member of the Mount Royal Tennis Club and badminton and squash club. Did you participate actively in sports in earlier years?

DR. BEARDMORE: Yes, I did. But, you know, I found it difficult because I’d just get out on the tennis court and I’d be called back to the hospital. So I wasn’t terribly active, but I enjoyed the time I spent there.

What else did you ask? Oh, you want to know what my hobbies were? Well, a lot of people wonder about that and they wonder how I did it, but I had a herd of 22 purebred Canadian cows. My farm is across the lake. You can’t see it from here, but it’s there. I had a farm manager and one hired hand and I looked after 22 purebred Canadian cows.

DR. GROSFELD: What kind of cows were they?
DR. BEARDMORE: They were black, Canadian cows [known as black jerseys in the United States]. They are a special breed of cow that was developed for life in this sort of country.

DR. GROSFELD: You also did some hunting in the past.

DR. BEARDMORE: Yes. I did some hunting here for years. I did hunting at the Turtle Lake Club in Michigan and I did some hunting at an island down in the St. Lawrence River. I shot a deer this year and I shot a deer last year. The rack is hanging over the fireplace; I don’t know whether you saw it or not.

DR. GROSFELD: I’ll have to take a closer look; I didn’t pay attention to it initially.

DR. BEARDMORE: It’s beautiful, eight points.

DR. GROSFELD: What type of rifle did you use?

DR. BEARDMORE: I’m not fancy. I used a 30-30 shot. Something about the sights that I like. The one I shot last year, the boys over there mounted it on a board and I put it over the fireplace. The deer that I shot this fall is still over there; it was a seven point.

DR. GROSFELD: Of all of your accomplishments and the things you’ve achieved in your professional life, which stands out as being most important to you?

DR. BEARDMORE: There are many things that I consider important. If you considered going to college and running a farm with 22 milk cows and shipping the milk to the creamery and raising pigs . . . I used to raise pigs and I’d leave here early in the morning and drive down to Canada Packers with two or three pigs in the back of the truck. I’ve had people say to me, “How the hell did you do it? How did you run 2,469 acres of property, do the lumbering that you did, run a farm with 22 cows and ship cream and milk?” I guess the answer is, because it was just there to do it.

DR. GROSFELD: You did what you had to, is that right?

DR. BEARDMORE: No, I did what I wanted to. That’s the difference.
DR. GROSFELD: How did that all mix in with your pediatric surgery career?

DR. BEARDMORE: Well, it was fine because I had one-month of holiday a year and I took off. It took me an hour and a half to drive to the hospital before they put in the highway, and after they put in the highway it only took me an hour. So I could do what I had to do and then come up here. When I turned in at the bottom of that road I was relaxed.

DR. GROSFELD: Well, this is a very serene location and very pleasant. You have a nice view of the woods.

DR. BEARDMORE: I also have two lakes on the property.

DR. GROSFELD: The woods and two lakes are very nice. I’m sure this environment took away some of the stress of your clinical practice, sometime allowing you to just relax up here.

DR. BEARDMORE: When I turned into the end of that road, I could just feel myself relax.

DR. GROSFELD: You are a fortunate man. A lot of people don’t have a place to come to and get away from the stresses and strains of their activities elsewhere.

Getting back to pediatric surgery, where do you think the field of pediatric surgery is headed in the next ten years?

DR. BEARDMORE: I think it’s established as a specialty. I don’t think that we are going to go backwards. I think we are going to go forward. I know that recently we have just put a cardiac surgical unit into the Montreal Children’s Hospital. That’s a step forward! As a matter of fact, I think the unit was just opened this week or last week. Dr. David Murphy had been doing cardiac surgery there for quite a while.

DR. GROSFELD: You worked with Dr. Murphy for many years and also with Dr. Gordon Karn before he passed away.

DR. BEARDMORE: Oh, Dr. Murphy was the chief.

DR. GROSFELD: And you were the training director, is that right?
DR. BEARDMORE: Yes.

DR. GROSFELD: At the time, it was you and Gordon Karn, Dr. Murphy and Dr. Owen, is that correct?

DR. BEARDMORE: That’s right.

DR. GROSFELD: What do you think of the current lot of pediatric surgeons at Children’s Hospital at this time?

DR. BEARDMORE: Oh, I think that they’re doing very well. I think that the chief of pediatric surgery there is well-trained and that he is popular and I think that it isn’t going anywhere but up.

DR. GROSFELD: Do you think the surgical care of the children in the Montreal community is at a high level?

DR. BEARDMORE: Yes, I do, because in the Montreal community we have two children’s hospitals. We have one that is a teaching hospital of McGill. And the other one [St. Justine] is a teaching hospital of the University of Montreal.

DR. GROSFELD: What is the population of the province of Quebec?

DR. BEARDMORE: About 6.5 million people.

DR. GROSFELD: We’re going to stop and turn the tape over at this time.

DR. BEARDMORE: There are pediatric units in some of the other hospitals. In Quebec, there is a children’s hospital in Quebec City, and there are two in Montreal.

DR. GROSFELD: Do you think that physicians entering pediatric surgery today can have as worthwhile a career as you have had?

DR. BEARDMORE: I think they can have a good career in pediatric surgery. I think that it has become more sophisticated than when we began. You know, I did everything, and gradually the divisions were in place to have orthopedics and plastic and neurosurgery.
DR. GROSFELD: You mentioned a lot of the good things that you experienced. What were the worst things that you experienced in your career as a pediatric surgeon?

DR. BEARDMORE: I don’t know how to answer that. I guess you have to include in the worst things certain patients, but I don’t know how to answer that. What are the worst things I experienced?

DR. GROSFELD: Sometimes you have a patient that you can’t cure. And even though you try, things just don’t seem to work out very well.

DR. BEARDMORE: That’s right. I’ve had some of those. I’ve had some where the mother held the child and I held the mother while the child died. I mean, those are heart-wrenching experiences. It didn’t happen very often. I guess that’s why I remember it. Early on we used to operate on babies that had no possibility of living because of their make-up. So now we have specialties where there’s advance notice of a diagnosis which warns you not to operate because it’s impossible to have a child live. Do you know what I’m trying to say?

DR. GROSFELD: Yes, I believe you are referring to prenatal diagnosis.

PAUSE

DR. BEARDMORE: When I trained in surgery, there was a men’s ward and a women’s ward and there were about 30 beds in each ward. And one thing I found interesting was there was always a difference in the activity of the patients in the men’s ward or in the women’s ward. The women would sit up in bed with a couple of pillows behind their backs and they’d knit or sew or do whatever. If you went into a men’s ward it was very restless. They would walk up and down, sit up in bed and lie down in bed, turn around and hang their feet. In those days they could smoke a pipe or something. We went to a deer yard where there were does, stags and bucks there, and you found that there were many more bucks that had died than does in the very, very cold Quebec winters. The does were docile and expended less energy than bucks. I mean, the bucks were mobile. So if you went to look and see who had died, you’d find that there were many more bucks dead than does.

DR. GROSFELD: Dr. Beardmore, when you first began training, tell me about the level of patient care. Did you have intravenous fluids available at that time?
DR. BEARDMORE: Occasional intravenous fluids, but most of the fluids were administered by clysis, into the subcutaneous tissue.

DR. GROSFELD: How much fluid could you put into a newborn baby by clysis at that time?

DR. BEARDMORE: Oh, I can’t tell you in cc’s. You knew by looking at the subcutaneous swelling. Take it out and it would be absorbed.

DR. GROSFELD: And the babies handled this well?

DR. BEARDMORE: Yes. They were more often under hydrated than over hydrated.

DR. GROSFELD: Was it sort of like a revelation when IV fluids became available with scalp veins?

DR. BEARDMORE: Well, we had that and, of course, early on we favored scalp veins; but we had other venous entry sites that were used.

DR. GROSFELD: Do you think the development of total parenteral nutrition was an important advance?

DR. BEARDMORE: Yes, I do. I do in the sense that if you had a very, very sick patient, total parenteral nutrition was important.

DR. GROSFELD: Do you think it was a life-saving advance?

DR. BEARDMORE: I think it contributed to better patient care, postoperative care. It was a more direct route and it was in a vein.

DR. GROSFELD: What do you think were the most important advances in pediatric surgical care in the last quarter century?

DR. BEARDMORE: I think anesthesia. I think that you could take a baby to the operating room and our anesthesiologists were well-trained. They took three years of training, so there was no nurse who decided she was the one who was going to insert a catheter in the vein. You could be reasonably certain that if you took a baby to the operating room that you could just turn
it over to the anesthesiologist, although you were still responsible for the patient.

DR. GROSFELD: What about the development of neonatology?

DR. BEARDMORE: Well, it started out by having newborns in a small area between two wards, which was where the charge nurse desk was. The very urgent patients were kept in cots close to the nurse’s desk. After that, we developed an area, which was sort of a constant care area, and the sick babies were concentrated there.

DR. GROSFELD: What about the neonatal intensive care unit [NICU]? Did that have an impact on the survival of newborns with surgical anomalies?

DR. BEARDMORE: Yes, but that was more pediatrics than pediatric surgery.

DR. GROSFELD: Were pediatric surgical patients kept in the NICU?

DR. BEARDMORE: Yes, but those patients were sort of huddled together.

DR. GROSFELD: So the surgical area was in one specific area of the NICU?

DR. BEARDMORE: Yes, it was long and narrow and at each end there was an area. At one end in that area is where very sick patients were kept and watched very closely.

DR. GROSFELD: Did you think the advent of neonatal ventilators had a tremendous impact on your patients.

DR. BEARDMORE: I don’t know how to answer that. I don’t have any mechanical means of judging that. I don’t know.

DR. GROSFELD: What was your impression about the improvements in the outcomes for children with cancer. I am sure when you first started training, many of the children who presented to the children’s hospital with a malignancy had an early death. With the development of chemotherapy that changed dramatically. How did that affect your practice?

DR. BEARDMORE: Well, patients like that were taken entirely away from me, to the specialists for chemotherapy.
DR. GROSFELD: Surgeons still played a major role in the care of the children because the primary tumor had to be removed.

DR. BEARDMORE: Oh, yes, but the fluid and the electrolyte balance and the chemotherapy were looked after by another group.

DR. GROSFELD: Was the pediatric surgeon then part of a team that took care of these patients?

DR. BEARDMORE: Well, in that respect I think so. When the diagnosis was made and the decision was made to operate and he did the operation and fluid and electrolytes were looked after by another group. The surgeon himself would not be responsible for everything.

DR. GROSFELD: It was a shared responsibility, with a team approach.

DR. BEARDMORE: Yes, I think that’s right. I think the surgeon was in a position where he made decisions but it was a team approach as to how much, how often, etc., certain care was carried out.

DR. GROSFELD: What did you think about the development of membrane oxygenators and extracorporeal life support systems? Was that something that was a remarkable advance in your opinion?

DR. BEARDMORE: Well, I think it was an advance, but I don’t know how advanced it was, how much it would take over the care of the patient. It was a written law that the surgical patient was your patient; you were in on all the consultations and decisions.

DR. GROSFELD: Was that concept employed in your patients with congenital diaphragmatic hernia?

DR. BEARDMORE: Yes, I think that the well-trained anesthesiologist was the one who played a major role in patient care.

DR. GROSFELD: When you were beginning your training, you spent time in the laboratory. I thought it was of interest that some of your early research concerned the blood supply to the intestine in fetal dogs and the development of intestinal atresias in those animals. Can you give us some insight into that?
DR. BEARDMORE: The intestinal atresia was the result of a diminution in the blood supply to a portion of the bowel.

DR. GROSFELD: Could you demonstrate that in your experimental animals? This was some of the earliest work done in the field, is that correct? In fetal surgery?

DR. BEARDMORE: Yes.

DR. GROSFELD: What got you interested in that?

DR. BEARDMORE: Babies. I finished my training in adult surgery. I moved onto the staff of a children’s hospital never having operated on a baby. But I had spent a great deal of time observing and operating and doing autopsies. It was a short jump from an autopsy of a baby to clinical care of a baby.

DR. GROSFELD: And that goes back to your background of training in pathology as being an important experience that influenced your clinical judgment and the like.

DR. BEARDMORE: And I did more of that than I really should have. Because when I was in Boston it was common for them to have very sick babies. When the baby became moribund they would phone me and when it came autopsy time I went over to that hospital and I either watched the autopsy or I did a portion of the autopsy myself. I found that experience invaluable. Because there wasn’t any condition I’d see in a viable baby that I hadn’t already seen at autopsy.

DR. GROSFELD: So it was a great educational opportunity, wasn’t it?

DR. BEARDMORE: Oh, it was. It was, indeed.

DR. GROSFELD: Experience in the pathology laboratory often isn’t part of the current surgical training curriculum for residents. Do you think that surgical pathology ought to be included in the curriculum?

DR. BEARDMORE: Well, I think that if you’re in a position where you can follow the line through surgical pathology, that’s where you should be. But if you’re in a position where that is not available to you then I think you are at a disadvantage. Because when you do an autopsy you’re going to be able to
say, “well, that’s that and that’s probably what I should do to that baby” and then you do it. And if you didn’t do that you’d be starting from scratch each time you open a baby.

DR. GROSFELD: Well, unfortunately, in the current era, the rate of acquisition of autopsies has dwindled tremendously.

DR. BEARDMORE: Really?

DR. GROSFELD: Yes, and I think people pay more attention to what the computed tomography [CT] scan shows, or the ultrasound study shows, and in 25% of the cases the actual cause of demise of the infant might be missed without performing an autopsy. I think your concern about that is well-taken. Acquiring an autopsy is certainly still very important in allowing us to understand what happened to our patients that succumb.

DR. BEARDMORE: I think that’s true. And I also think that it is an important fact that you as a surgeon are responsible for that baby and the rapport that you have with the parents makes all the difference in the world, both in caring for the infant and acquiring permission for an autopsy.

DR. GROSFELD: Do you think the current residents do not have the same skills in communicating with the patient and the family?

DR. BEARDMORE: I do. When they started to put numbers on the hours in a week that a resident can spend at the hospital, that was a step in the wrong direction.

DR. GROSFELD: How do you think the development of outpatient surgery has impacted on the specialty.

DR. BEARDMORE: Well, I think the same surgeons do the outpatient as do the inpatient.

DR. GROSFELD: Does it take away an opportunity for the residents in training in children’s surgery to develop good bedside manners and develop rapport with patient families because of the outpatient situation giving them limited time with the family?

DR. BEARDMORE: I don’t understand the question.
DR. GROSFELD: Well, when patients were inpatients, the trainees had a chance to get to know the families and spend time with the patient. With outpatient surgery, they only have time for a brief encounter with the family. So they do not have an opportunity to establish a bedside manner or to get to know the family well enough to gain their confidence.

DR. BEARDMORE: You mean if they come in in the morning fasting and have an operation in the afternoon and the parents take them home?

DR. GROSFELD: Right.

DR. BEARDMORE: Well, that might be all right for some patients. It has to be. If it isn’t right for some patients, they shouldn’t be outpatients.

DR. GROSFELD: Well, it is beneficial for some, but not for all.

DR. BEARDMORE: I think so.

DR. GROSFELD: Of all the operations you performed, which was your favorite procedure?

DR. BEARDMORE: I think esophageal atresia.

DR. GROSFELD: Because of the complexity of the anomaly or because of the fact that the patient often had many other problems and it was more of a critical case.

DR. BEARDMORE: I think because I was kind of a simple surgeon and if I had a baby with esophageal atresia, there were only a couple of ways that that could be approached and the simplest procedure was usually the best.

DR. GROSFELD: In those babies that had esophageal atresia without a fistula and a long gap between the proximal atresia and the distal esophagus, and you had to replace the esophagus. What procedure was your method of choice?

DR. BEARDMORE: An early esophagostomy. That means that the baby can feed and the baby can learn to swallow and have it refed through a gastrostomy. I don’t know what is the best procedure for replacement. What do you think about it?
DR. GROSFELD: There are a variety of methods that are available. We’ve used a colon interposition, a gastric pullup or a gastric tube. There is some controversy as to which procedure is the best. I think most people would say that keeping the baby’s native esophagus would be the best thing, but in some instances it’s not possible and replacement is necessary.

DR. BEARDMORE: Colon may be the best.

DR. GROSFELD: One of the clinical problems that you have written about is abnormalities of the large intestine in the newborn. How did you get interested in that?

DR. BEARDMORE: I guess my prime interest was Hirschsprung’s disease.

DR. GROSFELD: You also published materials about patients who had meconium, problems passing meconium, meconium ileus, etc. Has the care of babies with meconium ileus changed dramatically over the years?

DR. BEARDMORE: Do you think it has changed over the years?

DR. GROSFELD: To some degree it has.

Dr. Beardmore, do you recall the circumstances of the first board examination that led to special certification in pediatric surgery? The exam was proctored by the executive director of the Board at that time, Dr. Jim [James] Humphries. They wanted to have the exam at an APSA meeting, but the APSA meeting that year was going to be in Puerto Rico. Do you remember the events leading to that?

DR. BEARDMORE: Well, I thought we had an exam in Puerto Rico. Because I can remember I think with Judson [Randolph], flying down to Puerto Rico and looking at the exam facilities and availability and flying back. We had some 200 people, I think, that were eligible to take that first exam.

We flew down in a little airplane and I remember the pilot was female and she had flaming red hair. We got off the plane in Puerto Rico and we did what we had to do. Then we flew back. At the meeting time, I flew down with Frances. I think the airplane had seven seats of something. I was wearing eyeglasses that were like pilots wear. The girl pilot looked at me and said, “Haven’t we flown together before.” And I said, “Yes.” She said, “I
want you to come up here and sit in the copilot seat.” My wife was in a single seat at the back of the airplane, just about going crazy.

DR. GROSFELD: Seeing you up front.

DR. BEARDMORE: Yes, and when the pilot got up, we were on, what do you call it?

DR. GROSFELD: Autopilot.

DR. BEARDMORE: When the pilot got up and walked back down the aisle I thought my wife was going to have a hemorrhage. The pilot turned and said to me, “Keep your wing tip up.” So it was really a very interesting flight.

I remember when Mark Rowe and I flew from Puerto Rico back to where we had to go, having examined the examination facilities, the pilot started the aircraft but one engine didn’t work. We were out on the runway and one engine was revved and Mark Rowe said, [knocking sound] “What is that all about?”

DR. GROSFELD: There weren’t a lot of lady pilots in those days.

DR. BEARDMORE: No, there weren’t. I felt a little better after Mark pointed out to her to start the other engine.

There was a pediatric surgeon who used to fly?

DR. GROSFELD: George Dorman.

DR. BEARDMORE: I guess maybe that is it. From San Antonio or somewhere?

DR. GROSFELD: He was from Phoenix.

DR. BEARDMORE: Well, I think he’d flown to San Antonio or something. Anyway, he asked me if I would take a flight with him. So I said, “OK.” I looked at him and I said, “That’s the idling adjustment screw. Change it.”

Old airplanes are marvelous. I can remember flying up into the lakes in northern Quebec to go fishing. You’d be in one of those airplanes beside the
pilot and have him read a magazine while we went somewhere. When we came to land at the lake, we came around to one end of the lake and he pushed everything forward and sat there and the airplane came down all by itself onto the lake.

DR. GROSFELD: So it had pontoons.

DR. BEARDMORE: Yes, he never touched anything. I was always worried, not worried but concerned, that there might be a log or something floating on the surface of the lake, just about this much out of the water.

DR. GROSFELD: Were there any complaints from people after that first examination.

DR. BEARDMORE: I don’t think so. Did you hear of any?

DR. GROSFELD: No, I remember it as a very exciting time in our specialty.

DR. BEARDMORE: Yes, it was.

DR. GROSFELD: It was the culmination of a dream of many children’s surgeons, being recognized, having credibility as a profession.

DR. BEARDMORE: Yes, it’s true. There were some old goats there at that exam. Some old fellows that didn’t like to be examined or be subjected to a written exam.

DR. GROSFELD: Now you, Dr. Randolph and Dr. Rowe first took a preliminary exam that was administered by adult surgeons on the Board.

DR. BEARDMORE: That’s right. So then we made up the exam for the other pediatric surgeons and we had to decide on people’s eligibility to take that exam. I remember there were quite a few people, more than 200, at the first exam. We were adamant that nobody was going to become a pediatric surgeon without taking an exam. So that’s why the three of us took the preliminary exam.

DR. GROSFELD: The pediatric surgeons were the first group of surgeons that had no grandfather clause?

DR. BEARDMORE: Yes.
DR. GROSFELD: Were pediatric surgeons also the first group that had to recertify.

DR. BEARDMORE: Yes.

DR. GROSFELD: Was that part of the deal with the American Board of Surgery in order to get the certificate?

DR. BEARDMORE: No, I think that was part of the deal that we agreed to. There should be a repeat examination.

DR. GROSFELD: Did recertifying set a new standard for other surgeons?

DR. BEARDMORE: I don’t think I can answer that. Because I don’t think I was ever recertified. Maybe I was.

DR. GROSFELD: Actually, you were in 1982.

DR. BEARDMORE: I was recertified. I don’t remember studying for it.

DR. GROSFELD: [Laughs] That was a landmark event. It was the first group of surgeons to recertify.

DR. BEARDMORE: Well, there is nothing wrong with that.

DR. GROSFELD: I agree, it was a good idea. Actually, your legwork in getting this done helped give pediatric surgery a great deal of credibility among surgeons and even the pediatricians as being recognized as a specialty.

You also served as an associate editor for the Journal of Pediatric Surgery.

DR. BEARDMORE: That’s right. For a number of years.

DR. GROSFELD: Was that a worthwhile endeavor?

DR. BEARDMORE: No, I didn’t like it.

DR. GROSFELD: Did it take too much time away from your practice?
**DR. BEARDMORE:** Partially it did. Partially it was like the minutes of the last meeting, you know what I mean.

**DR. GROSFELD:** The journal has come a long way over the years.

**DR. BEARDMORE:** It has indeed.

**DR. GROSFELD:** And it provides an important opportunity for young pediatric surgeons to publish their materials.

**DR. BEARDMORE:** Yes.

**DR. GROSFELD:** The organization that you developed, CAPS, publishes their papers each year in the journal, as does the American Academy of Pediatrics, and APSA and the Pacific Association [of Pediatric Surgeons] and the British Association. Now you also served as a councilor for the British Association of Paediatric Surgeons.

**DR. BEARDMORE:** I did. I was there a number of years. I was on the council.

**DR. GROSFELD:** Was travel in Europe and Asia, sharing information regarding pediatric surgery, a valuable experience?

**DR. BEARDMORE:** Yes, yes. I got to meet a lot of those surgeons and be cognizant of what they were doing and how they were thinking, which I think was important.

**DR. GROSFELD:** This was a way of sharing knowledge?

**DR. BEARDMORE:** In an informal sort of way. It wasn’t formal sharing of knowledge. And some of it was more into it than just reading papers in the journal.

**DR. GROSFELD:** In general, do you think that pediatric surgeons have a closer camaraderie than other specialties?

**DR. BEARDMORE:** I would hazard a guess and say yes. We did come together. What do you think about that?
DR. GROSFELD: I think there’s a closeness among children’s surgeons because it is still a relatively small specialty compared to others. There is a common bond related to the enjoyment derived from caring for children.

DR. BEARDMORE: The other thing is that the amount of subject matter is smaller than in some other specialties. You know, as a pediatric surgeon, you could sit down and count on your fingers what the important factors are. If you become efficient in one, then that is fine. There isn’t the volume of material in pediatric surgery that comprises general surgery. Do you believe that?

DR. GROSFELD: I think pediatric surgeons in essence are general surgeons. In fact, perhaps we’re the last of the great general surgeons in that we still have an expanded capability of performing many different procedures.

DR. BEARDMORE: You don’t have to stay in the chest.

DR. GROSFELD: Right. Trauma, thoracic, abdominal. Cancer surgery. Sort of the man for all seasons if you will. Do you think that is one of the things that attracts young people to enter the field?

DR. BEARDMORE: You mean if they enter the field they are not far away from what’s in the field.

DR. GROSFELD: Well, they have an opportunity to do a broad number of procedures.

DR. BEARDMORE: Yes, it is not regional.

DR. GROSFELD: Where do you see the future of children’s surgery going?

DR. BEARDMORE: Well, I’d like to say that I’d like to see the development of a department of pediatric surgery for our children’s hospital, with a very large population area. Then I’d like to see that the surgeons that are going to look after them are well trained and experienced in the area of pediatrics. So that you not only have a pediatric surgeon, but you have a pediatrician that is involved.

DR. GROSFELD: Were there any special events that occurred in your experience as a pediatric surgeon that stand out?
DR. BEARDMORE: Well, I think I can remember the first baby with an esophageal atresia with tracheoesophageal fistula that didn’t die on the seventh or eighth day of life. It wasn’t really due to the surgery; it was due to the care that the patient had. I can’t think of anything that was done by a pediatric surgeon that was a monumental feat, can you?

DR. GROSFELD: I think the improvement in the survival of the babies with various different surgical anomalies and acquired conditions has been remarkable over the years.

DR. BEARDMORE: Because?

DR. GROSFELD: Because of improved surgical technique and anesthesia and neonatal care. A whole variety of factors enter into it.

Over the years because of your extensive experience and travel, were there occasional instances that you remember that bring you specific joy in your profession? Like visiting any specific person or particular area that you can remember, some unusually pleasant event in your experience?

DR. BEARDMORE: Well, I can remember the operations that were popularized in certain countries. Like [Franco] Soave for example.

DR. GROSFELD: Did you visit with Professor Soave in Genoa?

DR. BEARDMORE: Did I visit with him? Oh, I knew him well. He stayed with me. I knew a lot of those people on a personal basis.

Sometimes we traveled with a group of surgeons. Seven of us, together from six or seven countries. And each of us had our own little thing to do. In many of those countries, pediatric surgery was done by the general surgeons and it was only later on that people got involved in children’s hospitals where there was a very cohesive group of pediatric surgeons that worked together. I remember how the American Academy of Pediatrics was. We always used to try to have one pediatric surgery case on the program, on the pediatric program. I mean, somebody would go to a meeting of the American Academy of Pediatrics and we would try to have one correlated pediatric surgical paper on the program. And I think that was very important, because it opened the eyes of a lot of pediatricians to what sort of surgery was going on. I once met a surgeon who was glowing. He shook hands with me. He said that he just operated on a baby, and I’ve forgotten what the
condition was. He said the reason he had done it was because I had lectured on this subject and he had written notes at my lecture longhand and he took them to the operating room and he did the procedure step-by-step and the baby lived.

DR. GROSFELD: That is very gratifying, isn’t it?

DR. BEARDMORE: Well, I thought he was very brave to do it. I guess he didn’t have any choice. It was necessity being the mother of invention.

I remember I did all my own slides. I can remember doing a series of slides on a pediatric surgical operation and then for about five years I saw people giving lectures using my slides. [Laughs] They were good slides.

DR. GROSFELD: Of all the people that you trained at the Montreal Children’s Hospital, which of your former residents stand out as being exceptional.

DR. BEARDMORE: Well I think the one that has gone the farthest on the least training is Bradley Rodgers. He got thrown off the program, you know. He had a fight with somebody who was his boss. He was one year shy of being recognized as fully trained. He came to my office and we had a talk and I sent him across the hall to see Herb Owen and when he came back I gave him a job. He did the second year with us and he’s never looked back. He is the president of everything and he’s the chief of his hospital. Do you know him?

DR. GROSFELD: Very well. He is a fine pediatric surgeon. Are there any others that stand out in your mind?

DR. BEARDMORE: Well, there are a couple at the University of Toronto, Hospital for Sick Children that spent time here. There is a whole group of general surgery residents at McGill. We had a training program in general surgery and during the program there were some surgeons that spent a three or four month rotation with me, away from the general surgery training. So I think they had a good start, because there were a few of them that stayed with pediatric surgery.

DR. GROSFELD: Is there a good relationship between the two children’s hospitals in Montreal?
DR. BEARDMORE: Yes, as a matter of fact, my relationship, my personal relationship with the other hospital was very good and at one point I used to phone up and ask if I could bring somebody to visit. That was very much what St. Justine’s needed, although I never operated in that hospital. But I took many of my overseas visitors there because it was a marvelous hospital physically. It is a good hospital. Physically it is a good hospital.

In regard to the American Board of Surgery, I got a little upset with the approaches that various people took to make pediatric surgery a certified specialty. I’d go and ask somebody about it and somebody would say no and that would be the end of the negotiations for a while. And in those days I was doing quite a bit of traveling, as a visiting professor to various areas. When I went to various areas, I would stay an extra day to discuss with people about the possibility of working with them until I had everybody that was important on the Board in favor of certification except one. Eventually he considered the situation very satisfactory as far as he was concerned and he wanted to support pediatric surgery certification. It took two years to get it accomplished.

DR. GROSFELD: Which individuals on the Board were most helpful in getting this accomplished?

DR. BEARDMORE: Oh, your friend who was secretary of the Board of Surgery.

DR. GROSFELD: General Jim Humphries? He was a good guy.

DR. BEARDMORE: He and I got along very well and he facilitated things as best he could.

DR. GROSFELD: Well, there is a new generation of young pediatric surgeons that sort of filled the gap.

DR. BEARDMORE: Sometimes there is a little help.

DR. GROSFELD: The young people today have to learn an expanded fund of new information.

DR. BEARDMORE: I can remember those early meetings of the surgical section of the Academy and how exciting it was to hear the news of new
approaches and new operations. At the early meetings, you learned more in small groups in your hotel room than you did at the main meeting.

DR. GROSFELD: The discussions often had more depth than the papers.

DR. BEARDMORE: That is true.

DR. GROSFELD: Were there any meetings of the surgical section of the American Academy of Pediatrics that stand out as being special?

DR. BEARDMORE: I can remember that it was a meeting at the University of Pennsylvania and Dr. [C. Everett] Koop was retiring, and I was going to give a speech.

DR. GROSFELD: That was at the time that he was going to leave the children’s hospital and go to Washington to become the Surgeon General?

DR. BEARDMORE: I don’t know. I know an interesting story about Chick. During the war, Chick Koop was never in the army. He had never been resplendent in a uniform. When he was surgeon general he enjoyed wearing his dress uniform.

DR. GROSFELD: He was Surgeon General from 1981 to 1989.

DR. BEARDMORE: It was an appointment that was decided by his wife.

DR. GROSFELD: How would she make that decision?

DR. BEARDMORE: We said, “What’s Chick going to do?” And she said, “Oh, well, I’ll make him surgeon general.”

DR. GROSFELD: Wives can be very influential.

DR. BEARDMORE: I think so.

DR. GROSFELD: Did your wife, Frances, have a great influence on the things you did?

DR. BEARDMORE: She attempted to.
DR. GROSFELD: Other than to take care of Frances, did you stay up here in Morin Heights most of the time or did you stay in Montreal?

DR. BEARDMORE: I stayed up here most of the time. You don’t really appreciate it, if you don’t have the curiosity to look particularly at an iris or a rose or a tulip.

DR. GROSFELD: Do you like gardening, growing flowers? Horticulture?

DR. BEARDMORE: I was also very interested in our vegetable garden because of raspberries; you can sell them in the village. I remember one night we were invited to dinner at a friend’s house and they said, “We have a very special dessert for you tonight.” And it was raspberries. It was raspberries that I had taken from here and sold to the store and she had gone and bought them. Raspberries are a very difficult fruit to keep because of the mold.

DR. GROSFELD: Were you involved in fundraising for the Montreal Children’s Hospital during your tenure there?

DR. BEARDMORE: A little bit of funding. Companies and things like that.

DR. GROSFELD: Was that for resident research?

DR. BEARDMORE: Yes.

DR. GROSFELD: Why did you choose a career where you were a teacher rather than just going out into practice?

DR. BEARDMORE: Well, I think it was something that I did very well and I enjoyed doing it. I think that there were people that I was affixed to that enjoyed it that way as well.

DR. GROSFELD: Did you enjoy teaching more at the bedside or the operating theater?

DR. BEARDMORE: I enjoyed teaching in the operating room, but I also did a lot of teaching at the bedside.

DR. GROSFELD: How many residents did you have on your service at the time when you were most active?
DR. BEARDMORE: Residents that rotated from the general surgery service at the university, they would come and spend three or four months in pediatric surgery as part of their training.

DR. GROSFELD: Dr. Beardmore, what do you think were the most important advances in pediatric surgery during your lifetime aside from the development of pediatric anesthesia?

DR. BEARDMORE: Well, that’s just what I was going to say, pediatric anesthesia.

DR. GROSFELD: You had mentioned that when we talked yesterday. But on the surgical side of things which areas did you think have been the most impressive, where improvements have been made.

DR. BEARDMORE: Cardiac surgery has come a long way.

DR. GROSFELD: Do you think the neonatal care is better?

DR. BEARDMORE: Yes, I do, from two points of view. One, that there are people now who are neonatologists, who spend most of their time with neonates. Also, a segment of nursing, which has improved greatly. The NICU nurses are well trained to better care for neonates.

DR. GROSFELD: When you began your practice, most babies that weighed less than 1500 grams used to die if they had a congenital anomaly. Now, there has been a big change in the survivorship of even the tiniest premies. Do you find that a remarkable change?

DR. BEARDMORE: Well, I do in a way, because there are the mechanical modalities that make looking after them better, easier. And there are nurses who look after newborns better than they used to be looked after.

DR. GROSFELD: Dr. Beardmore, you had a very big family. What did your children think about your profession and the time you spent away from home taking care of other children?

DR. BEARDMORE: Well, I think they were very sympathetic, very sympathetic. I think it was easier for them because I had a big family. You know, when I wasn’t there there was always somebody else around. I used to
have an hour drive up here. My family moved up here to Morin Heights for the whole summer and I used to commute so I could see them. They had friends, too. So I don’t think they felt deprived of my presence in any way.

DR. GROSFELD: Well, I’m sure they were very proud of you and all your accomplishments.

DR. BEARDMORE: If they knew of any. I don’t know the definition of accomplishment. You don’t think I accomplished a lot, do you?

DR. GROSFELD: Well, I certainly think you accomplished a great deal. That’s why we’re here interviewing you. All the accolades you have received for what you’ve done for pediatric surgery in the past certainly attest to the fact that you are a very accomplished person.

DR. BEARDMORE: Well, it is nice of you to say so. But I don’t think my children ever thought of that because I was never advertised at home.

DR. GROSFELD: Where do you see the future of children’s surgical care heading?

DR. BEARDMORE: I think there will, hopefully, be a saturation where every facility that is capable of looking after children will be occupied by people who are specialists in the field and that more and more children will be better looked after when we have more children’s hospitals.

DR. GROSFELD: What would you say would be the number of children that you need for a pediatric surgeon to maintain a high level of expertise and have enough work to do?

DR. BEARDMORE: Can you give me the first part of that question again?

DR. GROSFELD: How many children do you need to have in a community to have a pediatric surgeon gain enough experience and do enough work to keep them sharp?

DR. BEARDMORE: Well, I guess you could use Montreal as an example, with two children’s hospitals. Now, I am not sure that if the community wasn’t bilingual, or there weren’t two bilingual universities that we would have or need two children’s hospitals. I’m not sure about that.
DR. GROSFELD: Do you think Canada has enough training programs? You currently have seven.

DR. BEARDMORE: Well, I think it’s a better thing to have young surgeons who are interested in pediatric surgery vying for training positions than to have so many positions that they just take any one into the service.

DR. GROSFELD: Do you need to have a huge population base to have enough patients and work for training young people?

DR. BEARDMORE: Oh, I think so. Otherwise, there are fewer and fewer patients.

DR. GROSFELD: I think you need a good population center. At one time, we believed you needed one pediatric surgeon per million people to have enough newborns to satisfy the needs of that person maintaining their skills. But if you had one pediatric surgeon, you needed two because one person couldn’t work every day. That brought it down to 500,000 people. More recently, this has been reduced to about 350,000 people. If you need one pediatric surgeon per 350,000 population, you could calculate how many surgeons you would need based on the population of the country. But it isn’t always that simple because of the different concentration of people in big cities as compared to rural areas. Does that allow people in rural areas to have the same access to care?

DR. BEARDMORE: You don’t think the people in your rural areas have the same?

DR. GROSFELD: They don’t have it in their local environment. They would have to be referred and travel to a major center to get the same level of care.

DR. BEARDMORE: Transportation is so improved that I don’t think that is a big deterrent.

DR. GROSFELD: Even in a big country like Canada where the major cities are pretty spread out?

DR. BEARDMORE: Yes. The transportation between those cities is good. There is a group of accomplished pediatric surgeons and now that small group is spreading out peripherally and there are more people doing
pediatric surgery. Instead of being congregated in one area those surgeons have forayed out and are doing surgery in different areas.

DR. GROSFELD: There are more pediatric surgeons available to the public in more areas of the country than there were in past years?

DR. BEARDMORE: Oh, yes.

DR. GROSFELD: That would provide better care to more children in a more convenient manner for the families.

DR. BEARDMORE: Oh, that’s one of the big things. You can’t take parents that far away from not only the patient but also the other children in the family.

DR. GROSFELD: Have you performed endoscopic procedures on children?

DR. BEARDMORE: It was done mostly by ENTs. The general pediatric surgeons never really did endoscopy except for removal of foreign bodies or something like that. We have always had a very active ear, nose and throat division. Most of the endoscopy was done early on by ENTs.

Our ENT department had always been in conjunction with the Royal Victoria Hospital so that most of the endoscopies were done by ENT surgeons who were on our staff but who came from Royal Victoria.

DR. GROSFELD: What about the radiology department? Have there been major changes in the way children are imaged today?

DR. BEARDMORE: Well, the x-ray department, I think now is comprised of about five or six radiologists. In addition to doing x-ray examinations, x-ray guided procedures are done also. So it’s a very active department.

DR. GROSFELD: Do you think there has been a big change in the nursing care of the babies at your hospital?

DR. BEARDMORE: Oh, yes, I do. I think we have very well trained nurses. And the best-trained nurses are the ones that look after the smaller babies. We have different wards with ENT and other children that are looked after by the ear, nose and throat department.
DR. GROSFELD: If you had this all to start over again and you were a medical student and you were looking to pursue a career, would you still make the same choices that you made years ago.

DR. BEARDMORE: Well, years ago I didn’t make the choice. Because I had been overseas with an infantry regiment and when I came back, Dr. Ross, who was the chief, stayed on an extra year so that I could have exposure to pediatric surgery. Before he gave up his post, I had been posted there so that I was very fortunate from that point of view. But I was a veteran of World War II and at that time there was some sympathy, or some empathy, for people who were coming back. I really had a spot there that was saved for me.

DR. GROSFELD: Dr. Beardmore, we’ve asked you a lot of questions over the past couple of days and I just want to say how much I appreciated your very kind hospitality and your willingness to discuss your background with us. You gave us insight into your illustrious career and background information about all the major contributions that you’ve made to the field of pediatric surgery and pediatrics in general. We’re very grateful to have had this opportunity to have you share this with us.

DR. BEARDMORE: Did I do that?

DR. GROSFELD: Yes, you did. We thank you very much for bearing with us and sharing your life history with us.

DR. BEARDMORE: Well, it’s been all my pleasure. It was easier for me to have someone listen to me.

DR. GROSFELD: That was my pleasure. Thank you very much.
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CURRICULUM VITAE

Harvey E. Beardmore

Date: August, 1984

Office Address: The Montreal Children’s Hospital,
2300 Tupper St., Suite C-1137,
Montreal, Quebec H3H 1P3

Date of Birth: February 4th, 1921
Place of Birth: Windsor, Ontario
Marital Status: Married – 1945 – Frances Seymour Barnes
Children: Richard Murdoch, 1946
          Ann Elizabeth, 1948
          Patricia Louise, 1949
          Ian Harold, 1953
          Carol Harvey, 1955
          Diane Frances, 1959

Education: Primary education – public schools,
            Walkerville, Ont.
            1946 B.Sc. McGill University,
            Montreal, Quebec
            1948 M.D., C.M. McGill University,
            Montreal, Quebec

Other Degrees: 1953 – F.R.C.S. (C)
                1953 – C.S.P.Q.
                1955 – F.A.A.P.
                1958 – F.A.C.S.

Hospital Residencies and Postgraduate Study:

1948-49 General Rotating Internship,
        Montreal General Hospital, Montreal
1949-50 Senior Intern Surgery,
        Queen Mary Veterans’ Hospital, Montreal
1950-51 Senior Assistant Resident Surgery,
        Queen Mary Veterans’ Hospital, Montreal
1951-52  Teaching Fellow, Dept. of Pathology,  
           Tufts College Medical School
1952-54  Chief Surgical Resident,  
           Children’s Memorial Hospital, Montreal

Licenses to Practice:  1949 – Medical Council of Canada
                       1949 - Quebec College of Physicians and Surgeons

Practice:  Pediatric Surgery – July 1, 1954 to date

Teaching Appointments:

1954-57  Hosmer Teaching Fellow, Department of Surgery,  
         McGill University
1955-62  Demonstrator, Dept. of Surgery, McGill University
1960-68  Annual Lecturer – Pediatric Surgery, Surgical  
         Fellowship Course
1962-67  Lecturer, Department of Surgery, McGill University
1967-72  Assistant Professor, Dept. of Surgery, McGill University
1972-    Associate Professor, Dept. of Surgery, McGill University

Hospital Staff Appointments:

1954  Clinical Assistant – Dept. of Surgery, Children’s  
      Memorial Hospital
1956  Assistant Surgeon – Dept. of Surgery, Montreal  
      Children’s Hospital
1956-70  Member, Advisory & Co-Ordinating Committee for  
         Research, Montreal Children’s Hospital
1958  Associate Surgeon – Dept. of Surgery, Montreal  
      Children’s Hospital
1960-70  Chairman – Post Graduate Committee, Montreal  
         Children’s Hospital
1960-70  Member, Committee on Continuing Medical Education,  
         Faculty McGill University
1970  Member, Committee on Perinatal Mortality, Montreal  
      Children’s Hospital

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1970  Member, Executive Committee, Medical Board, Montreal Children’s Hospital
1970  Member, Post-Graduate Committee, Montreal Children’s Hospital
1974-81 Training Director, Post-Graduate Course, Pediatric General Surgery

Specialty Board:

1953 Certified Specialist – Royal College of Physicians & Surgeons of Canada (General Hospital)
1953 Certified Specialist – College of Physicians & Surgeons of Prov. Quebec
1974 Certified for Special Competence in Pediatric Surgery – American Board of Surgery
1976 Certified for Special Competence in Pediatric General Surgery, The Royal College of Physicians and Surgeons of Canada
1982 Re-certified for Special Competence in Pediatric Surgery – American Board of Surgery

War Service:

1943-45 Infantry Platoon Commander – Princess Patricia’s Canadian Light Infantry – Italy and N.W. Europe, Rank – Lieut.
1949-59 R.C.A.M.C. (Reserve of Active Officers), Rank – Capt.
1959-date R.C.A.M.C. Supplementary Reserve, Rank – Capt.

Appointments:

1963- North American Vice President, Pan American Medical Association (Pediatric Surgery)
1966-72 Elected to Membership of Executive Committee of Surgical Section of American Academy of Pediatrics
1967-73 President (Founding) Canadian Association of Pediatric Surgeons
1968-75 Member, Editorial Board of the Journal of Pediatric Surgery
1969-71 Chairman, Section on Surgery, American Academic of Pediatrics
1969-73 Member, Advisory Council on Pediatric Surgery of the American College of Surgeons
1970-73 Member of Council, British Association of Pediatric Surgeons
1972 Member of the Executive, Panamerican Association of Pediatric Surgeons
1957-60 & 1973-76 Trustee, Montreal Medico-Chirurgical Society
1973-74 President-Elect, American Pediatric Surgical Association
1973-79 Member, Committee for Pediatric Surgery of the American Board of Surgery
1974-75 President, American Pediatric Surgical Assoc.
1974-77 President, World Federation of Associations of Pediatric Surgeons
1977 Honorary Texas Citizen, August 15, 1977
1977 Chairman, Training Program, Pediatric Surgery, McGill University, Postgraduate Medical Education
1975- Member of Pediatric Surgery Committee, Royal College of Physicians & Surgeons of Canada
1979- Senior Member, American Board of Surgery
1980 Member, The McGill Cancer Centre, Committee on Pediatric Surgery
1980 Chairman, Committee World Federation of Associations of Pediatric Surgeons Interaction Between Developed and Developing Countries
1980 Surgical Representative, Southwest Oncology Group
1976 Member, Advisory Council for Pediatric Surgery to the International Pediatric Association
1980-81 Member, Executive Committee, Ascension Fish & Game Club
1981-84 Vice-President, Ascension Fish & Game Club
1984 Associate Editor, Journal of Pediatric Surgery

Medical Societies:

1. Beta Mu Medical Society, 1948
2. Medical Council of Canada, 1949
3. Member, Canadian Medical Association, 1949
4. Fellow, Royal College of Physicians & Surgeons, 1953
5. Member, College of Physicians & Surgeons, Province of Quebec, 1954
6. Fellow, American Academy of Pediatrics (Surgical Section), 1955
7. Member, Interurban Surgical Society, 1956
8. Member, Montreal Medico-Chirurgical Society, 1957
9. Fellow, American College of Surgeons, 1958
10. Overseas Member, British Association of Pediatric Surgeons, 1958
11. Canadian Paediatric Society, 1959
12. Association of Surgeons of the Province of Quebec, 1961
13. Tri-City Committees on Trauma, American College of Surgeons, 1960
14. Pan American Medical Association, 1963
15. New York Academy of Sciences
16. Pediatric Surgical Biology Club, 1966
17. Canadian Association of Paediatric Surgeons, 1967
19. Canadian Association for the Advancement of Health Science, 1968
22. Corresponding Member, Societe Suisse de Chirurgie Infantile, 1971
23. American Trauma Society, 1972
24. Honorary Fellow, Chicago Surgical Society, 1976
25. Honorary Fellow, Texas Pediatric Society, 1977
26. Honorary Member, Brazilian Association of Pediatric surgery (Sociedade Brasileira de Cirurgia Pediatrica), October, 1974
27. Honorary Member, Venezuelan Association of Pediatric Surgeons (Organizado por la Asociacion Venezolana de Cirugia Pediatrica), September, 1978
29. Member, International Paediatric Surgical History Club (IPSHC), July, 1983
30. Life Member, Canadian Paediatric Society, 1984
31. Honorary Member, British Association of Paediatric Surgeons, 1984
32. Honorary Member, Faculty of Chungking Medical College, Peoples Republic of China, November, 1984
Special Honor:

1980       Citation award from Protestant School Board of Greater Montreal
1982       Robert E. Gross Award

Exhibits:


Research Activities:

1. To improve the technique of operating on the unborn fetus of a dog.
2. Intra-abdominal operative interventions on the unborn fetal intestinal tract by ligature deprivation of the blood supply.
3. Vascular deprivation to the intestinal tract of the unborn fetus by the injection of microspheres into the fetal circulation.

Research Appointments:

1. Referee, Research Advisory Committee (Pediatric Surgery), Department of National Health & Welfare, 1966

Clubs:

1. Mount Royal Tennis Club
2. Ascension Fish & Game Club
3. Montreal Badminton and Squash Club
4. Bourbonnais-Kiamika Hunting & Fish Club
5. Chevrier de la Chaine des Rotisseurs
7. Mount Stephen Club
Publications:

1. Transorbital Lobotomy – A Warning. Published in the Canadian Services Medical Journal, October 1950.


Visiting Professor:

2. Visiting Professor of Pediatric Surgery, Babies and Children’s Hospital, Western Reserve University, Cleveland, Ohio, 1966.
4. Visiting Professor of Pediatric Surgery, The Children’s Hospital and the Academy of Medicine of Toledo and Lucas County, December 4, 1968.
5. Visiting Professor of Pediatric Surgery, Milwaukee Children’s Hospital, Milwaukee, Wisconsin, October 25, 1969.
6. Visiting Professor of Pediatric Surgery, Royal Children’s Hospital, Melbourne, Australia, March 11-25, 1970.
7. Visiting Professor of Pediatric Surgery, Children’s Hospital, Athens, Greece, April 2, 1970.
8. Visiting Professor of Pediatric Surgery, Yale University, New Haven, Connecticut, May 7-10, 1970.
10. Visiting Professor of Pediatric Surgery, Tokushima University, Tokushima, Japan, June 8-12, 1972.
13. Visiting Professor of Pediatric Surgery, The Prince of Wales Hospital, Sydney, Australia, October 25, 1972.
15. Visiting Professor of Pediatric Surgery, Mexico City, April 15, 1974.
17. Visiting Professor of Pediatric Surgery, Queen’s Univ., Kingston, Ontario, November 6, 1974.
18. Visiting Professor of Pediatric Surgery, University of Sherbrooke, Quebec, May 1, 1975.
19. Visiting Professor of Pediatric Surgery, Hospital National Security for Children, Mexico City, Mexico, September 13, 1975.
20. Visiting Professor of Pediatric Surgery, University of Venezuela, May 2-9, 1976, Caracas, Venezuela.
24. Visiting Professor of Pediatric Surgery, Norfolk, Virginia, March 11-12, 1982.