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, 2008/2009

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ABOUT THE INTERVIEWER

Richard G. Azizkhan, MD

Richard G. Azizkhan, MD, age 53, is Surgeon-in-Chief and Director, Division of Pediatric General and Thoracic Surgery at Cincinnati Children’s Hospital Medical Center. He is the first occupant of the Lester W. Martin Chair in Pediatric Surgery. Dr. Azizkhan came to Cincinnati Children’s in 1998 after serving as Surgeon-in-Chief and director of the pediatric surgery training program at Children’s Hospital of Buffalo since 1993. From 1985 to 1993 he was chief of pediatric surgery at the University of North Carolina. A graduate of the Pennsylvania State University School of Medicine, Dr. Azizkhan did his postgraduate training at the University of Virginia Medical Center; Children’s Hospital Boston (Harvard Medical School); and Johns Hopkins University Hospital. Dr. Azizkhan has published extensively and is author of more than 150 papers and three books. Dr. Azizkhan’s experience and innovations in the management of complex mediastinal airway disorders, surgical oncology, neonatal anomalies, chest wall deformities, vascular malformations, esophageal disorders and pediatric trauma have led to international recognition and awards. Dr. Azizkhan serves in leadership roles in numerous national surgical organizations including the American Academy of Pediatrics Section on Surgery, American Pediatric Surgical Association and the American College of Surgeons. He has been active in establishing international medical education exchange programs and humanitarian activities in Central Europe, the Middle East, Latin America and Asia.
Interview of Alberto Peña, MD

DR. AZIZKHAN: This is Dr. Richard Azizkhan, the surgeon-in-chief at Cincinnati Children’s Hospital, having the pleasure and honor of interviewing Dr. Alberto Peña, who is professor of surgery and pediatrics at the Cincinnati Children’s Hospital [Medical Center] and the University of Cincinnati College of Medicine. Dr. Peña is also the director of the Colorectal Center here at Cincinnati Children’s Hospital. Today’s date is May 22, 2008. Dr. Dr. Peña and I are having a very nice conversation in my office at Cincinnati Children’s Hospital. Welcome, Dr. Peña.

DR. PEÑA: Thank you.

DR. AZIZKHAN: It’s wonderful to have the opportunity, honor and privilege to speak with you about your background and some of the things that influenced you during your lifetime. So we’ll start with your early childhood. Tell me about your parents and where you were born and the conditions of your early childhood.

DR. PEÑA: I was born in Mexico City [Mexico] on August 16th of 1938, in a private little maternity hospital, in downtown Mexico City. My father was an agricultural engineer. I was number four from my brothers and sisters; we had three previous siblings who died. One four-year-old girl died from typhoid fever; another, two-year-old-child, died from infectious diarrhea; and the third one died from some sort of congenital anomaly. In those years there were no accurate diagnoses and there were no children’s hospitals. There were no antibiotics and no IV [intravenous] fluids. So that happened frequently in all the families. We were five survivors, and I’m number four in that group.

My father worked for the government in different places in the country. He was sent to work on the border of Mexico and the United States in Ciudad Juárez on the border with El Paso, Texas. I was told that we used to cross the border to go shopping to the United States and the immigration officer looked at all of us and looked at me, and said, “He looks very much like an American. He seems to be a gringo,” he said (the immigration officer). Then my family decided to call me “Gringo,” because I have green eyes. I’m the only one in the family. I like to say that they called me “Gringo” so many times that finally one day I decided to emigrate to the United States.

DR. AZIZKHAN: That’s a great story. So tell me a little bit about your schooling and how that influenced you and why you decided to go into medicine.

DR. PEÑA: Well, the first six years of my life, or I mean of elementary school, were kind of rough because my parents were divorced, and we had a difficult life. We were moving from one city to another, so I
almost never finished one year in one school. But I managed to finish elementary school and then high school. When I was about 12 years old, my two sisters met two young men that were finishing medical school at the Military Medical School in Mexico. The Military Medical School had a great reputation in Mexico. It happened to be very selective; it was the best medical school in Mexico. So I met them, and they influenced me very much. That’s when I decided to be a doctor, and to enter the Military Medical School.

DR. AZIZKHAN: So in medical school I know you met a mentor that was very important to you, Dr. Jesús Lozoya [-Solís].

DR. PEÑA: Yes.

DR. AZIZKHAN: Tell me about your relationship with him and how you became interested in pediatrics and pediatric surgery.

DR. PEÑA: During medical school, I was undecided as to what kind of specialty I wanted. I just simply wanted to be a doctor and perhaps to move to a small town in Mexico and practice medicine and surgery, to be a general practitioner or something like that. I did not have a clear idea. But the last year of medical school, we took the subject pediatrics. The professor was Dr. Jesús Lozoya. And Dr. Lozoya was a very prominent person in Mexico. He was a pediatrician in Mexico. In 1939 he went to Boston to see what was happening in pediatric surgery. He met Dr. William [E.] Ladd, spent a few months there; and became a very good friend of Dr. Robert [E.] Gross. Then he went back to Mexico and was one of the founders of the first children’s hospital in Mexico City in 1943. He became the first chief-of-surgery of the Hospital Infantil de México in Mexico City, the old children’s hospital.

He was a military doctor at the same time, so he was a general. He was a very successful businessperson; he was the owner of pharmaceutical laboratories. He was a senator in Mexico for his state of Chihuahua, and eventually became governor of his state. And he was a professor of pediatrics and pediatric surgery at the [Central] Military Hospital. He could have all those titles. So when I took that class, I mean pediatrics, he was the professor. A few months before that, he lost his son who was a medical student. So he created a prize for the best student in his class and every year he gave a medal with the name of his son. In that particular year, 1961, I was the best medical student in pediatrics, and he gave me that medal. That started a relationship that lasted until he died, so he was my mentor in many ways.
He was teaching us both medical and surgical pediatrics. One of his preferred lectures was on intestinal malrotation and the Ladd’s bands, I remember. He used to draw pictures of intestinal rotation anomalies and show photographs of William Ladd and so forth. That’s when I became interested in pediatrics, and of course pediatric surgery was part of that. That’s when I bought my first book of pediatric surgery, the Robert Gross book of pediatric surgery [Surgery of Infancy and Childhood], you remember, written in 1953.

DR. AZIZKHAN: And you still have that book, I understand.

DR. PEÑA: I still have that book, yes.

DR. AZIZKHAN: That’s wonderful. So after you finished medical school, you started your surgical training.

DR. PEÑA: Yes.

DR. AZIZKHAN: At the Central Military Hospital.

DR. PEÑA: In the Military Hospital in Mexico City. Four years of general surgery. When I was a first-year resident, they gave me also an award for the best resident in the department of thoracic surgery (non-cardiac thoracic surgery). Basically it was tuberculosis surgery that we were doing there. We were doing lobectomies and thoracoplasties for tuberculosis. And the award consisted of sending me for one month to Ann Arbor, Michigan, to meet Dr. Cameron Haight. Not because of the esophageal atresia, but because Dr. Cameron Haight trained with John Alexander in Ann Arbor, Michigan and John Alexander was an expert in thoracoplasties. When you resected a lobe, you’re supposed to do a plasty of the chest to avoid over-extension of the remaining lobe. John Alexander was the creator of that.

I was sent there to see those kinds of operations because that was the kind of operation that were done in Mexico. But we didn’t take into consideration the fact that the tuberculosis surgery in the United States was minimum at that time already. In Mexico it was an every day event, but not in the United States. I didn’t know who was Cameron Haight and when I arrived in Ann Arbor, I found that he was the expert in esophageal atresia. During the month that I was there, I watched him do two esophageal atresia cases. Don’t ask me about the details of the technique; you look at those cases with different eyes when you’re young.

DR. AZIZKHAN: Yes.
DR. PEÑA: But it was a very important month in my life, the one that I spent here in Ann Arbor, Michigan (University Hospital). There was no children’s hospital at that time.

DR. AZIZKHAN: Did you have an appreciation that he was doing something extraordinary for children at that time?

DR. PEÑA: Yes. There’s no question that he impressed me when I watched him operating those esophageal atresia cases. And he was very kind, a very nice man. Later he visited us in Mexico City, but of course that was too early in my surgical career. I did not appreciate all that.

Then I finished surgery. And then Dr. Lozoya insisted that in order to be a good pediatric surgeon, you have to be a pediatrician. So I went through two years of medical pediatrics, which, by the way, is not so bad because you learn many things about children.

After that, I finished those six years in Mexico, but I was not happy about my training. So I decided that I wanted to do more, I wanted to come to the United States. I went to Dr. Lozoya, and Dr. Lozoya said, “Okay. Go there for one year and then come back. Just watch and come back.” I said, “No, I want to do more than watching.” Then we had a discussion for about three hours. He didn’t want me to come for more than a year because he said, “If you go for more than a year, you will never come back.” He was very obsessed about that. I wanted to come to the USA for seven years, but then he said, “Okay, go for three years. I will get the permission from the Army, and you go for three years.”

But before that my wife and I went through a very important event, that was the event of my son who was born with biliary atresia. That’s why I decided to become a pediatric surgeon. That was when I was in the second year of surgical residency when my first son was born with biliary atresia.

DR. AZIZKHAN: So when your son was diagnosed with biliary atresia, did you then decide that you wanted to take him to the United States to see if they could do something in Boston?

DR. PEÑA: Yes. I was reading the chapter on biliary atresia from Dr. Robert Gross’ book, and I couldn’t believe what a terrible disease was biliary atresia. When my son was born, he did not look much jaundiced at birth. But after a month he started looking more and more jaundiced. We took him to the old children’s hospital in Mexico City, and they offered to explore him surgically. When we were leaving children’s hospital one afternoon, purely coincidentally, we saw Dr. Lozoya coming to visit the old children’s hospital. He didn’t work there anymore, but he was visiting for
some reason. He saw my wife crying, and he said, “Why are you crying?” She said, “My son has biliary atresia probably.” He said, “If you are not happy here, I can help you to take your son to any other place in the world.” In those years the Soviet Union was supposed to be very advanced in medicine and surgery. We didn’t know that it was all propaganda. You remember those years?

DR. AZIZKHAN: Yes.

DR. PEÑA: Dr. Lozoya said, “You can go to the Soviet Union or you can go to the United States.” And I said, “Well, I’m reading a book of Dr. Robert Gross. Perhaps he could help us.” He said, “Come to my house this afternoon.” So we went to his house. He grabbed the phone, and talked to Dr. Gross. I didn’t know that they were very close friends. So he said, “Bob, I have one of my residents here. He has a son with jaundice, and he would like to go to Children’s Hospital [Boston] in Boston.” Dr. Gross said, “There’s not much that we can offer him.” “But anyway, he wants to go there,” Dr. Lozoya said. So Dr. Lozoya wrote me a check for the airplane tickets for my wife and myself, and he said, “Pay me whenever you want.” I didn’t have any money. He said, “When you arrive in Boston, you ask Bob Gross to help you to get credit from the administration of the hospital so you can pay in installments after the operation.”

So we arrived in Boston, and actually Ms. Jean Lootz was waiting for us at the airport with Dr. Gross’ car. From the airport we went to the Children’s Hospital. Two days later he was operated on. Dr. Gross did a laparotomy. All this was happening before Kasai operations and before liver transplants. In those years surgeons only opened the abdomen in those cases because they said that between one and five percent of the cases could have some sort of biliary obstruction that could be repaired. Dr. Gross opened and found that there was biliary atresia in the way you know it, and there was nothing to do. So he closed the abdomen. He predicted that my son will survive for about nine months. Actually, Gustavo—that’s the name of my son—survived for four and a half years, without any treatment.

DR. AZIZKHAN: That’s amazing.

DR. PEÑA: With no treatment, with nothing. But of course those were four and a half years of suffering, particularly for my wife, because I was in the hospital. Because those children have, as you know, rickets, pathologic fractures, bleedings, all kinds of problems. We were in Boston for ten days. But when I asked for credit to pay in installments, they told me that there was no bill because Dr. Gross took care of everything. So we went back to Mexico without having spent a single cent from that experience.
DR. AZIZKHAN: Amazing.

DR. PEÑA: Dr. Gross and Jean took us to their house for the weekend and took us to restaurants. They were really paternal. They were really very, very good. During the ten days that I was there, I said, “Dr. Gross, can I follow you one day in your daily activities and watch you operating?” He said, “Sure. Come.” So I went with him every morning. In those years he was still surgeon-in-chief. That was before Dr. [M.] Judah Folkman arrived. Anyway, in a typical day he would do an orchiopexy, a Wilms’ tumor, and a tetralogy of Fallot. That’s the kind of activities he would have. So I watched him operating; that was the year 1965.

Dr. Gross was a master surgeon, actually. I came from a hospital where surgery was a rather wild activity. In other words, my professors in Mexico City, some of them were very good; but a typical professor of surgery would scream in the operating room, would swear, would throw instruments on the floor, will curse, will blame the assistant for everything that went wrong. It was a bloody affair. It was very difficult to watch and understand what surgeons were trying to do. So I was not very enthusiastic about doing surgery because I looked into the operative fields, and it was difficult for me to understand what they were doing.

It was watching Dr. Gross operating in those times when I realized that surgery could be nice, elegant, neat, smooth, and efficient. And I really fell in love with that. That’s the particular time when I was “bitten by the spider”—I like to say that—and never recovered from that. And that’s very important because I think that that may happen to everybody. In fact, everybody can tell you something about such an experience. Musicians tell you about that one particular event that changed their lives. From the human point of view, the experience of taking my son to Boston was a unique one. In Boston we met kind people that influenced us a lot. I think that’s part of the key for my success. I have been very successful professionally. But every time I see a young couple coming with a child with a congenital malformation, it reminds me of that experience.

You know, we surgeons and doctors in general have difficult cases, have difficult days. We have serious concerns, sometimes; we become irritable. But, compared with the suffering of the parents of a sick child, that’s nothing actually. So I remember that I promised myself never to respond to any kind of upset parents. Parents sometimes are very angry, they are angry with life because of what’s happened to them. They are angry because they are suffering. But if you have been there, you understand what it’s all about. Our concerns, our everyday troubles as surgeons, are nothing compared with the suffering of the parents. For my wife and I, it was a great human lesson. We met great people. Also, we met people who were not so nice in Mexico.
We were afraid of coming to the United States because we didn’t know much about this country, and it was a great lesson to come. Everybody was so friendly. Dr. Gross told the chief resident Angelo [J. Eraklis] to join us to go to the airport with our son to be sure that everything went well. They gave us bottles of formula for the trip and all that. He was really great. So that was a great experience.

At the same time that that happened, we went to the Baptist Church in Boston, in Brookline, on Sunday. My wife is Baptist. And we decided to go there. The minister of that church, Victor Scalise [Jr.], came to us and said, “What are you doing here in Boston? Where do you come from?” We became immediate friends, a friendship that lasted for life. And the church gave us a check. I said, “Victor, you don’t have to give me a check because we have not spent any money and I’m not even Baptist.” He said, “We know that. But you can buy something.” So we actually went back to Mexico with more money than what we had when we came to the United States. Our last son is a doctor; we called him Victor because of Victor Scalise. Years later, when I was a resident at Children’s Hospital in Boston, Victor Scalise, Jr., and his lovely wife, Mary, were very protective with us. They were our protective angels.

That week in Boston was a great experience. It influenced me professionally, from the technical point of view, to see the relationships between Dr. Gross and his scrub nurse; they didn’t even talk. Things went like in a concert. Their movements were precise. It was beautiful, it was smooth. It was nice. So I liked that concept and I liked the idea that I could repeat that and actually it happened. I can tell you stories of traveling to different parts of the world; there are many doctors who watch your operations, and you don’t really make an impact on them. But there are others that you really fall in love with it, and I loved the idea of repeating the same experience in young people. That’s our role, our job actually to do that.

DR. AZIZKHAN: That’s wonderful. When you went back to Mexico with your son and your wife, you continued your surgical training. What was the next step for you? Because you ended up coming back to Boston. Describe to me the next steps.

DR. PEÑA: I was in the second year of residency when my son was born. We went back to Mexico to finish my training. Those were very difficult years because my son was at home sick, and we had another very healthy child. I finished four years of general surgery, plus two years of medical pediatrics, and then I thought about going back to Boston. I sent a letter to Dr. Gross. I just took a piece of paper, and I said, “Dear Dr. Gross, I decided to become a pediatric surgeon. And I decided to train with you.” This is very important I think, because somebody said, “Do you think I can
win the Nobel Prize?" I said, “I don’t know if you can win a Nobel Prize.
But certainly if you don’t believe you can win, you will never win it.” So you
have to be naïve but to believe in something, at least to try.

I didn’t know that Harvard was very competitive. I just said, “Dr. Gross,
I’ve decided to train with you. And in order to do that, I already passed the
ECFMG [Educational Commission for Foreign Medical Graduates
certification]. So tell me when can I go there?” And of course Dr. Lozoya
sent him a letter also. Dr. Gross answered saying, “We’ll be happy to take
you only as research fellow. Now I’m only chief of cardiac surgery, because
now we have a new surgeon in chief which is Dr. Judah Folkman. So I don’t
control the surgical residencies. If you want to come it will be for a research
fellowship in cardiac surgery and only for one year.” I said, “That’s OK. I
accept that.” I had a commitment with the Mexican Army, and they gave me
permission for three years to go to the United States, with a salary of $180.00
per month (Mexican Army salary). I signed to work for six years when I
went back to Mexico to work for the Mexican Army.

My wife was pregnant with our third child, and my son, the child with biliary
atresia, was already four years old and sick. So that was not an easy plan, to
go to the United States. My salary in Boston was going to be like another
$180.00, or something like that. But we decided to go. My wife said, “Sure,
wherever you go.” So we went there. And Victor Scalise, the Baptist
minister, great friend, was taking care of us.

We arrived into Boston in February of 1969. From day one that I arrived
there, I was working in the laboratory. We were doing pulmonary re-
implants. Remove the lung of a dog and put it back in the same dog,
thinking in the future to do lung transplants. And also we were doing aortic-
pulmonary shunts in dogs, because we were trying to calculate what was the
ideal size of the shunt to avoid pulmonary edema and allow oxygenation of
the lungs as a palliative surgery for the newborns. Remember in those years
there was no open-heart surgery in newborns. We were doing palliative
surgery in the hyperbaric chamber in Boston. I was assigned to work with
Dr. [S.] Bert Litwin, cardiac surgeon from the Mass [Massachusetts] General
Hospital, who was working with Dr. Gross. They gave me privileges to scrub
in the hyperbaric chamber every time a resident could not take the high
pressure of the chamber. I was always there in no time, and I’d scrub with
Bert Litwin. He was a great surgeon, very meticulous. We were doing
shunts, creating atrial septum defects for transposition of the great vessels,
bandings of the pulmonary artery for VSDs [ventricular septal defects].
That was a great experience.

The director of the training program was Dr. Robert [M.] Filler. Dr. Judah
Folkman was the chief of surgery; Dr. Folkman was very busy between his
laboratory and clinical practice. He used to make rounds with us every week. Every day I’d finish my activities at the laboratory and run to watch in the operating room and to make rounds, particularly with Dr. Folkman. That was such an inspiring experience, to make rounds with him. I was telling everybody that I wanted to be a surgical resident naturally. But there were no positions available.

Then came the Vietnam War, and a couple of junior residents were drafted. The junior residents in those years were surgical residents from the [Peter Bent] Brigham [Hospital] that rotated one entire year as a junior resident of Boston Children’s Hospital. It was a great experience, one year of pure pediatric surgery. So there was a space for me. I already had eight months of research, so I didn’t finish the year of research. Dr. Robert Filler said to me, “Do you want to be a junior?” I said, “Sure. I would like to be.” He said, “But only one year.” I said, “That’s okay. I’ll take one.” I took that year, and finally I started operating there. That was a great experience.

Then happened something with no precedent: There was a young fellow in pediatric surgery, when he was in his first year, he had 15 more months to go as a fellow, and he was not feeling well. He got a chest film that showed a lung cavity from tuberculosis. He couldn’t finish his training and they asked me if I wanted to take his place for 15 more months. And that’s exactly what happened. My colleagues made jokes; they said that during the night when the fellow was sleeping, I put some tuberculosis bacilli from Mexico in his trachea. [Laughter] Unfortunately, he never became a pediatric surgeon.

DR. AZIZKHAN: That’s unfortunate.

DR. PEÑA: I met him a few times in the American College of Surgeons. That was a very sad and unique situation for him, but very fortunate for me. There were 15 months left in his training, and there were 15 months left in my time for the permission that the Army gave me. I was supposed to finish on December 31st of 1971.

DR. AZIZKHAN: So this was fantastic that you were able to do that.

DR. PEÑA: I have friends who are very religious and say, ‘You don’t get it? There was a plan . . . ’

DR. AZIZKHAN: There was a plan.

DR. PEÑA: And I say it’s a lovely idea. It’s really great. But it’s too arrogant to think that way. Certainly it was amazing what happened. My son died in Boston during the first year of the residency. He died in December of 1969. He was almost five years old when he died. And again,
Dr. Gross and Jean were very, very generous with us. When I arrived in the winter (February 1969) in Boston, I didn’t have a coat. Dr. Gross and Jean gave me one. Dr. Gross was a man of very few words. He didn’t talk very much, but he was obsessed about certain things. For instance, our shoes were supposed to be always impeccably white and clean. If they aren’t, he will not talk to you; he will send the secretary to tell you to clean your shoes. One day his secretary said to me, “Dr. Gross says tomorrow be very clean and neat.” So I arrived home, and I told my wife that message. And she said, “Perhaps they are making some sort of inspection. Go and cut your fingernails and cut your hair?”

The next day they called me from the administration. Actually it was to give me an award that they give every year to the best foreign resident at Children’s Hospital. Obviously that was Dr. Gross behind that; you could see that he instrumented that. So Dr. Gross didn’t talk very much, but he was particularly warm with us; he was a very friendly person. In retrospect I believe that he was very shy. We had dinner with him a couple of times and he’d cry when you told him something sentimental. He was considered arrogant among some people, but with us, he was very warm, a very nice person. That’s what I remember about him.

From the purely technical point of view, the most influential person in my training in Boston was Dr. Arnold Colodny. He was a superb surgeon, a low-keyed person, but very solid. Didn’t talk much, but when he talked, people listened to him. He’s the one who said, or used to say, “If you are going to do an operation that is not indicated, you’d better do it right.” [Laughter] He is the person that I remember as the best professor of surgery there from the technical point of view. Taking care of patients, he was also first class. And during the following years, when I went back to Mexico, I used to call him at night to ask him about patients because I knew that his answer was an absolutely mature answer based on his experience. He was a person that one could trust.

DR. AZIZKHAN: He was a unique person. He did both urology as well as general pediatric surgery.

DR. PEÑA: Yes. Yes, that’s right. In Boston also I met another extraordinary person who was one year above me, a fellow in pediatric surgery, Dr. Willis Williams. He finished his training in pediatric surgery, and then he continued in cardiac surgery to become a pediatric cardiac surgeon, become the chief of pediatric cardiac surgery in Atlanta, Georgia, at [Henrietta] Egleston [Hospital for Children] Children’s Hospital. Then he got sick; he’s no longer in practice. But he is a superb human being and a superb surgeon; I learned many things from him. He came from the Massachusetts General Hospital. One day he told me, “Alberto, I want you
to go in the evenings and watch [W.] Hardy Hendren [III] operating at the Massachusetts General Hospital, because you will learn a lot. But don’t tell anybody.” It was a secret because you’re not supposed to talk about Hardy Hendren in Boston Children’s Hospital in those years.

Willis Williams called Hardy Hendren’s secretary and Hardy loved to have the fellows from the Children’s Hospital in Boston come to watch him. And you could watch him at night because he went for hours and hours operating. One could finish at seven pm at Children’s Hospital and take a taxi to the Mass General and watch him. He was very happy to have you there. Actually he was also an excellent surgeon and I learned many things from Hardy Hendren just by watching him.

DR. AZIZKHAN: Did you have any inkling that the things that you were seeing Hardy Hendren doing would end up influencing you later with the development of the posterior sagittal approach to anorectal malformations?

DR. PEÑA: Hardy was extremely influential in my career. After Boston, I invited him to Mexico to operate: colon interpositions, megaureters, posterior urethral valves, things that he knew how to do. When I started to describe the posterior sagittal approach for anorectal malformations, I was particularly interested in making a movie and traveling to Boston to show that movie to Arnold Colodny and Hardy Hendren, to hear the opinion of these two people. Hardy Hendren was not like Colodny. They were contemporaries. Hardy Hendren, by the way, always listened to Arnold Colodny. When Dr. Colodny talked, everybody listened to him. Arnold Colodny was less passionate and more mature in his judgments.

In 1981, I made a special trip, went to the Massachusetts General Hospital to show Hardy Hendren a movie, a Super 8 movie film, a homemade movie, and my slides. I was afraid that perhaps Hardy would watch that and would immediately start lecturing me as to how to do those operations. Rather than that, he remained quiet. He said, “Show me more of that.” He spent two hours just watching what I was showing. At the end, he said, “Alberto, this is the approach for the future.” And he said, “But it’s going to take you at least eight years to introduce this into the pediatric surgical community.”

DR. AZIZKHAN: And what year was that?

DR. PEÑA: That was 1981. And I said, “But why eight years?” He said, “Because it takes a long time to convince people to change. And that is,” he said, “provided you use real good audiovisual materials, not this garbage that you have.” [Laughter] Arnold Colodny invited me to Boston to operate a case using the posterior approach, and to give grand rounds. That was ten years after I left Boston. That was very important for me to go back
to Boston Children’s Hospital, invited by Dr. Colodny. And at the same time I went to visit Hardy Hendren.

When I left Mexico City, I was a military doctor and was supposed to go back to work at the Military Hospital for six years after Boston. That was specified in a contract that I signed before going to Boston in 1969. The Military Hospital in Mexico City had a department of pediatric surgery with six pediatric surgeons older than me. We’re talking about six pediatric surgeons in a department that could be run by American standards now by two pediatric surgeons. That would be more than enough for that little department of pediatric surgery. But they had six and older than me. And seniority in the Army means a lot.

DR. AZIZKHAN: Means something?

DR. PEÑA: Meant you have to wait until everybody dies before they let you do something. So that was my future going back to Mexico. In those years, the Mexican government was talking about building a brand new children’s hospital, called the [National] Institute of Pediatrics. During the three years that I was in Boston, they built the new Institute of Pediatrics. So I’m supposed to go back to Mexico on January 1st of 1972. But in October of 1971, I was making rounds in Boston and my beeper sounded. I answered it. It was a phone call from Mexico City. The general director of the new children’s hospital—the hospital just was inaugurated—was calling. The president’s wife in Mexico was traditionally in charge of protecting the Mexican children, and that included being the benefactor of the new hospital. So they said, “Are you Dr. Dr. Peña? We want to invite you to become the chief of surgery of the new children’s hospital.”

DR. AZIZKHAN: I bet that was a total surprise.

DR. PEÑA: Oh, I was shocked. And I said, “But you must understand that I’m a military doctor, and I have an obligation with the Army.” They said, “Don’t worry. We’ll take care of that.” That was the answer. We were talking about the president’s wife, a very powerful person in Mexico. I felt morally obligated with the Military Hospital, my alma mater. But I thought about that, and I said, “This is an opportunity that I cannot let go.” So I accepted. My last day as a resident in Boston was December 30th. And on January 2nd I was chief of surgery at the new Institute of Pediatrics in Mexico City. The equipment was fantastic. It was like a dream. We had more Storz equipment than in Boston. It was really amazing. The president’s wife walked through the hospital every week, surrounded by all her assistants. She loved the hospital; she observed, “Clean here, clean this, repair that.” So the hospital was impeccable. When we went to a national medical meeting in Mexico, we traveled in the
presidential plane. Every year we had breakfast in the presidential house. We were spoiled. It was really fantastic.

But then the military doctors got upset because I was only working at the Institute of Pediatrics. They complained to the secretary of defense about this. They had discussions about me and finally they decided that I was going to be from seven am to eleven am at the Military Hospital. The rest of the time after that, I will work at the Institute of Pediatrics. I spent seven years doing that, going from one place to another. Suddenly, all the pediatric surgeons in the military retired, so I became the chief of pediatric surgery at the Military Hospital also.

DR. AZIZKHAN: So you had two institutions to manage. [Laughter]

DR. PEÑA: I had two institutions. I had my lunch in a little Volkswagen driving from one place to another at noontime. But anyway it was a great time because at the Institute of Pediatrics I was the chief, and I worked with young people. There were no senior people interfering with what I was doing. It was a great experience.

I designed a master plan and talked to my young attending pediatric surgeons at the Institute of Pediatrics and told them, “We are the Institute of Pediatrics. We are supposed to be the leaders in pediatric surgery in Mexico. Therefore, in order to be the leaders, I think each one of us should take an area of special interest in pediatric surgery. That is the only way to make a contribution and really progress. If each one of us tries to be good in everything, we’ll not achieve anything. Tell me which areas you want. And whatever you don’t take, I will take.”

They didn’t take anorectal malformation. Anorectal malformations, I think, is an area that has never been elegant. In addition, the results of our treatments, in terms of bowel control were very bad. Most patients suffered from fecal incontinence. I suppose that’s the reason why very few surgeons were interested in that field. I also believe that that’s one of the reasons why there is not much science being applied to that particular area. If you think of how much science has been applied into cancer and prenatal medicine, and almost no scientific work on anorectal malformations. That’s bad, of course, but that also represents an opportunity to make a contribution in a relatively easy way. Because just by putting attention and working a little bit more, with dedication, it could be very rewarding.

DR. AZIZKHAN: So how long after you became the chief did you then start working on the anorectal malformations area as your focus?
DR. PEÑA: When I was in Boston Children’s Hospital, we received a fellow from Melbourne, Australia. His name is Justin Kelly. He was trained by Dr. [F. Douglas] Stephens and Dr. [E.] Durham Smith. In Melbourne, they had a very strong training in anatomy and embryology in those days because Dr. Stephens was very much like an embryologist.

Justin Kelly came as a fellow, for two years of fellowship in Boston. The ideas of Dr. Stephens in those years were not well known in the United States. Dr. Stephens was beginning to talk about the puborectalis muscle and the sacral approach. Dr. Justin Kelly, as a fellow, lectured to the professors in Boston about the anatomy of the puborectalis muscle. I learned from him the approach that Dr. Stephens was using. The great thing about Dr. Stephens is that he is the person that for the first time decided to study cadavers of children born with anorectal malformations to see the anatomy of the malformation and to compare with the normal anatomy, which is a natural step in the study of all congenital anomalies.

If you heard Dr. Robert Gross talking about the process of performing the first patent ductus arteriosus repair. First he spent a year in pathology. I think the pathologist was Dr. [S. Burt] Wolbach. Dr. Gross always said that year in the pathology department was very important in his life. Children came for autopsies. He opened the chest and found the patent ductus arteriosus. And he knew the normal anatomy, so he conceived the idea of ligating the patent ductus arteriosus for the first time. The history of the surgical treatment of most congenital malformations includes the knowledge of the abnormal anatomy being compared with the normal anatomy. Then one bold, ambitious surgeon conceived the idea of the surgical repair, and tried. Many tried; but the one who succeeded became famous, the next day. So that was usually the situation.

In anorectal malformation, something was missing. For many years we were operating on those children without knowing their internal anatomy!! One cannot find in the literature accurate descriptions of how the urogenital tract and the rectum join. There are no anatomic descriptions. Look at the diagrams from those years, and there’s no description of the muscle anatomy in the drawings. There are only drawings, never photographs. When we operated through the abdomen, by the time that we tried to reach the pelvis, the exposure became very poor. If one went from below, by the time that we reached the crucial anatomic area, it was very difficult to see the anatomy of the junction of rectum with the urogenital tract.

Trying to study the intrinsic anatomy of these patients, Dr. Stephens managed to dissect 12 cadavers, which was great. But I think that the conclusions that he reached, based on those studies, are not valid. The reason for that is because those 12 cadavers are not representatives of what
we call the spectrum of anorectal malformations. Those patients who die with anorectal malformations are the patients which have the worst defects. Fortunately, most patients born with anorectal malformations have what we call benign anatomy, meaning that we can reconstruct them and have good functional results. Most of these patients do not die.

DR. AZIZKHAN: Right.

DR. PEÑA: Dr. Stephens concluded from his studies in cadavers that there was no sphincter in these babies other than the so-called puborectalis sling, which may be true for the very worst cases. That was his conclusion. By the way, he was kind enough to give me the pictures of his dissections. He deserves great praise because he was the first person who studied the anatomy of these patients. Dr. Stephens said that in order to use the puborectalis muscle, we have to operate on these babies face down (prone position). Put a metallic sound in the urethra. Make a small incision below the coccyx. Then, with a right-angle clamp, make a tunnel behind the urethra. And through that tunnel pass the rectum to “preserve the puborectalis.” But all that was blind. And that’s what Dr. Justin Kelly explained to us. That’s what I and many surgeons in Boston learned from him. When I went back to Mexico, I decided to do exactly the same. Dr. [William B.] Kiesewetter at [Children’s Hospital of] Pittsburgh, embraced the ideas of Dr. Stephens, and designed the sacral abdominoperineal pull-through. In 1972, I went back to Mexico, and as I said, because my attendings were not interested in anorectal malformations, I started taking care of all patients with anorectal malformations, following Dr. Stephens and Kiesewetter principles.

Eight years I worked that way. In those eight years I accumulated 56 of the so-called “high anorectal malformations.” During the first four years, 80 percent of the time we had to open the abdomen to complete the repair. But during those eight years I started making a longer sacral incision, in order to expose better the anatomy. Then I decided to use an electrical stimulator in order to identify better the sphincter mechanism, and I saw muscle contracting. I remember seeing a muscle contracting and I said, “Oh! That’s the puborectalis.” In order to see more, I decided to cut part of that muscle. The longer incision and dividing those muscles, made the operation much easier. During the following four years, I noticed that I have to open the abdomen only 20 percent of the times. (At present time, we only need to open the abdomen 10 percent of the time.)

DR. AZIZKHAN: That is interesting!

DR. PEÑA: I was learning how to do the operation better. So I decided that I was ready to present my experience in one of the international
meetings. That was 1980. I had eight years of experience, gradually modifying the Stephens approach.

DR. AZIZKHAN: When did you meet Pieter [A.] DeVries?

DR. PEÑA: Well, I went to the meeting of the Pacific Association of Pediatric Surgeons in Colorado Springs, March of 1980, to present my 56 cases. Dr. Durham Smith from Melbourne, Australia was in that meeting. Stephens was not there. Dr. Pieter DeVries was there; he was from Sacramento, California. I presented my paper and a movie, and Durham Smith was very critical about it. He said that what I was showing in the movie was not the puborectalis muscle because, he said, the puborectalis was located too deep, and couldn’t be seen with my approach. I couldn’t argue with him; he was supposed to be the expert in that. Then we went for a tour to the Air Force Academy in Colorado Springs. In the bus, I was sitting next to Dr. Pieter DeVries. He was very friendly, and he and I started having a conversation.

During the two days following my presentation, I was irritated, excited, and upset with the comments of Dr. Durham Smith. I thought, “If nobody has seen the puborectalis, why are we talking about it? I am going back to Mexico, and I’m going to extend my incision. I’m going to open from the middle portion of the sacrum all the way down to the scrotum. I will use an electrical stimulator to identify the muscles better. I will take pictures, and I will be able to discuss the subject.” I was telling everybody what I was planning to do, including Dr. DeVries. When I talked to other doctors, they were not enthusiastic about what I was planning. They just ignored me. But Dr. DeVries said, “That’s interesting. I think that’s a good idea.” I said, “Would you like to come to Mexico?” Pieter DeVries said, “I would like to come.” I said, “Okay, you are invited.”

All this happened in March of 1980. I went back to Mexico. And on August 10th of 1980, Dr. [M.] Vargas, one of my attendings, and myself, opened the first patient posterior sagitally, in Mexico City at the National Institute for Pediatrics. In September Pieter DeVries arrived as a visitor. Why in September? Because in that month we celebrated the World Symposium of Pediatric Surgery in Acapulco. That symposium was the first step toward the World Federation of Associations of Pediatric Surgeons, and Dr. Lozoya was one of the founders of that federation.

DR. AZIZKHAN: Right.

DR. PEÑA: So I went to Acapulco, Dr. Stephens and Dr. [H. H.] Nixon from England were invited. There were many doctors there. A few days before, Peter DeVries arrived in Mexico. We put together four cases,
and he assisted me in those four operations. We took good pictures. We went to Acapulco; I was included in a roundtable with Dr. Stephens and I was expected to present my experience with those 56 cases, using my modification to Dr. Stephens technique, the same presentation from Colorado Springs. But rather than presenting that, I said, “We want to show you what we just found in Mexico City a few days ago,” and showed the pictures of the anatomy taken in those four cases. I was showing that we could not see anything that looked like the puborectalis. Dr. Stephens didn’t comment anything.

By the way, some of the Mexican colleagues accused me of inviting an American surgeon to do experimental surgery on Mexican children, referring to the fact that Dr. DeVries came to join me. I told that to Pieter and he said, “I invite you to Sacramento.” He was in Sacramento at the time. He said, “I invite a Mexican surgeon to do experimental surgery on American children.” [Laughter] He was just joking, of course. However, I went there, and I assisted him in four cases of imperforate anus repair.

DR. AZIZKHAN: So those are your eight cases together.

DR. PEÑA: That’s right. We presented our experience at the next PAPS [Pacific Association of Pediatric Surgeons] meeting in Hawaii, together. That was in the spring of 1981.

Then came the American Academy of Pediatrics meeting in New Orleans. Again, we presented our experience together. He was operating on some cases, and I was operating many more cases in Mexico. We had many more cases in Mexico of course. But we brought together our collective work and presented that at the American Academy of Pediatrics. The next thing was, unexpectedly, without a notice, he published that experience with his name as the first author. We never discussed that. As a reaction to that, about two months later, I sent another paper to the Journal of Pediatric Surgery that was accepted. In that second paper I’m the first author, and he’s the second author.

DR. AZIZKHAN: I’ve seen that on your curriculum vitae.

DR. PEÑA: Our relationship after that was just cordial. We’d just hello in the meetings, but we stopped working together. We never talk about these things anymore. Then I submitted a paper for presentation to the APSA [American Pediatric Surgical Association] meeting. It was related with the posterior sagittal approach in secondary operations. But I was not aware that he also submitted a paper with the same title. But they [APSA] accepted my paper. They did not accept his paper. [Laughter] That irritated Pieter, and he sent a letter to the directors of the American
Pediatric Surgical Association; not a very flattering letter. But I never talked with him; I never had any more relationship with him. That’s how it happened. During the months that we worked together, we were very friendly because we had a great time talking. However, when we finished our operations, we used to make diagrams. And his diagrams looked different from my diagrams, so there were some differences in our concepts. During the time that we worked together, he was very cordial, we got along very well. But then after that we didn’t work together anymore.

DR. AZIZKHAN: So you were starting to do more and more of these cases. When did Schneider Children’s Hospital approach you to consider coming there?

DR. PEÑA: Remember all this happened in 1980-81. Then I started having invitations to come to operate on children in the United States. One of the first invitations was to San Antonio, Texas. Dr. [Irving A.] Ratner, who was a senior pediatric surgeon invited me. I don’t remember which one was earlier. But Victor [F.] Garcia approached me. He was the chief of surgery at the Walter Reed [General] Hospital. He was a lieutenant colonel in those years, very young. And at one of the APSA meetings when I presented my work, he came to me and asked if I wanted to go there to operate. I did two cases at the Walter Reed Hospital and then I was invited again. I started going to many cities in the United States operating. And then I organized what we called ‘marathons’ of anorectal malformations at the Institute of Pediatrics. I welcomed three, four, five, or six pediatric surgeons from the United States or from Europe who came to watch the operations in Mexico City. It was not the formal course that you know now. It was more informal; we gave them sandwiches, and there were no videos. They had to be watching the operation itself.

The first invitation to come to move to work on a permanent basis in the United States came from Atlanta, Georgia. My friend Willis Williams was the chief of surgery at Egleston. [Richard] Ricketts had just arrived there. There was a private group of pediatric surgeons that invited me there. So I went there with my wife for an interview. They were very nice, and we said, “Yes.” I accepted the job to go there. That was in the fall of 1984, and then came the New Year’s Eve party at home. All my relatives were there. We had drinks, we sang, and I said, “I’m not leaving Mexico.” [Laughter]

DR. AZIZKHAN: You were having too much fun!

DR. PEÑA: I was extremely successful in Mexico. I was successful in private practice. I had the best private practice job; the best pediatricians referred patients to me. I had the best academic job. I couldn’t ask for more in Mexico City. But Mexico City was becoming a difficult city to live in, and to educate children there. It was a beautiful city when I was a child, but it
became too crowded, contaminated, with crime, inflation, and corruption. That was the problem. I spent two hours driving in the big city between the private practice, the Military Hospital, and the Institute of Pediatrics. Because of that, I accepted. But then, during that New Years Eve party I said, “I’m not leaving Mexico City.” So I called my friends in Georgia and said, “I’m sorry for the inconvenience. I’m not leaving. I’m very happy here.” So I stayed there.

Then came an invitation from Hartford, Connecticut, Dr. Donald Hight, my friend, was the one who promoted that. They were just planning to build a children’s hospital there and they invited me to go there. I was seriously considering that, but then I got an invitation from Long Island Jewish Medical Center to operate on a child on Long Island before they finished building Schneider Children’s Hospital. It was just a general hospital. Drs. Burton Bronsther and Martin Abrams invited me. Weeks after that operation, Dr. Martin Abrams came to Mexico to watch some of my operations. Then he went back to Long Island Jewish and suggested the chairman of surgery to invite me there. I went for an interview, and saw Schneider Children’s Hospital, a beautiful, small children’s hospital. They offered to me to be the chief of pediatric surgery and this time I accepted.

My family and I moved in July 1st of 1985 to Long Island. That was really a great decision, because my oldest son was 17 and the youngest was 11. They went to middle and high school there. Subsequently they went to the best universities, and I was able to pay for all that. That was really great. The location of the hospital in New York was excellent to receive patients and visitors from all over the world. And it had the Ronald McDonald House. So it was a great, great time in New York. I appreciate all that very much. Now in retrospect I’d like to say that I didn’t know that Cincinnati Children’s Hospital existed. I didn’t know that there were institutions like this one to compare with. But at that time, coming from Mexico, I thought it was a great honor and privilege to work there. And I had a great time in that place.

DR. AZIZKHAN: So tell me a little bit about your tenure as chief of surgery at Schneider Children’s Hospital and how it was organized, and how you were able to build your international reputation as a master surgeon with this operation, posterior sagittal anorectoplasty?

DR. PEÑA: That’s a very interesting question. When I arrived there, I was the first full-time pediatric surgeon in that hospital. There were ten private pediatric surgeons divided into three groups there; they had their private offices away from the hospital, and they worked in seven different hospitals, including the Schneider. They were fighting between themselves. They thought that the administration and I created a conspiracy to take
patients away from them. As a consequence, every time I operated on a patient, one of them came to look into the chart of my patient to be sure that the patient was not referred by one of the local pediatricians.

It took about two years to convince them that my patients came from other places. Fortunately, I did not move there to operate on hernias referred by local pediatricians. My patients came from all over the world. Once the local pediatric surgeons became convinced of that, then our relationship improved significantly. But at the beginning they were very angry, because they thought that I was going to take patients away from them. When you are a full time surgeon, you’re sitting there all day, and there are patients in the emergency room waiting to be seen by a pediatric surgeon, but it took two hours or three hours for a private pediatric surgeon to come. The residents in desperation sometimes called me to see one of those patients. That led the pediatric surgeons to believe more that there was some sort of conspiracy. But actually there was absolutely nothing like that.

I faced the dilemma of how much time to dedicate to creating a strong department of pediatric surgery, to try to be more selective to determine which pediatric surgeons should work there and try to create high standards for pediatric surgery. How much time to administrate and how much time to dedicate to my own pediatric surgery, more specifically anorectal malformations and colorectal problems. I made a conscious decision to spend more time on my own practice and the development of colorectal pediatric surgery. Perhaps, if you ask the administrators at Long Island Jewish Hospital from that time, they may tell you that I was not very good in the administration, attendance to committees and meetings. There were many political problems. My decision was to concentrate in an activity from which I could obtain palpable, immediate positive dividends and progress. In other words, the leadership of Long Island Jewish could easily find a good administrative oriented pediatric surgeon to try to organize the division better and try to solve the political problems. I believed that it would be far more relevant in the long range to do what I was doing about anorectal malformations. This was a unique opportunity to make a series of contributions that will result in the benefit of many children all over the world. I had a unique opportunity to explore, in depth, one specific area of our specialty, to collect and systematize the largest series of cases of anorectal malformations, to make significant observations and to teach many surgeons.

A similar dilemma and decision I had previously made in Mexico. At some point I was appointed director of the National Institute of Pediatrics in 1980. This happened about the same time as the development of the first posterior sagittal operation. I accepted the job, which was a mistake, but it was a great experience. I accepted the job of director of the hospital. I had an office larger than this with seven phones, with a chauffeur, and three secretaries. I
resigned after a year and a half. Probably if I did not resign, they would have fired me because I was trying to do all the kinds of surgery, to work on anorectal malformations, and at the same time be the director of the hospital. But unfortunately—or fortunately—surgery is, as you know, a very demanding discipline.

There were three significant events that made me resign as the director of the Institute of Pediatrics. One, I remember one afternoon I was sitting in my office, and a first-year surgical resident knocked at the door of the office. The chief resident sent him, inviting me to make rounds with them because “for the last three months, I did not make rounds with them,” with all the residents. He said, “The chief resident sent me to invite you to come and make rounds with us.” I felt very bad. I felt miserable. I immediately went with him, of course. We were walking toward the floor, and he said, “Dr. Peña, I entered to this hospital as a surgical resident because of you. And in the months that I have been here, I’ve never watched you operating.” That was very painful for me.

The second event occurred when I was doing one of the first posterior sagittal operations. I had a call from the president of Mexico’s office. They said, “Mrs. Imelda Marcos, the first lady of the Philippines, and Mrs. Lopez Portillo, the wife of the Mexican president will be visiting our hospital.” They expected me to be at the main entrance of the hospital in 30 minutes!!.

DR. AZIZKHAN:  Imelda Marcos.

DR. PEÑA:  Imelda Marcos, the lady that had 200 pairs of shoes. I left the operating room. I left one of my young attendings taking care of the operation, and I went downstairs to wait for these two ladies. They came with all the entourage, you know, all the body guards. I guided them around the hospital. But I felt that I did not belong there. I didn’t feel well in that environment. My hands were full of powder from the surgical gloves and my mind was still exploring the anatomic dilemmas of the first surgical explorations of an unexplored surgical territory.

The third and final event was that one day at noontime, the workers from the kitchen decided to go on strike. They came to my office, and said, “We are not serving lunch today.” (For 700 people.) I started discussing the issues with the union representatives. By the way, I was not very good at these administrative issues anyway. Anyway, around one pm, I was called from the OR, and they said, “Your patient is intubated waiting for you.” I made a final decision and said, “If you don’t serve lunch, there is no dialog. You serve lunch, and I will see you late in the afternoon to continue this dialog.” I left, entered the operating room, and saw my patient intubated. I realized that I did not remember what operation I was going to do. I had to look into
the chart to see what kind of case was that. And as I did, I said, “This is the end. That’s it. I must either go in one direction or the other.” And I decided to resign as a director and dedicate my full time and mental energy to my job as a pediatric surgeon.

By the time that I arrived in New York, I already had learned a lesson in Mexico. The administrators at Long Island Jewish wanted me to be the surgeon-in-chief of Schneider Children’s Hospital. But I did not accept that. I decided to be only the chief of pediatric surgery. [Laughter] So that was not much to administrate. But that was intentional. You know more than anybody how difficult it is to be responsible not only for what you do but what the others are doing. I came from Mexico; I didn’t know much about local politics in Long Island. I didn’t know much about legal issues, insurances and HMOs [health maintenance organizations]. I recognized my limitations and decided to work more in something that I knew I was good at. Eventually we hired full-time pediatric surgeons, and eventually we even had a training program directed by Dr. [Andrew R.] Hong.

DR. AZIZKHAN: So who was your first full-time associate?

DR. PEÑA: My first full-time associate was Dr. Ken Kimura. I met him in the meetings in the Pacific Association of Pediatric Surgeons. He always presented very creative papers. He was a very creative person, and we socialized very well. But I learned a lesson. It’s one thing to socialize, another thing is to work together. He expressed his desire to come to the United States. So I said, “Would you like to come?” My chairman supported me in hiring one person. So I had a choice: to hire a young American-trained pediatric surgeon or to bring a mature pediatric surgeon my age, 45 years old, with experience and international reputation. He was the chief of pediatric surgery in Kobe, Japan. So I said, “It’s going to be a great; two mature surgeons working together, creating a lot of things.”

Actually, the project did not work. The cultural shock for Ken Kimura was really terrible. The differences in the way pediatric surgery is practiced in Japan compared to the way it’s practiced in New York were too much for him. It was really something terrible. He didn’t understand why a private pediatric surgeon could operate on a patient suffering from biliary atresia and did not invite him to be present. You know, Japanese pediatric surgeons have a large experience in that condition. He considered that an insult. When he was asked to sit for the FLEX exam, as a condition to get his license, he couldn’t understand that. He said, “I’m a surgeon with an international reputation; why should I sit for that?” I said, “Ken, this is the United States. This is not Japan. Here, you have to follow the rules. You may be a king in another place, but here you are not a king. These are the rules. This is the United States.” He couldn’t take it. He suffered a lot for
one year. And then he was hired in Iowa in a more protected environment, a university-type of environment. But on Long Island, I’m sure it was difficult. I never talked to him about this experience. He just left. But I’m sure he was very, very upset.

DR. AZIZKHAN: He just left one day?

DR. PEÑA: One day with no warning; he didn’t say goodbye. He just left and went to Iowa. He could not understand, for instance, that he walked into the neonatal unit to see a patient, and the nurses did not come to him to tell him what was happening, you know. As a chief of surgery in Kobe, he was never doing cut-downs, for instance. And you know, the practice in the United States in general pediatric surgery, you have to do that. For him it was a torture to do that.

DR. AZIZKHAN: So after he left, who did you recruit?

DR. PEÑA: Then I recruited Peter Shrock, a pediatric surgeon that came from Chicago and spent a couple of years working there and retired. And then I recruited Dr. Hong.

DR. AZIZKHAN: Andy Hong.

DR. PEÑA: Yes. Dr. Andy Hong. Andy Hong was part of Jerry [Jerrold] Becker’s private group. He expressed his desire to become more academic. Actually Dr. Marc [A.] Levitt suggested me to invite Andy Hong. He joined us, and that was great. Andy Hong is an excellent pediatric surgeon. He worked hard to have the training program; he became the director of the training program.

DR. AZIZKHAN: Now Marc Levitt at that time was a resident or was a medical student?

DR. PEÑA: When he suggested that, he was already a resident.

DR. AZIZKHAN: He was a resident.

DR. PEÑA: But I met him as a medical student. He rotated with me, and then he was “bitten by the spider.”

DR. AZIZKHAN: Yes, he clearly has told me that he was “bitten by the spider.”

DR. PEÑA: And then he went to finish his surgical training at the....
DR. AZIZKHAN: Sinai?

DR. PEÑA: Mount Sinai [Medical Center] in New York. After that he went for training at [Children’s Hospital of] Buffalo, and he stayed there. One day he called me and said, “I miss you.” So I said, “Okay. Come.” And he came. [Laughs] So he moved to Long Island. Later on, we hired two more young pediatric surgeons. We started growing very nicely. Together, Marc and I completed the first thousand cases at Schneider Children’s Hospital and continued accumulating experience. The experience has been absolutely extraordinary, to operate; and being able to review our files and see what we have learned through all these years has been great. Not only professionally, technically, but from the human point of view. Also, the opportunity to travel all over the world and to operate in other countries, as you have had similar experiences, has been excellent, has been superb. That’s something that I highly recommend to all American pediatric surgeons, to go to other countries to operate. That allowed me to learn about the privilege that it represents to work and live in the United States. It reinforces that privilege. You come back from traveling to underdeveloped countries, and you understand how great it is to practice pediatric surgery here.

One day we were discussing at a roundtable about medical-legal problems in the United States. We were talking about how difficult it is the litigation problem in the United States and so forth. I was asked, “What do you think about that? How is the problem in Mexico?” I said, “Well, we don’t have that problem in Mexico because in Mexico they don’t sue you. In Mexico they shoot at you. They kill you.” And actually two friends of mine got killed by an angry patient. I was never sued. I have been very privileged that I never had that kind of problem in 23 years of practicing in the USA.

But, to tell you the truth, I have been in countries where there are surgeons that are almost criminals. They continue practicing and nobody does anything to them. I have been in countries where a poor-class person cannot dream of suing an important surgeon. If you are not rich, you cannot sue anybody in some countries. I don’t see a big problem in the medico-legal issue in USA. Of course everybody abuses the system in one way or another. But here in the USA, the humblest human being can sue the most prominent surgeon. I don’t see that as something bad. Of course we are human beings, and we tend to abuse every kind of system. But it’s nice to know that the law is open, and it seems to be fair for everybody. I hope I never have a medical legal problem. I see how the medical legal problems can be created right from the first interview with the patient. Very much depends on the kind of relationship that you have with the family.

DR. AZIZKHAN: Yes, I agree.
DR. PEÑA: Of course there must be some sociopaths that sue you because they need the money. We pediatric surgeons are taking care of the most precious kind of human being, a child. All the parents want to know or to feel is that the surgeon is REALLY concerned about their child. When they feel that, they are really appreciative. One of my concerns when I came to the United States was how would I communicate and “connect” with American parents. In Mexico I was very successful in that respect because I speak the language; I mastered the sense of humor of the Mexican society. You know when you have reached the point that allows you to make a joke with the parents of your patient. When you go to another country and you don’t master their language, you have to be very careful about the sense of humor. You can say something very inappropriate at the wrong time. So that was my concern: Am I going to be so successful in USA, as I am in Mexico? Now I can tell you, in retrospect, that there’s something universal about our job. I have been all over the world. The parents look at you even if you do not speak their language, if they perceive that you are sincerely interested in the benefit of their child, they give themselves, they trust you.

DR. AZIZKHAN: Yes, I agree with you.

DR. PEÑA: I like to take as personal challenges the so-called difficult parents. When they tell me that this couple is terrible, the nurses are crying because the parents scream at them, I volunteer to talk to them. And in general my experience has been very positive with the parents.

DR. AZIZKHAN: Well, you have a wonderful way with patients and families. And to see your humanity and your caring, it’s truly an amazing experience to see you with them.

DR. PEÑA: There was one particularly child, Richard, who was operated on here by one of our attendings. He had a stricture of the rectum. The mother was very angry with the attending surgeon. The surgeon asked me if I could see this patient. So I went to see the patient with the attending surgeon and with the mother, and I explained to her that the patient needed another operation. The mother said, “I’m going to Dayton, Ohio. That’s where they’re going to operate on my son.” And she was holding the baby in her arms. I continued explaining everything that we were planning to do. Suddenly the baby extended his arms and came to me. And I said, “You know something, Mrs. Smith?” (Whatever the name was.) “I think he already decided.” Well, the angry mother could not stop laughing. We did the operation, and there was a happy ending.

DR. AZIZKHAN: Oh, that’s great. So getting back to Long Island. One of the things that you are well recognized for, in addition to being a master surgeon,
is being a master educator. And you started to put together these wonderful three-
day to four-day courses, and you’ve done hundreds of these courses both in the
United States and abroad. How did you think about putting that together? How
did it evolve? Tell us about that.

DR. PEÑA: Yes. You see, the anatomy of the human body is well
known by surgeons of the different specialties. If you talk about the
mediastinum, there are plenty of beautiful pictures and drawings of the
mediastinum, and you don’t have to teach a thoracic surgeon what the
mediastinum looks like. But in this particular area where I work, the fact is
that before 1980, nobody has seen that anatomy. I am talking about the
peculiar anatomic relationship existing between the rectum, the urinary tract
and the vagina in each type of congenital anorectal malformation. We were
operating on those patients in a blind way. Hard to believe. I was invited to
Padua, you know, where the first anatomic studies started, with Andreas
Vesalius, Wirsung, Harvey, Fallopio, etc. When I was there, I was thinking
it’s very interesting that all these anatomic studies started in the Middle
Ages. Before that the Inquisition did not allow to do those studies. Looking
at the original amphitheatre where those studies were done, I was thinking,
“My reputation and my success in this life came from a contribution in
anatomic facts!!” To conceive the posterior sagittal approach, everything
started with a controversy on the intrinsic anatomy of these malformations.
Hard to believe that in 1980, after a man already walked on the moon, when
we were beginning to manipulate genetic material, we human beings are
doing fantastic things in science; we still did not know the basic anatomy of
the anorectal malformations.

The general surgical residents that rotate here from the University of
Cincinnati sometimes scrub and assist in one of these anorectal operations.
They look at the anatomy, and they say, “And you started doing this?” And
I said, “Yes, I started.” “And before this, what was being done?” And I tell
them, “If I tell you, you would not believe it.” [Laughter] And they cannot
believe what we were doing, trying to repair these malformations from the
abdomen, from below (the perineum), blindly, and damaging important
structures. Sometimes we left pieces of rectum attached to the urethra.
Sometimes the urethra was seriously damaged, the prostate was moved.
Important nerves were injured, leaving as a sequela neurogenic bladder
and/or impotence. Sometimes we were fortunate, sometimes we were not.

When I started demonstrating these operations, it was necessary to show the
real, detailed anatomy. For that we needed good audiovisual material and
technology or live demonstrations. We were showing structures and
anatomic relationships never seen before by pediatric surgeons. In addition,
most pediatric surgeons had already pre-conceived anatomic concepts; most
of them already had repaired many anorectal malformations using blind or
semi-blind techniques, based on the literature available at their time. Only by showing them the real anatomy, in vivo or with good movies or photographs, we had a chance to convince them. Only by understanding the real defective anatomy they will be able to understand the rationale of the technique. Another extraordinary experience that I had in those years was to see the reaction of people when you come out with something new. That was fantastic. The first surgeons who invited me to the United States were predominantly young people. Many times they invited me against the desire of their chief. There was usually a young attending who was open-minded. Senior surgeons who for 30 years had been doing the traditional approach usually were not ready to say, “I have been doing something wrong; I want to learn the right way.” I must say, I met senior surgeons who, after 30 years of doing something different, say, “I was wrong.” That’s extraordinary in senior people. There are doctors like that. It’s not common. Very unique. Usually senior people don’t change.

DR. AZIZKHAN: Yes, they’re fossilized by then. [Laughter]

DR. PEÑA: I like to say that, “In the past, we were blind believers.” We believed in a structure, the puborectalis muscle, that we never saw. We talked about the puborectalis muscle the same way that we are now talking about the “internal sphincter,” even when nobody has seen that. It’s amazing to look at in retrospect and to realize how predictable we human beings are in our behavior. We tend to be like that. Then came the time when we opened, exposed and demonstrated the real anatomy. We said, “There is the anatomy.” Most observers learned and embraced the new concepts immediately, since they were looking directly at the real detailed anatomy. Yet, hard to believe, many observers went back home and continued doing the old operations and writing about the puborectalis muscle. In other words, they were seeing the anatomy, and they still did not believe it. Then I realized that we have moved from the time of “blind believers” to the time of “seeing non-believers.” In 1983, Dr. Stephens visited me in Mexico. That was quite an experience. He and I, by the way, are good friends. He’s 93 years old. He’s a superb human being. We disagree 100 percent. But he’s a charming gentleman and a very nice person. But anyway, your question was? I’m sorry I diverted.

DR. AZIZKHAN: We were talking more about the anorectal malformations. And part of what I was trying to get to is the origin of the three day course.

DR. PEÑA: In Mexico, I had those two to three day operative demonstrations that I called marathons. Hardy Hendren suggested to me to have good audiovisual material. And there was a rich man in Mexico who had a child that died with esophageal atresia, operated on by another surgeon. He became motivated to do something about congenital anomalies.
So he and I worked together in an organization called Gen, G-E-N. He promoted many things related to congenital anomalies. And he paid for a 16 mm movie of mine of my operation. I traveled with that excellent movie, showing it. But then they invited me to operate. I love to demonstrate these operations because I learn and I believe that the only way that a surgeon can really convince another surgeon about something is in the operating room. Because we go to meetings, and we see beautifully presented papers, edited movies that show the good parts of an operation but not the real, real procedure. So you want to be there when things happen. You want to see the real, live operation.

In fact I suggest to our young trainees: If you go to a meeting, and you watch a surgeon presenting something fantastic, something unbelievable, really beautiful, go to his place. Go and visit him. You may find the following: You may find that he is real, that he’s really a great surgeon. You may look into certain tricks that were not shown in the meeting, and you will learn about an extraordinary human being. At the same time, if you spend a few days with him, you will be able to see what kind of person he is. How is he related to the doorman? How does he relate to the nurses? How does he relate to the waiter, to the waitresses? How is he in his office? How much time does he spend in his office? How much time in the operating room? How much time is he in the laboratory? After that experience, you will know how to interpret his future presentations and publications. He could be a man that talks about long-term results, and actually he never goes to the clinic. Here’s a man that talks about surgery; you were there two weeks and he never operated. Or perhaps you will discover a surgeon that really knows what he’s talking about because he really operates.

Dale Johnson presented once in one of the PAPS meetings one hundred cases of esophageal atresia with minimal complications. A lot of people in the audience were very skeptical. And I said, “I believe him because I have been there. I know him. I have been with him in his everyday life and in his hospital, and he’s a great surgeon. He’s absolutely honest, and he’s a dedicated person.” You know him.

DR. AZIZKhan: He is a wonderful man.

DR. PEÑA: That’s why I came up with the idea to organize courses with live surgery so that people can see how the surgeons react, when the bleeding cannot stop, when the exposure is bad, when the light doesn’t work. The real surgery. So I believe that’s the way it should always be. I was doing that in Mexico, in the so-called “marathons of anorectal surgery.” When I arrived in Long Island, I contacted the continuing education department and told them I wanted to organize a course. They organized everything for me; I did not have to worry about buying sandwiches and coffee anymore. And
ever since that time we have been doing this course. And I’m very happy to
do it that way.

DR. AZIZKHAN: Now, you’ve done how many courses in the United States?

DR. PEÑA: In the United States since 1985, 46 courses in the United
States. And at least another 46 in other countries.

DR. AZIZKHAN: Almost a hundred.

DR. PEÑA: I think it is an excellent experience because you can see
how people get excited. You and I had the opportunity to be in India doing
that, and you were able to see the positive reaction of the audience,
particularly the young people. They were all excited about the operative
demonstrations.

DR. AZIZKHAN: You’re like the pied piper. They follow you around
everywhere. It was an amazing experience to be with you there.

DR. PEÑA: Good and delicate surgical technique is something that I
learned in Boston from people like Arnold Colodny. Subsequently, I kept
trying to improve every day. For instance, from Hardy Hendren I learned to
have your own personal morbidity autocrirical session. When we finish an
operation we must ask ourselves, “If I have to do this case tomorrow, how am
I going to do it better?” Even when you finish the most beautiful operation,
there is always a way to do it better. It’s a never-ending situation.

I’m getting old, and I’ve already accepted the fact that you can never master
this art. You just keep trying until you die. Actually, when you start
believing that you’ve mastered this, you are ready for the big, big trouble.
Mother Nature sends you little messages to remind you that you are just
another human being. Not that I had terrible catastrophes, but I had very
disappointing cases when I thought that I was going to do a very easy case
today in three hours, very neat, and it turned up that everything went wrong.
Then you realize that there is no easy case, and that the art of surgery
demands from you your full attention. It must be particularly difficult for a
person like you to go into the operating room and to separate yourself from
everything that is happening in this office and in this institution. The child
and the operation itself demands our full attention. The moment we start
talking too much or distracting, something goes wrong, then we have a
terrible feeling. Actually, most of our errors are never discussed in the
M&M. We do many wrong maneuvers and yet nothing happens to the
patient, but we know it could be done better. It never results in a real
complication that is discussed or goes to medical legal problems. If we
retrospectively analyze what we did, we can always say, “Tomorrow I’m
going to do it better. I can do it more smoothly. I can do it easier. The exposure was not good. I was in a hurry. I wanted to finish. I was tired, and I didn’t do enough hemostasis. I was rough.” There’s always something. We must always try to do this exercise, it is a healthy practice. I heard that for the first time from Hardy Hendren. I saw him after an eight-hour operation, not being happy with the final result, remove each one of the stitches and restart all over again. That’s what was really impressive about him. By the way, when I accepted the job in New York, I needed some letters of recommendation, and the best letter of recommendation came from Hardy Hendren.

DR. AZIZKHAN: That’s wonderful.

DR. PEÑA: Eventually, in a way, he and I competed with each other with the cloacas. [Laughter] But it was always very friendly, productive and constructive competition.

DR. AZIZKHAN: He’s very fond of you. He has told me that on many occasions. And he has a great respect for you and what you’ve accomplished as a pediatric surgeon and how you’ve helped all of us become better at understanding anorectal malformations and how to manage them.

You had a very productive period in Long Island. It was a place where you were also happy. Tell me a little bit about what made you think about other opportunities in the United States. For example, you’ve told me about some of your other institutions that you’ve visited like [Children’s Hospital of] Philadelphia and Pittsburgh. What made you decide to consider coming to Cincinnati?

DR. PEÑA: I was always interested in following my patients as long as possible, from case number one. I even went to Mexico several times to see my patients. I still follow them. I strongly recommend to all pediatric surgeons to follow their patients for life. Even with hernias I suggest that, because it’s a source of satisfaction and also a learning experience. That is the way we learn about the long term sequela of our operations. A good example of this is my experience with pectus excavatum. If we do something wrong in pediatric surgery, we have a sequela for 75 years, and the patient keeps coming, showing us the damage that we—not intentionally—did. Then we realize that we cannot make these patients normal. And we cannot abandon our patients. Then we realize that in order to take good care of those sequela, we need much more than just operating like we are doing. We need much more ambitious plans for the future.

I believe that the next generation of pediatric surgeons must focus more on the management and prevention of sequela, not only anorectal
malformations. It’s about all congenital defects, because our patients become adults. Adult surgeons don’t know much about these malformations and, in general, we are not allowed to follow them as an adult. There’s something missing in all this.

In anorectal malformations, 50 percent of the patients have a urologic problem, 30 percent need an orthopaedic surgeon, 25 percent need a neurosurgeon. All the patients had problems with motility of the colon. Then what about genetics? I mean, when are we going to study genetics in these patients, looking for more radical solutions for the future? You cannot just operate and operate and operate and forget about all this. What about the medical management of patients that suffer from fecal and urinary incontinence? What about the sexual problems that we see in young males born with anorectal malformations? What about the gynecological and obstetrics concerns of our female patients?

Those realities hit you in the face every day in the clinic. In Long Island I was the gynecologist, the psychiatrist, the gastroenterologist, the urologist; I was everything. Even a little bit of a neurosurgeon because some of my patients had an anterior meningocele that I repaired because the neurosurgeon was not always available. Obviously there must be a better way to do it. And that’s when I started talking to other institutions. My idea was to create a center that offers a comprehensive, multidisciplinary approach to these patients.

I found some enthusiastic colleagues. In Philadelphia Children’s Hospital [Children’s Hospital of Philadelphia], it was John [W.] Duckett and Howard Snyder who said, “That’s a great idea.” John was a powerful man in Philadelphia Children’s Hospital. So he talked to everybody there. I was invited and I talked to the CEO, who sounded very enthusiastic, but it never happened. I don’t know what happened internally, but the urologists were the most enthusiastic people about this.

Then in Pittsburgh it was Marc [I.] Rowe, the chief of surgery. We never met until I went there and he and I became friends immediately. Very straightforward, very rough person, but very sincere and honest. He supported the idea; he was enthusiastic. I went three times there. But then the administrators made a business analysis, and they concluded that it was not good. And that was the end of Pittsburgh.

Then I went to the Mass General. Pat [Patricia] Donahoe was enthusiastic. She and I are very good old friends. We went to the chief of surgery, and I never heard from them.
Then I went to Orlando. They were creating a new children’s hospital, smaller than Schneider in New York. The pediatric surgeons there were nervous about losing patients. Insecurity is one of the problems.

At the time when I thought that that would never happen, then Marc Levitt said, “Do you mind if I talk to a couple of persons about this?” I said, “No. You go ahead.” And then he talked to you, and he talked to the people at Lucille Packard Children’s Hospital in California, Stanford University. Almost simultaneously, I met Mr. Craig Ponzio, a member of the board of trustees of Denver, [The] Children’s Hospital. All of a sudden, we had good potential choices!!! It was totally incidental that a member of the board of trustees at Denver Children’s Hospital went with his own daughter to New York and then asked me to come to Denver. That’s how, at the same time, three institutions became interested. We went to Denver, then went to Lucille Packard, and we came here.

I remember that in one of the APSA meetings, Marc Levitt said, “Dr. Azizkhan wants to talk to you.” I talked to you, and then you decided to invite us. Marc and I came here. Because of my previous experiences, I said, “Marc, don’t get too excited. Things don’t happen that easy. I have been through this, and it’s not that easy. They have to go through the numbers and business plans. They will ask you, ‘How many cases are you going to bring here?’ There is also politics involved. It’s not that easy.”

I remember very well that I came here. You took me to Mr. [James M.] Anderson’s office. I prepared a 15-minute talk, PowerPoint, about the plan. You introduced me to him and said, “Dr. Peña, tell Mr. Anderson what you think.” And I presented my plan to him. He listened to everything. I remember that he said, “Okay. Let’s do it.” He said, “Richard, but remember, there must be a business plan.” We left that room, and Marc was very excited. I said, “Marc, don’t get excited. I heard those words before.” In Philadelphia, they took me to the CEO, a young man in a huge office, and his desk was impeccably clean. Not a single paper. And he explained. He said, “I don’t need papers here, I just make decisions,” he said. “So tell me what do you want to do?” And I told him everything. He said, “Dr. Peña, you know what’s my role here?” I said, “Well, you are the CEO.” He said, “My role is to be sure that plans like yours really happen.” I said, “That’s it. With a CEO like this, this is going to happen. This is going to fly.” Never happened.

So when we heard Mr. Anderson, I said, “Marc, don’t get excited. They talk like that. But then these things don’t happen.” And it happened!!! It was really amazing. Of course we still have many things to do in the future. We have many plans. But actually, it has been much better than what I expected. I would like to retire knowing that we started building our master
plan, with your support. If you take any area of pediatric surgery, such as vascular tumors or malformations, and you start getting deep into that, 20 years from now you are going to be more related with the scientists of the angiogenesis than with the general pediatric surgeons. Same is happening to us. We now have more in common with the urologists than with the liver transplant surgeons here, because we work on something very much related. I believe that’s the future for leading institutions that want to progress. We cannot progress if we try to be experts in everything. Leading children’s hospitals must create multidisciplinary teams to deal with specific challenges. At the end, our challenges are not medical or surgical. The separation into specialties is good for community hospital, not to push medicine forward.

DR. AZIZKHAN: I think it would be helpful for you to describe the concept that we planned together, where the Colorectal Center is really a complex group of healthcare providers: surgeons, urologists, gynecologists, GI physicians, the appropriate nursing staff, and therapists. Talk a little bit how you planned that and how it’s been executed here at Cincinnati Children’s.

DR. PEÑA: It becomes very obvious if you start dealing with these patients. A little girl that we operated with a cloaca has urinary tract infections, and you need to become the urologist or you ask for a urologist, and you may find a urologist that is very good in urology but doesn’t know anything about cloacas. So you need a special urologist that knows about cloacas. The patient becomes a teenager, has gynecologic problems. Then you look for a gynecologist, and you tell him that you have a patient with a cloaca, and he doesn’t know what cloaca means. And you are not a gynecologist. Then you have a patient that has a tethered cord and goes to one neurosurgeon, and that neurosurgeon gives one opinion. Finds another neurosurgeon with a completely opposite opinion and a third neurosurgeon with another opinion. Then you start looking at the neurosurgical literature, which is not your specialty, and you realize that there are many inconsistencies. So you want a pediatric neurosurgeon fully dedicated to neurosurgical problems of children with anorectal malformations. Because only going deep in the study of a problem do we have possibilities of being creative and innovative.

We also have patients suffering from fecal incontinence, constipation and/or urinary incontinence. We cannot abandon them; we have to do something. It was in desperation that came from the confrontation with these problems that little by little we created our “Bowel Management Program.” With this program we keep our patients artificially clean. But it’s medical, it’s not surgical. Yet, we surgeons spend part of our time doing that because pediatricians and gastroenterologists don’t know about this. In the future we expect to have pediatricians or gastroenterologists dedicated to this.
Most of our anorectal malformation and Hirschsprung’s patients suffer from colonic motility disorders. That is why we need the collaboration of specialized pediatric gastroenterologists. What can we do for patients suffering from fecal incontinence, other than the bowel management? That is always in the back of our minds. Are we going to create the sphincters? We already tried that in pigs in New York. We found that creating a sphincter is not the answer because bowel control is much more complicated than creating the sphincters. Bowel control depends on three elements: sensation, sphincters and rectosigmoid motility. We surgeons have been obsessed with sphincters, which is only part of the problem. Regulating the motility is more likely to take care of the problem of fecal incontinence. If a pharmacologist can come up with a medication that makes the bowel have a wave of peristalsis and empty the rectosigmoid and then another medication that paralyzes the colon, we don’t need sphincters. I believe that’s more feasible than trying to create sphincters. That is a potential area of collaboration with pharmacologists and basic scientists. Another, of course, is genetics. But that’s so far away from our area of expertise, We need enthusiastic geneticists. But in the meantime we can keep patients completely clean with the bowel management, working together, families, with us.

I believe that our Bowel Management Program is, at present time, like intermittent catheterization was in 1970s when Dr. [Jack] Lapides proposed intermittent catheterization for the management of urinary incontinence and many thought he was crazy. Now, hundreds of thousands of children stay dry because of intermittent catheterization. It’s not ideal; but it’s something useful until we come up with better treatments. Our plan included a gynecologist, but not simply a gynecologist; it had to be a special gynecologist that knows this pathology. So we are very fortunate because here in Cincinnati you provided that very enthusiastic person, Dr. Lesley Breech. She is exposed to an operation in the morning in a little baby with a cloaca, and the same afternoon she will be seeing a 17-year-old girl that I operated on for the same condition 17 years ago. She can see firsthand the sequela of these operations. That is a unique opportunity for our gynecologist. Our gynecologist ought to be (and she is) a sensitive person to be able to talk about sexual life with a 17-year-old girl that has been traumatized with surgery. It’s not just a regular gynecologist.

We need the collaboration with gastroenterology because of the motility problems that I mentioned. And there are not many. There are very few gastroenterologists dedicated to colonic motility. We’re still struggling with that; but I am sure that eventually we will find the right person. I’m an optimistic person; I believe that dreams come true. But the first requirement is that you believe in that. And it happens. It happened in my own life. In fact, reality for me is better than what I initially dreamed. I never planned to
do what I have been doing. I never planned on making a contribution in surgery. I learned that we just have to put the best of ourselves in everything that we do every day and believe in what we are doing, and leave the rest to the gods. When I travel, Richard, some young doctors come to me and say: “How do you manage to be successful? What’s the advice that you can give to a young person?”

And I don’t know if you have seen that program on the TV, it’s a school of cinematography and drama; there are like a hundred students of cinema, drama and theater. They invite a famous actor (Anthony Quinn, Paul Newman). The anchor, interviewer is asking questions of the famous actor, and everybody’s watching. And the sad part is that from those hundred students, only ten of them perhaps will become famous. The others will just try. But they are all looking for the keys for success. They expect a simple answer. . . When young surgeons ask me that question I usually respond, “What are you doing tomorrow in your hospital?” They say, “Well, I am doing just a hernia because they only let me do hernias.” So here is my advice, “Tomorrow you will try to do the best hernia repair in the world. After that, apply the same rule to every day of your life and leave the rest to the gods.” And they look at me like saying, “This guy’s absolutely nuts, he’s crazy.” [Laughter] Some people understand, but others don’t understand.

Back to the master plan of our center. For many years, hospitals have been divided into specialties: surgery, medicine, pediatrics, gynecology, orthopedics, etc. But at the end, when we explore deep into any particular medical or surgical problems, we end up studying basic sciences. You go deep into a vascular malformation and eventually you need the help of a basic scientist. We are heading in that direction. But in the meantime there are children that are born with these conditions and we must do what we can for them. We don’t have a quick answer. We have to continue operating. We hope to provide a comprehensive management, and this institution, Cincinnati Children’s Hospital, offers that. Now we have an orthopedic surgeon, a gynecologist and a team of urologists collaborating with us. We are learning about the long-term urologic sequela. We are detecting the groups at high risk of kidney damage. And those patients who have kidney damage now are having kidney transplants here.

But it’s a great satisfaction to see that almost everything can be done here. Our patients feel very comfortable. They know that here, they can walk in and talk about a cloaca, talk about intermittent catheterization, talk about bowel management, and those are not strange terms. When they go to a general hospital and they use those words, nobody understands. Nobody knows what the problem is. So that’s really great, what’s happening here.
DR. AZIZKHAN: Articulate for me your vision of spreading the knowledge that you have gained and the team that you have built so that this can be recapitulated in other places around the world, because there’s not enough hours in the day to take care of every child that has a complex anorectal malformation.

DR. PEÑA: The sad part of the story is that, as we are talking now about anorectal malformations, in someplace in the world, even in the United States, probably somebody’s operating on a child with an anorectal malformation, and he’s not doing it right. I believe that that’s a responsibility that we professors have to teach people how to do these operations. That’s part of the reason why we have this course. When we started doing this course of anorectal malformation, many attending surgeons came from many institutions. But then we decided to focus on the fellows, the young people. To achieve that we decided to invite, for each course, two directors of training programs. Because usually professors don’t come to courses. So we invited them to give a lecture. By doing that we hope they will find that the course is useful, and they will send their fellows. And that’s exactly what happened. We were very successful.

Nowadays, if you look at the attendance of our courses, 80 percent of them are fellows, and we are very happy about that. In some programs the chairmen and the directors of the programs consider it almost mandatory for the fellows to come here. And that is a great satisfaction.

Of course, we believe that our fellows should be the best-trained pediatric surgeons in anorectal malformations and colorectal problems.

We have to define what a general pediatric surgeon should know about anorectal malformations, and we’ve already defined that. There are certain malformations that all pediatric surgeons should know how to operate well, that happen to be the most common malformations and happen also to be those that have the best functional prognosis. We believe that it is possible to teach our fellows to repair in an impeccable manner the most common types of anorectal malformations. On the other hand, we also believe that complex defects should only be repaired by specialized teams of surgeons. The complexity of those defects requires experience, repetition and special training. In complex cases, it is impossible to separate the urologic part, the gynecologic part, and the bowel part. Everything must be repaired at the same time. These technically demanding operations must be done by a pediatric surgeon with special training in urology and gynecology or it has to be a pediatric urologist with special training in the surgical treatment of these defects. It’s not enough being a well-trained pediatric surgeon, not enough being a well-trained pediatric urologist.
We have very clear in our minds that our fellows must be the best trained pediatric surgeons in colorectal problems. Our course is also open to all the other fellows in the United States. And then we travel to repeat these courses in other countries. In addition, when we receive patients from other countries, we try to encourage the families to come with their surgeon so he can be here during the operation and then follow the patient, and hopefully to motivate him to do these operations well.

I believe that pediatric surgeons are getting better, of course. I believe that the new generations are better than us. Otherwise we’ll commit suicide. Anorectal malformations are managed better now than in 1980. No question about that. I read the operative reports of patients referred to me because they suffered from complications after an attempted failed repair. But the number of catastrophic events is decreasing, fortunately. Still happens, but it’s much less, particularly in the United States. There’s no question that the surgeons are more knowledgeable about the treatment of anorectal malformations. But there’s still a long way to go about that.

There are countries, amazingly, like China, very deficient and primitive in the treatment of anorectal malformations. We are now up to 40-something Chinese patients, operated on in China (very bad operations), abandoned by their parents and subsequently adopted by American parents who go there and adopt them knowing that they have a malformation. Some Americans adopt two of them with malformations. I mention China because it is rather upsetting to read about the remarkable economic growth of that country and the grotesque contrast perceived when looking at the way they treat these children.

DR. AZIZKHAN: That’s right.

DR. PEÑA: Most people in other countries do not know how many good Americans go and adopt children. Like Mr. Ponzio said, “I want two girls.” The Chinese offered him “two beautiful girls.” He said, “No, no, no, no. I want two girls with problems,” he said. And adopted two beautiful girls with congenital defects. You don’t see that in other parts of the world. I believe that China desperately needs these courses. When we talked about organizing a course there, they expected a philanthropic organization to pay for the course. That means that those children are not a priority in their values. Girls born with congenital malformations are simply abandoned.

DR. AZIZKHAN: I’ve seen a child, female child, with a hemangioma, abandoned.

DR. PEÑA: Yes.
DR. AZIZKHAN: And was adopted by local American parents.

DR. PEÑA: I believe that Americans that adopt children from other countries are the best messengers of the United States. Much better than the controversial foreign policy about war. By the way, something that impressed me from Cincinnati, something that did not happen in New York, was the high regard and pride that the community has for Cincinnati Children’s Hospital. In Cincinnati, when somebody identifies you as a doctor that works at Children’s Hospital, they only have flattering remarks to make. That’s really great because that tells you that this is a hospital created by the community. It’s really very sincere, what the people feel about it. They respect you immediately; they treat you differently because you work at Children’s Hospital. This did not happen in New York.

DR. AZIZKHAN: It’s more competitive there. Well, that’s very good. Do you want to take a break?

DR. PEÑA: You tell me, Richard.

DR. AZIZKHAN: Yes, we can take a little break.

[Pause]

So we’re rerecording now. Looks like we’re back on. So the next area I’d like to explore with you is about your relationship with Marc Levitt.

DR. PEÑA: Sure.

DR. AZIZKHAN: Marc has been a very close friend as well as your student for many years. But now he’s joined you as a partner in this great enterprise. Tell me a little bit about how your relationship with Marc developed.

DR. PEÑA: Yes, as I told you before, Marc Levitt joined me for a rotation as a medical student. One of the many characteristics of Dr. Levitt is how obsessive he is to achieve what he wants and what a hard worker he is. One day my secretary said, “There’s a medical student who wants to rotate here.” I said, “Okay. Tell him to come to meet me first so we can talk about it.” It was Friday. She said, “Yes, but he wants to see you Monday.” I said, “Well, Monday I have many things to do. Make an appointment for the following week.” “He called three times, and he wants to meet you Monday.” So I said, “Well, Monday I cannot.” And that kept going. He was calling like five times in a day. So finally I said, “Okay. If he wants to meet me Monday, Monday I will give a lecture at Maimonides [Medical Center] Hospital in Brooklyn.” Going from Long Island to Maimonides in Brooklyn is like going to another country. And there were no GPS systems. So I said,
“I will be there giving a lecture. He can meet me there at 7:00 am.” Marc was there on time and I was late because I got lost.

He rotated with me. At that time, in New York, they restricted the amount of time that a resident should be on call. And therefore the residents had to leave early. But nobody said anything about medical students. So as a consequence, Marc Levitt was a medical student, but he was assisting me in all the operations because the residents frequently had to leave. Marc Levitt became very much interested in this. Then, as a resident, he asked his chairman to spend an entire year with me, and he allowed him to do that. Then he went to [Children’s Hospital of] Buffalo, for his training in pediatric surgery.

DR. AZIZKHAN: I was the chief in Buffalo, and I recruited Marc.

DR. PEÑA: Yes.

DR. AZIZKHAN: And then I ended up leaving Buffalo before he was actually trained.

DR. PEÑA: So life now brought you both together.

DR. AZIZKHAN: We’re all back together.

DR. PEÑA: Now, Marc Levitt is an extremely organized person, obsessive about organization, about discipline, about hard working, highly responsible. He’s always in the office earlier than anybody else. I don’t have to worry about anything if he’s around. In other words, if I have a trip and he’s around, he takes care of everything. So we have the right combination because I’m not so organized as he is. Just look at our desks. It’s very good that this interview is in your office not in my office because my office is not as neat. Marc Levitt is extremely meticulous in everything he does. Running the computer, the email, the meetings, he organizes everything. We complement each other. I contribute with my seniority, my experience. He is no longer a junior attending; he’s a middle-aged person. Maturing every day more.

I think he’s getting ready to be an excellent chief. The problem that I can see in the future for him is that because of his efficiency and his dedication, he will have many temptations. In other words, in the future he will be offered to be chairman or to be chief in many places. I’m sure about that because he can run a department very, very efficiently. He knows how to do that. The dilemma for him will be eventually, how much time and effort to dedicate to the everyday contact with his colorectal patients including the operating room, the way we do it, and how much to expand in the administration. I’m
sure that the center will grow. I hope he stays in this area and hires young people to collaborate with him. Our plan is, as you know, to hire young pediatric surgeons fully dedicated to colorectal problems of children.

Many young pediatric surgeons are a little nervous about making a commitment with a subspecialty. That is understandable; it is not easy for a young pediatric surgeon to give up doing esophageal atresias and other beautiful “index cases,” to be fully dedicated to colorectal surgery. But the truth is that the way things evolved, if you really want to make a significant contribution you have to go deep into something. I see many prominent surgeons who give a lecture on neuroblastoma, and the next day they talk about esophageal problems, and the next day about Wilms’ tumor, and then about fetal surgery. To tell you the truth, I’m very skeptical about that. There’s no question, there are people that are extremely hard working and capable of doing many things. But I still remain skeptical about how knowledgeable, experienced and authoritative one can be in multiple subjects at the same time. Take any problem like I’m sure you do in your vascular area, an entire life is not enough to think about the problem and come out with solutions. You and I have the example of Dr. Judah Folkman who literally suffered being chief of surgery and then finally went back to his laboratory. It depends how deep we want to get into something. Obviously we have to pay a price for that. When was the last liver resection that I operated? Perhaps it was 15 years ago.

I have great expectations about Dr. Marc Levitt. I’m sure you have the same. And there’s no question that he’s going to be extremely successful.

DR. AZIZKHAN: Yes, I share your optimism.

DR. PEÑA: I’m grateful for all that he helped through these years. He collaborated with me faithfully, extremely respectful. And I feel very honored working with him.

DR. AZIZKHAN: Yes, I think he’s a wonderful young colleague. And I, too, have great expectations for his potential and his future as a leader in pediatric surgery and also taking the specific area of complex colorectal surgery and the treatment of children with complex colorectal problems to another level. What is your vision for pediatric surgery in the next, say, 30 to 50 years? Where do you think pediatric surgery needs to go?

DR. PEÑA: There’s no question that the United States is, if not the leader, one of the world leaders in pediatric surgery. I don’t want to say the leader because I am American, it sounds arrogant. But certainly here, in the United States, is where things are happening in medicine and in pediatric surgery. But if you ask me about what would be my main concerns about
young pediatric surgeons, I have two concerns. My first concern is, how much of the talent and knowledge, the young surgeons are willing to put to the service and benefit of the patients. My second concern is the surgical skills of the new surgeons. Some of them are excellent technical surgeons, some others are not. I believe that with all the sophistication and advance technology of this country, we have not found a good way to select our young surgeons and guarantee that all of them will be fully dedicated and concerned about the patient’s benefit and that all of them are skilled enough to perform the operations correctly. Every year during the interviews of the young surgeons who compete to become pediatric surgeons, we can see that all of them are extremely talented, all of them are knowledgeable. It’s almost a stereotype of person. When you read their curriculum, the letters from the Ivy League universities where they come from, the way they dress and speak; there’s no question that they are a very select group of talented individuals actually the selection starts from high school. You cannot become a doctor in the United States if you are not intelligent, knowledgeable and dedicated. And you cannot become a surgeon. So there’s no question about that.

Yet, my two concerns I believe are still legitimate. When I’m in the interviews, I feel very insecure about making a decision, because I cannot select from all those intelligent young men, which one is going to put his mind to the service of the patient and which one is not. I have seen many surgeons that are extremely intelligent and knowledgeable, but it doesn’t matter how intelligent they are if they do not use their talent for the benefit of the patient. After all, what we do, Richard, in medicine and surgery is conceptually really simplistic, particularly in surgery. From the conceptual point of view to explain what an operation is, is extremely simplistic. Doesn’t take much of an abstraction or an intellectual mind to comprehend what we do.

But the question is, how much is the surgeon really going to be thinking during the day, when he goes home, when he’s driving, how much is he going to be thinking about how to improve his patients? Because some may put their mind to the service, for instance, of their academic careers, which does not necessarily reflect an interest in the patient. In order for me to make the real good selection, I propose a different basis for selection. I will ask to let me work with the resident for two months, and in that way, perhaps I could come up with a better answer. My grandmother used to say, “It doesn’t matter how rich you are. What is important is how much are you willing to give?” You may be very rich, but you don’t give anything. So it's the same. You can have a great mind. But that mind is not to serve patients, but to serve you. As a matter of fact, some doctors use the patients for their own advantage.

The other concern, as I said, relates to the surgical skills, the art of surgery. The filters that we currently have do not allow us to detect which ones are
going to be good technical surgeons and which ones are not. To say this sounds politically incorrect, I’m afraid. But in every hospital in the world that I have been in, including the United States, everybody knows there are certain surgeons that are technically bad surgeons. We’re not supposed to talk about them officially. But unofficially everybody know about that. If I need an operation today, I don’t go asking for the most famous surgeon. I will ask you, I will ask a couple of surgeon friends here in Cincinnati to help me, telling me who is a good technical surgeon and a good, dedicated, humane individual to take care of me.

DR. AZIZKHAN: To go to.

DR. PEÑA: I also would ask, who is the person that I should not go to? The question is, is there a way to eliminate that eventually? Is there a way? How can we do that? By the time that we learn that a surgeon is not a good one, it’s too late. The surgeon is already a senior resident and it’s too late to stop them. I was confronted with a case like that in New York. An institution with a training program sent me a young man, pediatric surgical fellow, to spend three months with me. They didn’t tell me the reason. They just said that they wanted him to rotate with me, to learn. After those three months, they called me and said, “What do you think about him?” I said, “He’s a great person. Very intelligent, very smart.” They said, “Can he operate?” I said, “Well, he’s not very good with his hands. But he’s very intelligent.” They said, “No, you are very benign. He cannot operate, and we are going to stop him from becoming a pediatric surgeon. We wanted an independent, non-biased opinion and that is why we sent him to rotate with you.” All this happened two months before the end of his two years training. And they stopped him. This created a big legal controversy.

If we could find better ways to select surgeons in those two areas, I would feel much better. So there must be a way, a better way to detect the vocation and the dedication that it takes to be a real surgeon.

DR. AZIZKHAN: Psychometric testing and those sorts of things are not always reliable either.

DR. PEÑA: No. Dedication, real love for the patient’s benefit, the human part, the contact with the families, not all surgeons know how to interact. Also, behavior problems frequently escape conventional tests and filters. Intelligent individuals with serious behavior problems sometimes pass all these filters, and we don’t detect them, or when we detect them it is too late.

Another concern of mine is the practice of pediatric surgery and research. I frequently ask young pediatric surgeons, “How do you see yourself ten years
from now?” They frequently answer, “I see myself working in an academic environment, 50 percent of my time dedicated to research and 50 percent dedicated to clinical surgery.” I don’t make any comments. But I believe that research is something extremely serious. The moment you start doing research, you start “pulling the string.” The more you come up with answers, the more questions you have to answer. And it’s a never-ending endeavor. It is a fascinating field. I have a great deal of respect for sincere, dedicated, honest scientists. I always dream a little bit about doing research. There is a little scientist inside me.

But clinical surgery is also fascinating and demands your full time. Here you are seeing basically a very busy clinical surgeon. I have published three or four laboratory research papers. But I work mainly clinically. Dedicated my entire life to operate and take care of patients. The last 27 years mainly colorectal, yet I cannot claim that I mastered everything in clinical pediatric surgery. Now, imagine that I spent 50 percent of my life doing research. Do you think that what I would have achieved in that 50 percent time dedicated to research would be significant? In addition, taking away 50 percent of my clinical time would have limited my clinical experience. I think it is unrealistic to believe that one can make a significant scientific contribution in basic sciences, dedicating 50 percent of our time and without specific basic science training. I also believe that it is unrealistic to believe that one can be a good pediatric surgeon with high quality standards, working in clinical surgery only 50 percent of our time. Perhaps a more realistic scenario could be a young pediatric surgeon interested in a specific area of pediatric surgery could develop a line of research related with his area of interest. I concede that that could be something acceptable. As Dr. Folkman used to say, scientists do not trust surgeons doing research and clinical surgeons do not trust surgeons that spend a lot of time in the lab.

DR. AZIZKHAN: Yes, he did.

DR. PEÑA: So that’s a dilemma. Perhaps young surgeons with special interest, creativity and talent for research, could train in pediatric surgery just to find the motivations to do research and then going all the time into research. That is basically what Dr. Folkman did. It is hard to believe that in this time, where there are hundreds or thousands of scientists fully dedicated to investigate one problem, it could be possible that a busy clinical surgeon could compete with them, doing part time research.

DR. AZIZKHAN: Although the concept of partnering with scientists is a good one. And that’s what you have tried to do with the colorectal center, where you and Dr. Levitt are the primary surgeons for these patients. But you have relationships with people who are interested in the genetics and some of the new
markers that can be used in the gut to identify neuronal elements in the study of the bowel pathophysiology of these patients.

DR. PEÑA: That would be wonderful. If I had a lot of money and power, I would surround myself with basic scientists. I would tell them what our problems are. I would read a little bit about what they are doing, and I would motivate them to investigate something specific, related to our clinical concerns.

For the future, minimally invasive surgery is fascinating, and my prediction is that that will continue and will expand. Personally I believe that the instruments that we have now are still too rough for my standards. But there’s no question that it’s a matter of time. We need instruments that really replicate the movements of our hands. We don’t have that. You look into the screen, and you see rough, grotesque instruments, moving in a rather awkward way, as if they were moved by a monkey, like dinosaurs fighting. That’s what you see. However, I am sure that is going to change, no question. My recommendation for the young surgeons is keep practicing laparoscopic techniques. Keep working on that because that’s coming. The view that we have with those magnificent cameras is magnificent, unparalleled. In esophageal atresia, one can see both ends of the esophagus better than when you open the chest. But then suddenly one sees a grotesque instrument moving awkwardly. That is going to change.

DR. AZIZKHAN: Do you think robotics are going to have an impact in pediatric surgery and advance our field?

DR. PEÑA: Robotics means digital. There’s going to be several applications, but it’s still early. But there’s no question that when we have to do an extremely delicate repair, the robotic instrument is going to decrease the amplitude of our movements to make it tiny, and that’s going to be very precise. The digital principle of robotic instruments is going to have several important applications in pediatric surgery. Nowadays, we use mechanical instruments. Digital instruments will be created to replicate and minimize the amplitude of our moving hands, and in addition we will be able to feel with our fingers outside the body as if we were touching the tissues.

DR. AZIZKHAN: So you get the haptic feedback.

DR. PEÑA: That’s right. So that’s going to happen. Digital instruments will also have an impact in the training of surgeons, for the reasons that I explained about the problem of surgical skills. It is frustrating to see that young talented surgeon, giving lectures about sophisticated subjects with an impeccable curriculum. Then he assists you in a relatively simple operation, and at the end, he will ask a question that reveals that he
did not understand anything about the surgical technique. It’s amazing. There’s something almost mysterious about surgery, Richard. I am going to be politically incorrect again. What I mean is that even when conceptually surgery is so simple, not everybody can do it. As a matter of fact, some extremely talented individuals happen to be extremely bad surgeons. And it is irritating for them and for a lot of people because they can give you a beautiful talk about surgery. And yet when you go and watch them, they are not good surgeons. And some very good surgeons are not very intellectual.

DR. AZIZKHAN: They’re more like tradesmen. [Laughter]

DR. PEÑA: And of course there are also extremely intelligent and good technical surgeons. They are all kinds in the spectrum. There is something about surgery that makes you see a tumor in a CT scan and build a mental three-dimensional image, in order to know in which way to perform your dissection. Some people have difficulty doing that for some reason. I don’t know how to define what skills in surgery means. I’ve had conversations with famous surgeons who considered surgery something very simple, that you can teach monkeys to do. That’s because conceptually it is really very simple. But the fact is that not everybody can do it for many reasons that would take a long time to analyze. I don’t know exactly why.

DR. AZIZKHAN: If you were starting your career today as a young pediatric surgeon, what would you think are the two or three things that would be most interesting and challenging where you could make the biggest contribution going forward?

DR. PEÑA: That’s a really tough question.

DR. AZIZKHAN: Where do you think the biggest needs are in pediatric surgery today?

DR. PEÑA: You have to answer the question in two ways: in the United States or in the world?

DR. AZIZKHAN: First in the United States and then maybe also internationally?

DR. PEÑA: In the United States, I would put my efforts in the selection of surgeons for the reasons that I explained. I will try to detect those that have the most important ingredients: a real love for the art of surgery, dedication for the benefit of patients; and the specific qualities to become surgeons, such as decision-making capacity. In surgery we have to make decisions without being sure of what’s going to happen. It’s a little bit like in politics, you know. Some surgeons are intimidated by the fact that
they are going to make a decision. They are educated in the so-called evidence-based medicine. The truth is that in our everyday practice, we are still far away from evidence-based in making decisions. We make many decisions in every operation, second by second, and we don’t really have evidence that that is going to work or not. We are frequently right, sometimes wrong and must go home knowing that we made some things less than optimal. We must try to do it better tomorrow. Try not to be depressed, not to hesitate because somebody has to make a decision. Because, as you know, in surgery it is worse not to make a decision than to make a wrong decision. Surgery is all about making everyday decisions without having full evidence of the consequences of our decision.

An internist is very intimidated by that. And there are many surgeons with an internist type of personality that are terrified when they have to make decisions. They cannot make good surgeons. In surgery, if a person has no autocriticism, practices a “macho” type of surgery, is not afraid of anything, he could be a butcher with a license. In the other extreme of the spectrum is the intimidated person, incapable of making life and death decisions. To find the right balance, that is what is difficult in the selection of young surgeons. We need somebody that has balanced self-criticism.

DR. AZIZKHAN: You’ve always told me that you thought that the esophageal atresia was the pinnacle operation for a pediatric surgeon.

DR. PEÑA: That’s right.

DR. AZIZKHAN: But a lot of people like that surgery. But you’ve also picked an area that not too many people like. That’s why I asked you the question. Where do you see the unmet needs from the clinical medicine side, in pediatric surgery that we, as pediatric surgeons, should have some people focus on?

DR. PEÑA: Oh. I don’t know how to answer that question, Richard. I was not prepared for that question. You’re supposed to alert me.

[Laughter]

DR. AZIZKHAN: I’m trying to be a little provocative. But I can think of things like the whole arena of fetal surgery, for example, is one that is still very, very embryonic in its development, even though people like Michael [R.] Harrison have done phenomenal work for 20 years. But it’s still a field that only a handful of surgeons around the world have any experience in. Now what do you think about that?

DR. PEÑA: Well, I’m fascinated by hearing when they present fetal surgery cases here, in our hospital. I’m skeptical about how far we can go in
trying to repair malformations in utero, to tell you the truth. The question in congenital anomalies is: what is going to happen first? Is genetics going to eliminate congenital malformations? Or will repairing in utero be doing a better job than repairing them when they are born? Or science is going to come up with a series of answers for the treatment of the sequela? What’s going to happen first? I think that genetics is going to be first. Because in fetal surgery, with all the fascination that the field seems to have, I think we’ll reach a limit. I think that the limit will be like in embryology. By the time that we can see the malformation, it is already too late. And when you try to go earlier, it’s too early because you have a limit in terms of visualizing structures, like embryology.

Embryology has not much future; I mean embryology in terms of form. In studying embryology, there’s a limit because with the most powerful microscopes, you don’t see much. We must move into molecules.

DR. AZIZKHAN: How do we prevent some of these problems?

DR. PEÑA: But there we get into philosophy, Richard. Philosophically the question is: should we keep trying to cheat on Mother Nature or play a little bit more with Mother Nature? When we repair malformations, we are challenging Mother Nature, right? And in certain cases it’s perfectly justified. When we operate on a pyloric stenosis, an esophageal atresia without other associated malformations or an anorectal malformation with good prognosis, we feel that we are doing something really good. On the other hand, when we operate on a baby with multiple, devastating anomalies, we know that with our operation we allow that baby to survive, only to have a terrible quality of life. Then we ask ourselves: are we moving in the right direction?

DR. AZIZKHAN: Well, we don’t know where the limit is yet. In some ways fetal surgery is only one aspect of fetal therapy. And fetal therapy has potential to correct genetic and metabolic disorders that perhaps can be intervened early enough in utero that the sequela can be managed of certain diseases like cystic fibrosis and hemoglobinopathies and Tay-Sachs disease and other types of very difficult, lifelong, life-impeding diseases.

DR. PEÑA: I think we must continue studying and working on that, because we are going to discover collateral things that we did not expect. Remember when Mike Harrison started, and they found that the fetuses were born with no scars.

DR. AZIZKHAN: Yes.
DR. PEÑA: Those things happen. Those are the collateral benefits that we never expect. But the question is how much all pediatric surgeons are going to be doing this?

DR. AZIZKHAN: Oh, I don’t think all of them. But it’s what do we want our young people to think about? And some, not all, but some focus on those sorts of things.

DR. PEÑA: In the United States, our profession has become so competitive. It’s disappointing to see young pediatric surgeons, who worked very hard to reach the point of being attendings, after nine years of training, some of them are PhDs, have many publications and all that. They want to practice surgery and do research. But nobody pays for their research. They have to look for money for their research. In addition, they have to be on call. Then they have difficulty and complications for a simple problem, a hernia, a premature hernia. They have to play those two roles, and it’s a little frustrating. On the other hand, if we go back to the origin of our specialty, when we do a pyloric stenosis, we see the baby vomiting, very sick, before the operation and three days later is at home smiling, that’s enough justification for us to exist and to enjoy life. It is because of that, that I tell those young surgeons, “Don’t forget the essence of our profession. When you repair a strangulated hernia in the middle of the night, you did something great. You don’t have to be a genius. You don’t have to be a scientist. I mean if you are, great. But if you operate in the middle of the night and the child with appendicitis gets cured, that’s the essential part of our profession. That’s what we are supposed to be doing and feel well about that.”

DR. AZIZKHAN: Maybe we’re setting expectations that are too high for some of our young people.

DR. PEÑA: Yes.

DR. AZIZKHAN: Let me switch gears. I know that you’ve had a long-time interest in pectus excavatum, and you briefly mentioned that you wanted to talk about some of the things you decided to study when you were on Long Island or even before.

DR. PEÑA: Before, yes.

DR. AZIZKHAN: Some of the concerns that you had with our concepts of pectus excavatum and how we would treat it. Would you like to tell a little bit about that?

DR. PEÑA: Sure. You know when I went to Boston, Dr. Kenneth Welch was a pediatric surgeon there. And he had two areas of interest: One
was hypospadias and the other one was pectus. He was doing a pectus almost every day. He was doing the technique that was proposed by Dr. [Mark M.] Ravitch. He learned from him. And I learned from Dr. Welch.

DR. AZIZKHAN: I learned from Dr. Welch, too. [Laughter]

DR. PEÑA: Dr. Ravitch’s technique is one of those techniques that there are so many cartilage to remove, that there is enough to train the seniors, the fellows, the juniors, and the medical students how to remove costal cartilages. So I learned to do that. In Boston, I was trying to remember if I saw pectus in Mexico. I thought that perhaps it doesn’t exist in Mexico. However, I went back to Mexico, and I saw the first patient with a pectus, and I operated on him. And as soon as I operated on one, more patients started coming. There was one publication in Mexico related to pectus in adults, about ten patients. That’s all. I started collecting these patients; they started coming to us. And I become the champion of pectus excavatum in Mexico. Dr. Welch said that it was better to do it earlier because it was less painful and the results were better. In addition, the technique of the resection of the costal cartilage is much easier in a little baby. So we moved from four years to three years to two years old. We were doing two years old. And indeed, I can show you the pictures. The results were spectacular. The babies had much less pain than what we see with the Nuss procedure now.

Very soon we accumulated like a hundred cases in Mexico. Then I made a movie, and I won prizes in the Mexican Society of Pediatric Surgeons [Sociedad Mexicana de Cirugía Pediátrica]. Then I went to the Latin American associations meeting in South America. I was demonstrating the technique, and it was great. But again here comes what I was saying before: how important it is to follow the patients. Ten years later the patients that we operated when they were two years old looked terrible!!! In fact, I observed that the younger they were operated on, the worst they looked. The experience was both disappointing and scary. The chest did not grow. The cartilages that we did not resect, mainly number one and number two, continued overgrowing so they created like a protuberance in the upper part of the chest. So I have pictures. They look terrible, really spectacular pictures of that. I was very concerned.

It’s not so bad to make mistakes, Richard. The bad part is not to recognize them. I said, “Something is really wrong about what we are doing.” I called Dr. Welch and said, “Have you seen these?” “No, I have never seen that.” And I asked others. And they said, “Never have seen that.” That is when I decided to go ahead and do a study in dogs. Now, experimental surgery in Mexico? Who pays for that? Nobody. So I got four very enthusiastic medical students from the Military Medical School. They have to do a thesis
for graduation. Each one of them was going to put money, including me, to buy ten puppies. We took two puppies of the same litter. One had a sham operation, separate the pectoral muscle and put it back together, and the other puppy had a resection of costal cartilages third to tenth. We then followed them until they became adults. The questions were: Where are we going to follow them? Who is going to feed them? I suggested that each one of the medical students will take two puppies home or to their girlfriend’s house and feed them.

Every month we’re supposed to take chest films of the puppies. Again the question was: Where were we going to take the chest films? At night, secretly, the puppies will be taken into the x-ray department of the Military Hospital. Fortunately, they did not catch us. So we followed them. The results were spectacular: Those operated animals looked exactly like the patients that we followed. So when they become adults six months later, they had the same prominent overgrowth unrectectected upper cartilages and the lower chest did not grow. They have increased heart rate, increased respiratory rate. The chest looked like a sausage. It was really impressive. So we got good pictures of that.

We went to the American Academy of Pediatrics in San Francisco and presented that paper. There was Dr. [J. Alex] Haller [Jr.], and Dr. Welch, and another couple of surgeons who did a lot of pectuses. They all said that I was doing something wrong because they never saw that sequela. I must say that many years later, Alex Haller told me that I was right. He has seen this late sequela. Yet, my paper was not accepted for publication, they said, “Because it was a limited number of animals.”

DR. AZIZKHAN: Yes, Dr. Haller does agree.

DR. PEÑA: Because he has seen that. At the same time that all this happened, I was invited to Washington Children’s Hospital [Children’s National Medical Center] to demonstrate a PSARP [posterior sagittal anorectoplasty] in an anorectal malformation. And next door, guess what they were doing? They were resecting one of those overgrown costal cartilages in the upper part of the chest.

In 1985, when I arrived to Long Island and the chairman offered me money to do research, my first study was the same one that I did in Mexico, because remember our paper was not published. My paper presented at the American Academy of Pediatrics was not published. In Long Island, the study was done with 40 rabbits and we had exactly the same results. This time the paper was accepted in Pediatric Surgery International. Fortunately, now that operation is no longer done because now we have the Nuss procedure.
I like to believe that that is an example of the importance of persisting into something, following an idea. I did not continue working on the subject of pectus because I got involved in the anorectal malformations. Otherwise my next step would be to do partial resections of the cartilages because the cartilages also have a growth center. We could continue those studies to determine which parts of the cartilages we could resect without producing negative effects.

DR. AZIZKHAN: They are the central growth centers.

DR. PEÑA: The resection of the costal cartilages affected the growth of the entire chest.

DR. AZIZKHAN: Yes.

DR. PEÑA: At the present time, it all sounds like history. But I think there is a message here for the new generation.

DR. AZIZKHAN: It's still a problem.

DR. PEÑA: The message is for those that are doing the Nuss procedure now. The main thing to remember is that this is a developmental problem.

DR. AZIZKHAN: Right.

DR. PEÑA: If we do the Nuss procedure, let’s say at four years of age, what’s going to happen at eight years of age? What’s going to happen at 12, what’s going to happen at 16? We must come up with a plan. The treatment should be not based on the immediate outcome. I saw the Nuss procedure. Dr. [Donald] Nuss came to Long Island to demonstrate that. It’s impressive, spectacular, the way the chest deformity disappeared. It’s beautiful. But we pediatric surgeons and the new generations cannot stop there. Somebody has to study the nature of the condition. For instance, I learned that there’s a tendency to be familial. I saw entire families with this defect. We also saw families where half of them have carinatum and half of them have excavatum. Some others have asymmetric malformations. It is a developmental problem that has to be studied.

When we do a Nuss procedure, we must be aware of the fact that we are not curing the disease; we are just making a cosmetic improvement. We need a master plan following the patient until adulthood. We need a center for the study and treatment of pectus malformations. We need to study the cartilages and do genetic studies. During the growth of these patients, in
addition to the Nuss procedure done once or several times, some patients may benefit from what you have been proposing about the thoracic compression devices.

DR. AZIZKHAN: The bracing of pectus carinatum.

DR. PEÑA: After a Nuss procedure, we must determine how often are we going to change that? And what’s the master plan until you have a fully-developed adult. That’s the lesson that I learned. And I think we can extrapolate that to many other malformations.

DR. AZIZKHAN: I agree. It’s one of the reasons I wanted to bring that subject up. Just so that you know that when I finished my training in 1985, I went to [University of] North Carolina in Chapel Hill. And I started seeing patients who had been operated on by a pediatric surgeon in North Carolina who was doing very early operations, aged three, four, for pectus. And those children were coming back at age 10, 12, 14, with the same anomaly that you described in the puppies, with the bowing out of the upper part of the chest. I knew exactly that there was a problem with the original operation. So I had Dr. Haller see those patients. So he and I, we put the series together—we had 12 patients—and we published it in the *Annals of Surgery*. That’s why he was now convinced that your original observation, and your experimental observation was real. So it was a very good lesson for him and for me, both.

DR. PEÑA: Talking about the importance of following our patients as long as possible, in Boston I learned how to repair hypospadias. I went to Mexico and operated on many patients with hypospadias. I was very good with hypospadias, particularly those severe hypospadias where you reconstruct the entire urethra. I was so happy about my hypospadias patients, and I followed them. Years later, the beautiful neo-urethras that I made with skin became all torturous and dilated. So far, as far as I know, we have not found the ideal replacement for the urethra tissue.

Something similar happened to me with duodenal atresia. I was very proud of my beautiful operations, my patients did very well. One day, I was called to see a patient that I operated on seven years before. She never vomited. Then seven years later had one episode of vomiting. I got a contrast study and she had a megaduodenum with no obstruction. The anastomosis was perfectly patent, but the megaduodenum persisted. I learned then, to not only do a good duodenal anastomosis, but in addition to taper the megaduodenum. There is nothing more valuable than following your patients long term. They also give you great satisfaction when they send you a postcard from college, from their graduation. We have to infuse that in our fellows. We all need a touch of healthy skepticism about our long term results. Sequela are present in all malformations that we repair. Right?
DR. AZIZKHAN: Absolutely.

DR. PEÑA: In Hirschsprung’s disease, for instance, I like the idea of minimally invasive surgery. But we should not lose our perspective of what’s important. If somebody calls me now and tells me that he has a relative, a newborn baby, far away from here with Hirschsprung’s disease. And they ask me, do I suggest the patient to be operated laparoscopically or open? The answer is, “Who is doing the operation?” My main concern is to be sure that the patient has a good operation without technical misadventures that may leave the patient with a long term sequela such as fecal incontinence, urinary incontinence, fistula, strictures, etc. We must avoid all those preventable catastrophes. Unfortunately, those complications occur with and without laparoscopic. It’s not the laparoscopy. It’s who is doing it and how he’s doing it. The same with anorectal malformations. Of course we want to do it minimally invasive. But we should not change the priorities of what is really important. The important thing is the quality of life of that individual for the following 70 years. He’s not going to be concerned about the scar so much. He’s going to be concerned about the sequela.

In anorectal malformations, our main concern is those patients born with a “good” defect. Good defect means good prognosis for bowel control, provided they have a good operation. That should be the center of our interest. We have to train people to do impeccable operations, particularly in good malformations. A mistake, a complication, in that kind of defect means possible long term sequela of fecal incontinence! Those complications happen with or without laparoscopy; they happen because of lack knowledge of the basic principles of the treatment of anorectal malformations. If you can do a perfect operation laparoscopically, that’s even better. But the emphasis and the priority should be not to damage that child. Unfortunately, both in Hirschsprung’s disease and anorectal malformations, we see still many patients that had a bad operation that provoked life time sequela. Yet, there are very few publications on the subject.

DR. AZIZKHAN: Very few. Mmmm hmmm.

DR. PEÑA: And it’s happening.

DR. AZIZKHAN: Well, we’ve talked for three and a half hours at least.

DR. PEÑA: Oh, my God!

DR. AZIZKHAN: It’s been wonderful.

DR. PEÑA: Thank you for your time, Richard. It’s been great.
DR. AZIZKHAN: Are there any other things that you would like to say or to record for…?

DR. PEÑA: Well, let me tell you one more thing. I’m sorry to take your time, but I think this is important.

DR. AZIZKHAN: No, it’s our time together.

DR. PEÑA: Years ago, one of my brothers said that I was like a genius because of what I have done. A great friend of mine, a pediatric surgeon, said that I was not a genius. And then they embarked in that discussion. They decided to call me and asked what was my opinion about that? And I said, “If we think about genius like Einstein, Newton or Darwin (those are my great heroes), definitely put me out of that league. I am NOT a genius. If, on the other hand, you think I deserve some credit because you love me, I will tell you where I put my own credit for myself.”

We should not receive medals for having ideas. Those things happen. We don’t make any effort to have an idea. We are just there at the right time, and we see something, something that makes sense, as simple as opening the human body to see the anatomy and to find something previously unsuspected. In the area of anorectal malformations, our posterior sagittal findings and the conception of the way to repair a malformation is so simple that I can explain that to an elementary school child and he will understand that.

But going back to where do I think that I deserve credit? The answer is: the credit must come in recognition of persisting in an idea, in working hard and in overcoming other obstacles that we usually do not discuss. If you are born in a country like Mexico, you go to medical school and if you have a question about a medical subject, as a medical student, you go to the English textbook to decide who is right. And what the book says dictates the end of the discussion. That creates a state of mind that is not good. The underdevelopment is not only economical; it becomes intellectual underdevelopment because they teach you that. We grow up not questioning what is written in a textbook, particularly the textbooks in English. That’s a serious problem. I can tell you that traveling all over the world, I know many young doctors from underdeveloped countries that are extremely talented. And they come up with brilliant ideas. But from having an idea to implementing the idea, and then to take the idea to an international forum and defend your idea, not feeling intimidated, is a long distance. The real merit (if we want to find one) is precisely that. To jump from the underdeveloped world and to persist in pursuing your convictions, to trust your own observations even if they oppose the ideas of the experts.
We were talking about what I would like to do for future generations. I would like to take those young people with ideas and tell them, “Don’t be afraid. Believe in your ideas.” In fact, when I started working with the posterior sagittal approach, some friends told me, “How can you dare to contradict these Australian experts? They are experts. They have a large experience.”

DR. AZIZKHAN: They still have blinders.

DR. PEÑA: That’s right. When I presented those 57 cases in Colorado Springs, that was a personal experience. Somebody in the audience should stand up and say, “Dr. Dr. Peña, you operated on 57? That’s a very significant experience.” I believe that already at that time, there were not many people in the audience that had that kind of experience.

Years later I went to a meeting of the Mexican Society of Pediatric Surgery, and Dr. Ricardo Peniche, one of my trainees who works in Yucatan, presented 20 years of experience with esophageal atresia, 50 patients, operated on by him, and followed also, by him. About twenty-five percent mortality. The paper did not receive many comments in the association. So I said, “Do you realize what you just heard? This man went to the Yucatan Peninsula and operated the first esophageal atresia. And I remember under which circumstances he operated on those patients. No respirators. He had to sleep next to the patients until they recovered. And then he followed those patients: 25 percent mortality under those circumstances, being the pioneer there. Please, raise your hands those who operated and followed a similar number of cases. How many surgeons in the world have 50 cases personally operated? And how many of them operated on them in Yucatan? And how many of them followed them for 20 years? Then, gentlemen, this is a great paper.” That’s a real merit. When I go to talk to those countries, I tell them about these experiences. I basically tell them: It is possible! You know it is possible. The fact that a person was born in an underdeveloped country doesn’t mean that you cannot make a valuable observation. You can make a humble but valuable observation that may benefit many children. You’re not going to win the Nobel Prize, but you will have a great deal of satisfaction.

Another example is Dr. [Luis] De la Torre[-Mondragón] from Mexico who came out with the idea of transanal approach for Hirschsprung’s disease, a great idea. I’ve had conversations with him. I said, “Keep going. Keep going. You just got the idea. But now you have to expand. Keep going with it. Now people know that you have ideas.” And he’s a serious dedicated person, but working under very adverse circumstances. He has to prepare his presentations with his own money. Movies, books, travelling expenses for
meetings. Nobody pays for that in developing countries. Surgeons must operate many hernias to support their academic endeavors. That is the real merit.

The [William E.] Ladd Medal is an enormous satisfaction for me. I’d never dreamed about that. You remember in Boston? The room where I would sleep when I was on call was located in the old building. I used to see Dr. William Ladd’s painting almost every day, and I never thought about receiving the medal with his name! I’m extremely happy, extremely satisfied for having this.

I’m a living example of things that can happen. I grew up in difficult and adverse circumstances. So I achieved things that I never dreamed that it would happen. That is the reason why I am extremely optimistic and try to share that with the new generation.

DR. AZIZKHAN: Well, you may disagree, but I think most of us in pediatric surgery consider you not only a genius, but a true master, a maestro.

DR. PEÑA: Thank you, Richard.

DR. AZIZKHAN: And the Ladd Medal is one token of the affection and esteem that all of us feel for you and your contribution to children worldwide, not just in North America.

DR. PEÑA: Thank you, Richard, thank you.

DR. AZIZKHAN: So with that, we’ll conclude the interview and thank you again, Alberto, for spending the time with me and recording this for the future generations of our colleagues.

DR. PEÑA: I hope this is recorded, Richard. [Laughter]

DR. AZIZKHAN: I don’t want to have to do this again either.

DR. PEÑA: Thank you very much for your time.

DR. AZIZKHAN: Very good. Thank you.

DR. PEÑA: And everybody in the Academy.

[End of Interview]
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CURRICULUM VITAE

NAME: Alberto Peña, M.D.

DATE AND PLACE OF BIRTH: August 16, 1938
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PRESENT POSITION: Director, Colorectal Center for Children
Cincinnati Children’s Hospital Medical Center

ACADEMIC TITLE: Professor, Pediatric Surgery
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EDUCATION: Military Medical School, Mexico City
January 1957 to December 1962
M.D. Degree

PROFESSIONAL EXPERIENCE:
Internship and Surgical Residency January 1963 to December 1966
Central Military Hospital,
Mexico City, Mexico

ECFMG Examination #098-562 February 14, 1968

Research Fellow in Cardiovascular Surgery February 1969 to October 1969
Children's Hospital Medical Center
Boston, Massachusetts

Assistant Resident in Surgery November 1969 to October 1970
Children's Hospital Medical Center
Boston, Massachusetts

Senior Resident in Surgery November 1970 to December 1971
Children's Hospital Medical Center
Boston, Massachusetts

Surgeon-in-Chief January, 1972
National Institute of Pediatrics
Mexico City, Mexico
Professor of Pediatric Surgery  
University of Mexico  

June 30, 1985

Chief, Pediatric Surgery  
Schneider Children’s Hospital  
Long Island Jewish  
North Shore Health Systems  

New York, New York  

July 1985 to May 2005

Professor of Surgery and Pediatrics  
Albert Einstein College of Medicine  

New York, New York  

July 1985 to May 2005

Director, Colorectal Center for Children  
Cincinnati Children’s Hospital Medical Center  

Cincinnati OH  

May 2005 to Present

DISTINCTIONS AND AWARDS

• Award Jesus Lozoya to the Best Medical Student in Pediatrics. Military Medical School. Mexico, 1962.
• Von L. Meyer Award given to distinguished foreign residents. The Children's Hospital Medical Center, Boston, Mass. 1971.
• Award for the best paper entitled "Research in Mexican Pediatric Surgery," XI National Meeting of Pediatric Surgery, Mexico 1978.
• Award for the best surgical movie entitled "Esophageal Replacement," XI National Meeting of Pediatric Surgery, Mexico 1978.
• Award to the Best Clinical Case entitled "Pancreatectomy in the Newborn," XII National Meeting of Pediatric Surgery. Mexico, 1982.
• Annual Award of the Mexican Academy of Surgery for the paper entitled "An Original Treatment for Anorectal Malformations.” Mexico, 1982.
• Seventh Annual Robert E. Gross Award. February 16, 1985. University of Texas Health Science Center at Houston.
• First Prize for Best Paper entitled "Persistent Cloaca,” XXI Congress of the Mexican Association of Pediatric Surgery, Tabasco, Mexico, September 14-17, 1988
• Honorary Guest, XXII National Congress of the Mexican Society of Pediatric Surgeons, Puebla, Mexico, September 13-17, 1989
• Rudolfo Nieto Award. June 18, 1990, 9th Meeting of Pediatrics Hospital del Niño, Tabasco, Mexico
• Third Prize for videotape "Transanorectal Repair of a Urogenital Sinus,” presented at the American Urological Association in Toronto, June 1991 (co-authored with Dr. R. Bruce Filmer)
• First Prize for Best Paper entitled "Funcion rectal despues del abordaje sagital posterior
Estudio Manométrico presented at the 25th National Congress of Pediatric Surgery, Mazatlan, Mexico, September 10-19, 1992

- Award to Academic Excellence presented at the Panamerican Congress of Pediatric Surgery, Acapulco, Mexico, September 15, 2002.
- Honorary Member of Brazilian Academy of Pediatric Surgery, October 31st - November 7, 2002

ACADEMIC APPOINTMENTS:
June 2005 – present      Professor, Pediatric Surgery, University of Cincinnati, College of Medicine, Cincinnati
July 1989 – May 2005    Professor of Surgery, Albert Einstein College of Medicine, New York
October 1987 – June 1989  Professor of Surgery, State University of New York at Stony Brook, New York
June 1972 - June 1985  Professor of Pediatric Surgery, Faculty of Medicine, University of Mexico, Mexico

ORGANIZATIONS AND SOCIETIES:
- American Academy of Pediatrics, Surgical Fellow
- American Society of Colon & Rectal Surgeons, Fellow
- American Pediatric Surgical Association, Member
- American College of Surgeons, Fellow
- Austrian Association of Pediatric Surgeons, Honorary Member
- Brazilian Association of Pediatric Surgeons, Honorary Member
- British Association of Pediatric Surgeons Council, Overseas Member
- British Association of Pediatric Surgeons, Overseas Member
- Brooklyn and Long Island Chapter, ACS, Member
- Chilean Assoc. of Pediatric Surgeons, Corresponding Member
- Colombian Society of Pediatric Surgeons, Honorary Member
- Ecuadorian Society of Pediatrics, Honorary Member
- Guatemala Assoc. of Pediatric Surgeons, Honorary Member
- Greek Association of Pediatric Surgeons, Corresponding Member
- Mexican Academy of Pediatrics, Academician of Number
- Mexican Academy of Surgery, Academician of Number
- Mexican Association of Professors of Pediatrics, Member
- Mexican Society of Pediatric Surgeons, President (1984-1986)
• Israel Society of Pediatric Surgery, Honorary Member
• National Association of Pediatrics (Mexico), Member
• Pacific Association of Pediatric Surgeons, Active Member
• Panamerican Association of Pediatric Surgeons, Founding Member
• Peruvian Association of Pediatric Surgeons, Honorary Member
• Polish Association of Pediatric Surgeons, Honorary member
• Southeastern Surgical Congress, Active Member
• Universidad de la Frontera Temuco, Chile, Honorary Professor of the Faculty of Medicine
• Spaniard Association of Pediatric Surgery, “Cirugía Pediátrica” Editorial Board, Member
• Brazilian Academy of Pediatric Surgery, Member

COMMITTEES
• Boletín Médico del Hospital Infantil de México, Editorial Committee
• Pediatric Surgery International, Editorial Committee
• Research in Surgery, Scientific Committe
• TEF/VATER National Support Network, Medical Advisory Board
• Journal of Pediatric Surgery, Associate Editor
• Techniques in Coloproctology, Member, Editorial Board

COURSE TEACHING
Director and Instructor of Biannual 3 day intensive workshop and teaching course on the surgical treatment of anorectal malformations. Curriculum includes early diagnosis and management of anorectal defects, operating room demonstrations of surgical technique, indications for reoperation, posterior sagittal approach for other purposes, methods of evaluation, prognosis of deformities, bowel management, and case presentations.

PRESENTATIONS
• Guest Speaker, Mexican Societies and Hospitals 341 times (as of July 1985).
• Guest Speaker, Floating University (Tufts University), Boston, Massachusetts, April 28, 1983
• Guest Speaker, University of California School of Medicine, Department of Urology, San Francisco, California, May 14-15, 1984
• Guest Speaker, The Children's Memorial Hospital, Chicago, Illinois, May 29, 1984
• Guest Speaker, Presidential Address. Annual Meeting of the Mexican Society of Pediatric Surgery, Mexico, September 11-17, 1986
• Guest Speaker, "Advances in the Diagnosis and Management of Imperforate Anus" and "Potential Secondary Effects of Surgical Treatment of Chest Wall Deformities" at Pediatric Update, Department of Pediatrics, Schneider Children's Hospital, Long Island Jewish Medical Center, Cancun, Mexico, February 11-15, 1986
• Guest Speaker, "Urogenital Sinus Abnormalities - The Peña Procedure,” Pediatric Urology for the Practicing Urologist, Schneider Children's Hospital, Long Island Jewish Medical Center, New Hyde Park, New York, April 5-6, 1986
• Guest Speaker, Argentina Society of Pediatric Surgery, Mar Del Plata, Argentina, October 22-30, 1984
• Poster Presentation, American Urological Association, New York City, New York, May 20, 1986
• Guest Speaker, "Posterior Sagittal Anorectoplasty: Other surgical applications and potential usefulness in general surgery" and "Liver Resection in Pediatrics at General Surgery Update, University of New Mexico, Albuquerque, New Mexico, July 8-12, 1986
• Guest Speaker, 19th National Congress of Pediatric Surgery, Mexican Society of Pediatric Surgeons, San Luis, Mexico, September 12-16, 1986
• Guest Speaker, State University of New York, Syracuse, New York, October 31-November 1, 1986
• Guest Speaker, "New Advances in Pediatric Surgery" and "Surgical Management of Anorectal Malformations - Potential Applications in General Surgery" at 7th Annual Medical Congress of the Southwest Association of Hispanic American Physicians, November 7-10, 1986
• Guest Speaker, International Course on Gastrointestinal Medicine in Surgery, British American Cowdray Hospital, Mexico City, Mexico, November 10-14, 1986
• Guest Speaker, Grand Rounds, Westchester County Medical Center, Valhalla, New York, March 5, 1987
• Guest Speaker, Grand Rounds, Department of Pediatrics, Huntington Hospital, Huntington, New York, April 7, 1987
• Guest Speaker, Japanese Society of Pediatric Surgeons, Kobe, Japan, May 24-June 3, 1987
• Guest Speaker, University of Padova, Padova, Italy, October 1-4, 1987
• Guest Speaker, Robert Wood Johnson Medical School, New Brunswick, New Jersey, February 2, 1988
• Guest Speaker, "Surgical management of persistent cloacas - 54 cases" XXI National Congress of Mexican Society of Pediatric Surgery, Mexico City, Mexico, September 13-16, 1988
• Guest Speaker, "Experience with the management of persistent cloaca with a posterior sagittal approach" at the British Association of Pediatric Surgeons, XXXV Annual International Congress, Athens, Greece, September 21-24, 1988.
• Guest Speaker, Section on Urology, American Academy of Pediatrics, San Francisco, California, October 14-16, 1988
• Guest Speaker, 11th Congress of Panamerican Association of Pediatric Surgeons and 8th Peruvian Congress of Pediatric Surgery. Presented "New Concepts on Anorectal Malformations" Visiting Professor*, Post congress Course on Anorectal Malformations, Lima, Peru, October 18-November 4, 1988
• Guest Speaker, "Presente y Futuro de las Malformaciones Anorectales", 1st Congress of GEN, Mexico City, Mexico, February 6-11, 1989
• Guest Speaker, "The Acute Abdomen", Grand Rounds, Department of Surgery, Huntington Hospital, Huntington, New York, April 4, 1989
• Guest Speaker, "Technical Aspects of Posterior Sagittal Anorectoplasty and Follow-up Results", Grand Rounds, Department of Pediatric Surgery, Babies Hospital, Columbia Presbyterian Medical Center, New York, New York, April 13, 1989
• Guest Speaker, Grand Rounds, Department of Pediatric Surgery, State University of
New York Health Science Center at Brooklyn, New York, March 19, 1988
- Guest Speaker, Grand Rounds, Department of Surgery, Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, New York, February 26, 1988
- Guest Speaker, "Advances in Anorectal Malformations & "Artificial Sphincters", Tenth Meeting of the National Institute of Pediatrics, Mexico City, Mexico, February 9-14, 1988
- Guest Speaker, Course on Anorectal Malformations, 7th Congress Asian Surgical Association, Kuala Lumpur and Penang, Malaysia, February 16-25, 1989
- Guest Speaker, Course on Anorectal Malformations, Universita Degu Studi de Parma, Parma, Italy, March 20-25, 1989
- Guest Speaker, "Diagnosis and Types of Rectal Atresia", British Council Course on Neonatal and Pediatric Surgery, Royal Manchester Children's Hospital, Manchester, England, July 10-14, 1989
- Guest Speaker "Advances in Pediatric Surgery", XVI Annual Meeting of the Peruvian American Medical Society, New York, New York, August 9, 1989
- Guest Speaker, XXII National Congress of the Mexican Society of Pediatric Surgeons, Puebla, Mexico, September 13-17, 1989
- Guest Speaker, "Surgical Management of Refractory Constipation", Colonic Motility Symposium, Boston, Massachusetts, October 13, 1989
- Guest Speaker, Course on Anorectal Malformations, Ostra Sjukhuset, Goteborg, Sweden, November 27-December 6, 1989
- Guest Speaker, Course on Anorectal Malformations, Sponsored by Project Hope, Krakow, Poland, March 10-17, 1990
- Guest Speaker, Course on Anorectal Malformations, Turkish Association of Pediatric Surgeons, Istanbul, Turkey, April 16-28, 1990
- Guest Speaker, Course on Anorectal Malformations, Rambam Medical Center, Haifa, Israel, April 22-28, 1990
- Guest Speaker, Department of Surgery Grand Rounds, Children's Hospital & Medical Center, Seattle, Washington, May 16-18, 1990
- Guest Speaker, Pediatric Surgical Society of the National Institute of Pediatrics, Durango, Mexico, February 11-15, 1990
- Guest Speaker, Ninth Meeting of Pediatrics, Hospital del Nino, Tabasco, Mexico, June 16-23, 1990
- Guest Speaker, Grand Rounds, Department of Surgery, North Shore University Hospital, Manhasset, New York, September 5, 1990
- Guest Speaker, XXVII World Congress of the International College of Surgeons, Congress of Brazil, Sao Paulo, Brazil, September 7-13, 1990
- Guest Speaker, Tampa General Hospital, University of South Florida, Tampa, Florida, September 20-22, 1990
- Guest Speaker at Grand Rounds, Department of Pediatrics, The New York Hospital-Cornell Medical Center, New York, New York, October 24, 1990
- Guest Speaker, Saturday Surgical Conference, Department of Surgery, St. Joseph's Hospital & Medical Center, Paterson, New Jersey, October 27, 1990
- Guest Speaker, 20th Anniversary National Institute of Pediatrics, Mexico City, Mexico, November 3-8, 1990
- Guest Speaker, Grand Rounds, Department of Pediatrics, North Shore University Hospital, Cornell Medical College, Manhasset, New York, January 24, 1990
- Guest Speaker, 20th Annual National Reunion of the Association of Pediatric Surgical Residents, National Institute of Pediatrics, Mexico City, Mexico, February 18-22, 1991
- Guest Speaker, Cooke Lectureship Hartford Hospital, Hartford, Connecticut, April 5-6, 1991
- Guest Speaker, Course on Anorectal Malformations, Archbishop Makarios III Hospital, Nicosia, Cyprus, April 16-20, 1991.
- Guest Speaker, Course on Anorectal Malformations, Opesdale Generale Regionale Hospital, Treviso and Universita' Degli Studi di Messina, Sicily, Italy, April 20-28, 1991.
- Guest Speaker, Course on Anorectal Malformations, Hospital del Niño, Villahermosa, Tabasco, Mexico, June 24-28, 1991
- Guest Speaker, Ballantine Symposium, Hershey Medical Center, Hershey, Pennsylvania, June 6, 1991
- Guest Speaker, Neonatal and Paediatric Surgery, Royal Manchester Children's Hospital, Manchester, England, June 30-July 6, 1991.
- Guest Speaker, San Diego Urological Society, San Diego, California, November 21, 1991
- Guest Speaker, National Workshop on Anorectal Malformations, Postgraduate Institute of Medical Education & Research, Chandigarh, India, November 24-December 2, 1991
- Guest Speaker, Philippine College of Surgeons, Manila, Philippines, December 3-9, 1991
- Guest Speaker, Course on Anorectal Malformations, Chang Gung Memorial Hospital, Taiwan, ROC, December 9-16, 1991
- Guest Speaker, "Advances in the Management of Anorectal Malformations", and Course on The Surgical Treatment of Anorectal Malformations, IV Congress of the Arab Association of Paediatric Surgeons, Dubai, U.A.E., October 21-29, 1993
- Guest Speaker, Course on Anorectal Malformations, National Institute of Pediatrics, Mexico City, Mexico, May 29-June 5, 1992
- Guest Speaker, Department of Surgery Grand Rounds, Ochsner Medical Institutions, New Orleans, Louisiana, July 10-11, 1992
- Guest Speaker, Course on Anorectal Malformations, sponsored by Project Hope, Krakow, Poland March 15-22, 1992
- Guest Speaker, "New Approaches in the Evaluation and Management of Imperforate Anus," Grand Rounds, Virginia Commonwealth University, Children's Medical Center, Richmond Virginia, February 21-22, 1992
- Guest Speaker, "The Effects of the Posterior Sagittal Approach on Rectal
• Guest Speaker, "Posterior sagittal anoplasty in imperforate anus", Department of Urology Grand Rounds, Maimonides Medical Center, Brooklyn, New York, May 29, 1992
• Guest Speaker, "The posterior approach for the management of anorectal malformations. Implications in adult colorectal surgery", Harry E. Bacon Lectureship, Society of Colon & Rectal Surgery, San Francisco, California, June 10-12, 1992
• Guest Speaker, "Funcion rectal despues del abordaje sagital posterior Estudio Manométrico", (1st Prize) "Efectos fisológicos del abordaje sagital posterior", and Importancia de los esfínteres externo e interno para la continencia fecal" at the XXV Congress National of Mexican Pediatric Surgeons, Mazaltan, Mexico, September 10-19, 1992
• Guest Speaker, Video "Trans Anorectal Repair of Urogenital Sinus" at 1992 Clinical congress of the American College of Surgeons, New Orleans, Louisiana, October 14, 1992
• Guest Speaker, "Controversias en Cirugía Pediátrica (Presento un Futuro)," at the XXV Reunion of the National Association of Pediatric Residents at the National Institute of Pediatrics, Mexico City, Mexico, October 16-18, 1992
• Guest Speaker, North New Jersey Association for Pediatricians, Saddle Brook, New Jersey, November 19, 1992
• Guest Speaker, "A New Pediatric Surgical Procedure Providing Access to the Pelvis", Memorial Sloan-Kettering Cancer Center, New York City, New York, December 9, 1992
• Guest Speaker, "Postnatal and Perinatal Management of Gastrointestinal Anomalies", Multidisciplinary Approach to the Fetus and Neonate with Congenital Anomalies, sponsored by Long Island Jewish Medical Center, Schneider Children's Hospital, Garden City, New York, December 9, 1992
• Guest Speaker, The William B. Kisewetter Lecture, "Current Concepts in the Management of Anorectal Malformations", Children's Hospital of Pittsburgh, Pittsburgh, and "Posterior Sagittal Approach for General and Colorectal Surgeons", Department of Surgery Grand Rounds, University of Pittsburgh, School of Medicine, Pittsburgh, Pennsylvania February 12-13, 1993
• Guest Speaker, "Posterior Approach to the Rectum - Implications in General Surgery," Department of Surgery Grand Rounds, North Shore University Hospital-Cornell Medical Center, Manhasset, New York, February 17, 1993
• Guest Speaker, "Posterior Sagittal Approach to Urogenital Surgery," Grand Rounds, Department of Urology, Long Island Jewish Medical Center, New Hyde Park, NY, February 18, 1993
• Guest Speaker, Guatemala Association of Pediatricians, Guatamala City, Guatemala, February 27-March 5, 1993
• Guest Speaker, "Controversies in Pediatric Surgery - Present and Future", XVI Reunion of the Association of Pediatric Residents of the National Institute of Pediatrics, Ruidosa, New Mexico, March 24-18, 1993
• Guest Speaker, "Fistula Perianal en Pediatrica. ¿Debe Operarse?", Mexican Society of Pediatric Surgeons, Huatulco, Oaxaca, Mexico, September 12-16, 1993
• Guest Speaker, "The Importance of Sigmoid Motility in Fecal Continence", The American Pseudo-obstruction & Hirschsprung's Disease Society, Inc., Boston, Massachusetts, October 15, 1993
• Guest Speaker, Grand Rounds, Department of Surgery, Long Island Jewish Medical Center, New Hyde Park, New York, January 20, 1994
• Guest Speaker, "Valor Actual Del ECMO, Cirugia Fetal y Cirugia Endoscopica," X Curso de Actualización en Pediatria, Guadalajara, Mexico, January 23-30, 1994
• Guest Speaker, Course on Surgical Treatment of Anorectal Malformations, PEMEX Hospital, Mexico City, Mexico, June 15-17, 1994
• Guest Speaker, Japanese College of Surgeons, Kobe, Japan, June 28-29, 1994
• Guest Speaker, "Advances in the Management of Colorectal Problems in Children," Grand Rounds, Department of Pediatrics, Maimonides Medical Center, Brooklyn, New York, March 22, 1994
• Guest Speaker, Course on the Surgical Treatment of Anorectal Malformations, Samsun Medical Center, Seoul, Korea, and Wonju College of Medicine in Wonju, Korea October 27-November 1, 1994
• Guest Speaker, The Chinese University of Hong Kong, Prince of Wales Hospital, Santin, Hong Kong, November 2-7, 1994
• Guest Speaker, First International Meeting, Pediatric Colorectal Club, Hamburg, Germany, June 26, 1994
• Guest Speaker, United Ostomy Association National Meeting, August 11-14, 1994
• Guest Lecturer, Department of Surgery Grand Rounds, "The Posterior Sagittal Approach and It's Importance for Colorectal and General Surgeons," Mt. Sinai Medical Center, New York, NY September 7, 1994
• Guest Speaker, Department of Surgery Grand Rounds, "Importance of Surgical Technique in the Practice of Surgery," Long Island Jewish Medical Center, New Hyde Park, NY, September 8, 1994
• Guest Speaker, World Congresses of Gastroenterology, Los Angeles, California, October 2-7, 1994
• Guest Speaker, "Advances in the Management of Anorectal Malformations," Grand Rounds, Department of Pediatric Surgery, Children's Hospital of Los Angeles, Los Angeles, California, October 6, 1994
• Guest Speaker, La Asociacion de Medicos del Hospital Infantil de Morelia, "Advances en Cirugia Pediatrica," and "Malformaciones Anorectales," Morelia, Michoacan, Mexico, October 19-22, 1994
• Guest Lecturer, Scandinavian Association of Pediatric Surgeons, Goteborg, Sweden, May 10-14, 1994
• Guest Speaker, Course on the Surgical Treatment of Anorectal Malformations, Hospital Universitario "Dr. Antonio Maria Pineda", Barquisimeto, Venezuela, Jan 30-Feb 3, 1995
• Guest Speaker, Department of Pediatric Surgery Grand Rounds, Babies Hospital, Colombia-Presbyterian Medical Center, New York, New York, February 16, 1995
• Guest Speaker, Department of Pediatric Grand Rounds, Buffalo Children's Hospital, Buffalo, New York, February 17-18, 1995
• Guest Speaker, "Posterior Sagittal Approach: Importance for Colorectal & General Surgeons," SUNY Health Science Center, Syracuse, NY February 24-25, 1995
• Guest Speaker, Department of Pediatric Surgery Grand Rounds, Children's Hospital of Orange County, Orange, California, March 6-10, 1995
• Guest Speaker, Annual Meeting Sociedad de Cirujanos Pediatras Egresados del Instituto Nacional de Pediatria, March 15-19, 1995
• Guest Speaker, Grand Rounds, Department of Surgery, New York Hospital-Cornell Medical Center, New York, New York, March 22, 1995
• Guest Speaker, 1st European Congress of Paediatric Surgery, Graz, Austria, "Lessons learned from surgery of cloacal and anorectal malformations." May 4-6, 1995
• Guest Speaker, 5th Congress of the Asian Federation of Coloproctology,"Posterior

- Guest Speaker, 2nd Annual International Pediatric Colorectal Club, Dublin, Ireland, July 22, 1995
- Guest Speaker, "Resultados en el Manejo de Malformaciones Anorectales," and "La Reconstruccion Vaginal en Casos de Cloacas Complejas," Sociedad Mexicana de Cirugia Pediatrica, XXVII Congreso Nacional, September 13-16, 1995
- Guest Speaker, "Importancia de la Relacion Medico-Paciente en Pediatria" and "Avances en el Manejo de las Malformaciones Anorectales," Commemorative Congreso, Instituto Nacional de Pediatria, Mexico City, Mexico, November 16-20, 1995
- Guest Speaker, "Advances in the Management of Anal Rectal Malformations," Grand Rounds, Department of Pediatrics, St. Peter's Medical Center, New Brunswick, New Jersey, February 8, 1996
- Guest Speaker Pediatric Surgery Update and Bowel Management Issues - United Ostomy Association, Balboa Naval Hospital, San Diego, May 22, 1996
- Guest Speaker, American Pediatric Surgical Association, Total Urogenital Mobilization, San Diego, California May 19-22, 1996,
- Guest Speaker, Congress on Fetal Medicine, Cannes, France, November 21-23, 1996
- Guest Speaker, Course on “The Surgery of the Cloaca and Urinary Continent Diversion,” Azienda Ospedaliera S.Maria Degli Angeli, Pordenone, Italy, July 16-18, 1998
- Guest Speaker, Course on “The Surgical Management of Anorectal Malformations, Lisbon, Portugal, September 7-9, 1998
- Guest Speaker, “Continent Appendicostomy in the Bowel Management of Fecally Incontinent Children,” at the Pacific Association of Pediatric Surgeons, Phoenix, Arizona, April 10-14, 1997
- Guest Speaker, “Course on the Surgical Treatment of Anorectal Malformations,” at the Sociedade Paulista de Cirurgia Pediatrica, Sao Paulo, Brasil, June 30 to July 2, 1997
- Guest Speaker, Course on Surgical Treatment of Anorectal Malformations, The General Infirmary at Leeds, Leeds, United Kingdom, September 16-21, 1997
- Guest Speaker, II Curso Intensivo Sobre Tratamiento Quirurgico de las Malformaciones Anorectales, Hospital General Universitario “Gregorio Maraño,” Madrid, Spain, May 6-8, 1998
• Guest Speaker, Children’s Hospital, Greenville, South Carolina, February 13-16, 1997
• Guest Speaker, IV International Reunion of Pediatric Surgeons of the Sociedad de Cirujanos Pediatras del Issste, Morelia, Mexico, March 20-23, 1997
• Guest Speaker, The American Pseudo-obstruction and Hirschsprung’s Disease Society, Inc., Boston, Massachusetts, April 4-6, 1997
• Guest Speaker, General Surgery Grand Rounds, Children’s Hospital Medical Center, Cincinnati, Ohio, April 14-16, 1997
• Guest Speaker, International Symposium on “State of the Art” in Pediatric Surgery, Trinity College, Dublin, Ireland, July 19-20, 1997
• Guest Speaker, Fourth Meeting of the International Pediatric Colorectal Club, presented “Rectovestibular fistula with absent vagina: A unique anorectal malformation,” “Gynecological concerns in the teenage cloaca patient,” “Anorectal malformations and Down’s syndrome,” “Bowel management for fecal incontinence in patients with anorectal malformations,” and “Continent appendicostomy in the bowel management of fecally incontinent patients,” Istanbul, Turkey, July 21, 1997
• Guest Speaker, British Association of Pediatric Surgeons, presented “Bowel management for fecal incontinence in patients with anorectal malformations,” Istanbul, Turkey, July 24-26, 1997
• Guest Speaker, “Experiencia en Resección Sigmoidal and Hisotria”, Sociedad de Cirujanos Pediatras Egresados del Instituto Nacional de Pediatría, Tapalpa, Jalisco, Mexico, March 5-15, 1998
• Guest Speaker, Sociedad Mexicana de Cirugía Pediatrica, Presented “Malformaciones Anorectales y el Sindrome de Down,” and “La Appendicostomia Continente en el Manejo de la Incontinencia Fecal,” and “Problemas Ginecologicos en Adolescentes Nacidas con Cloaca,” Zacatecas, Mexico, September 10-15, 1997
• Guest Speaker, “Implications of the PSA (Posterior Sagittal Approach) in Pediatric Urology,” at the European Society of Paediatric Urology, Saltzburg, Austria, April 16-19, 1998
• Guest Lecturer, Fifth International Pediatric Colorectal Club Meeting, Cologne, Germany July 19-21, 1998
• Poster Presentation, “Posterior Urethral Diverticula after Imperforate Anus Repair,” British Association of Paediatric Surgeons, Bristol, U.K., July 19-23, 1998

• Guest Speaker, 49th Anniversary Celebration of Hospital del Niño DIF, in Hidalgo, Mexico, January 22-31, 1999

• Guest Speaker, II Congreso Nacional Sobre Defectos al Nacimiento, “Advances en el manejo de las malformaciones anorectales,” Mexico City, Mexico, March 4-6, 1999

• Guest Speaker, Sociedad de Cirujanos Pediatras Egresandos del Instituto Nacional de Pediatría, “Advances en Cirugía Ano/Rectal,” Madrid, Spain, March 8-10, 1999

• Guest Speaker, University of Tel Aviv, Shneider Children’s Hospital, Tel Aviv, Israel, March 14-20, 1999

• Guest Speaker, Department of Pediatrics Postgraduate Lecture Series, “Anorectal Malformations,” Nassau County Medical Center, East Meadow, NY, April 15, 1999

• Guest Speaker, “The posterior sagittal approach - implications for general, colorectal and urologic surgeons,” and “Advances in the management of anorectal malformation,” Grand Rounds, Mercy Medical Center, Pittsburgh, Pennsylvania, April 19-20, 1999

• Guest Speaker, “The Negative Effects of Bowel Pouches and Aganglionic Colon Patches,” British Association of Pediatric Surgeons, Liverpool, U.K., July 20-23, 1999

• Guest Speaker, “Posterior urethral diverticulum following imperforate anus repair,” “The negative effects of bowel pouches and aganglionic colon patches,” and “Posterior urethral diverticulum following imperforate anus repair,” Non-operative management of fistula-in-ano,” Sixth Annual Meeting of the Pediatric Colorectal Club, Stockholm, Sweden, July 24-26, 1999

• Guest Speaker, “Tratamiento actual de las malformaciones anorectales,” and “Cirugia in vivo,” Hospital “Teresa Herra”, A Coruña, España, December 9-10, 1999

• Guest Speaker, “Atencion Neonatal del recien nacido con ano Imperforado,” “Colostomia,” “Anorectoplastia Sagital Posteior,”“Reoperacion de ano imperforado,” “Movilizacion urogenital total,” “Cloaca,” and “Advances en Incontinencia Fecal.”, XXXII Congreso Nacional de Cirugia Pediatrica, of the Sociedad Mexicana de Cirugia Pediatrica Zacatecas, Mexico, September 8-16, 1999


• Guest Speaker, “The Future of Medicine,” XXIII InterAmerican Medical Dental Congress of the Sociedad Medica Hispanoamericana de Nueva York, Dr. Severo Ochoa Memorial Lecture, Queens, New York, October 10, 1999

• Guest Speaker, “Abordaje Sagital Posterior para Urologos,” “Implicaciones Urologicas de las Malformaciones Anorectales,” and “Tratamiento Quirurgico de la Cloaca,” at the XXII Congreso Chileno de Urologia, La Serena, Chile, October 28-31, 1999

• Guest Speaker, Cirurgia de las Malformaciones Anorectales, Hospital Italiano de Buenos Aires, Buenos Aires, Argentina, November 7-8, 1999

• Guest Speaker, XXXIII Congreso Argentino de Cirugia Pediatrica, Buenos Aires, Argentina, November 9-12, 1999

• Guest Speaker, “Research in Pediatric Surgery,” and “Urological Complications in Repair of Anorectal Malformations,” at the Sociedad de Cirujanos Pediatras, Egresados del Instituto
Nacional de Pediatria, Tabasco, Mexico, February 9-13, 2000

- Guest Speaker, “Colorectal Problems in Children,” Department of Pediatrics Grand Rounds, Nassau County Medical Center, East Meadow, New York, February 24, 2000
- Guest speaker, Society of Pediatric Surgeons of National Institute of Pediatric, Mexico. March 14-18, 2001
- Guest speaker, VIII Meeting of the International Pediatric Colorectal Club, presented “Recto-Vaginal Fistula: A common diganostic error with significant consequences in female patients with anorectal malformations”, “Urological injuries associated with the repair of anorectal malformations in male patients”, Kyoto, Japan, April 2-4, 2001
- Guest Speaker, Grand Rounds, Department of OBGYN, North Shore University Hospital, Manhasset, New York, June 16, 2001.
- Guest Speaker, “Enfermedad de Hirschsprung”, Hospital Monteprincipe Madrid, Spain. February 17, 2001
- Guest Speaker, Klinikum Oldenburg - Oldenburg, Germany May 27-28, 2002
- Guest Speaker, Grand Rounds, Department of Gastroenterology, North Shore University Hospital, Manhasset, New York, June 13, 2001.
• Guest Speaker, Altonaer KinderKrankenhaus Klinik fur Kinder-und Jugendmedizin, Hamburg, Germany, September 2001
• Guest Speaker, “Evolution and Current Treatment of Anorectal and Genitourinary Malformations in Children,” Loren R. Chandler Memorial, Lecture in Pediatric Surgery, Stanford University School of Medicine, California, November 2, 2001.
• Guest Speaker, Grand Rounds, Department of Surgery, Texas Tech University Health Sciences Center, School of Medicine, Lubbock, Texas, November 25-30, 2001.
• Guest Speaker, “Manejo de la Constipación” and “Enfermedad de Hirschsprung, Lo que frequentemente no se discute”, Spaniard Association of Pediatric Surgeons, Sociedad de Residentes y Ex-Residentes de Cirugía Pediátrica Egresados del Instituto Nacional de Pediatría III Reunion Mexico-España, Salamanca, May, 2002
• Guest Speaker, “Recto-Vaginal Fistula: A common diagnostic error with significant consequences”, IXth International Meeting of the Pediatric Colorectal Club, Marseille, France July 2002.
• Guest Speaker, XVIII Panamerican Congress of Pediatric Surgery, Acapulco, Mexico, September 2002
• Guest Speaker, “Anorectal and genito-urinary malformations in females: Implications for Gynecologists”, Department of Obstetrics and Gynecology Grand Rounds, Staten Island University Hospital, October 2, 2002
• Guest Speaker, Brazilian Association of Pediatric Surgeons - Operating Course. Brazilian Academy of Pediatric Surgery, October 31st - November 7, 2002.
• Guest Speaker and Visiting Surgeon, St. Joseph’s Hospital, Berlin, Germany, November 25-28, 2002
• Guest Speaker, Grand Rounds, Department of Obstetrics and Gynecology, “Pediatric Pelvic Disorders and Reconstruction”, Nassau Surgical Society and Brooklyn and Long Island Chapter of the American College of Surgeons, Nassau, New York December 4, 2002
• Guest Speaker, Hospital de la Misericordia, Bogota, Colombia, December 5-9, 2002.
• Guest Speaker, Advances in the management of anorectal malformations”, The Hospital for Sick Children, Toronto, Canada, February 27-18, 2003.
• Guest Speaker, XV Internacional De Urologia Pediatrica, II Curso De La Asociacion Andaluza de Urologia Para Residentes. XV International Course of Pediatric Urology,
Malaga, Spain, April 1-3, 2003.
- Guest Speaker, The Children’s Hospital, Denver Colorado, August 7-10, 2003.
- Guest Speaker, Nuevo Hospital Materno-Infantil, III Curso Intensivo sobre Tratamiento Quirurgico de Malformaciones Anorrectales, Madrid, Spain, October 12-21, 2003.
- Guest Speaker, St. Joseph Hospital, Berlin, Germany, November 2-8, 2003
- Guest Speaker, Grand Rounds, 8th Annual Colodny Lectureship in Surgery, University of Vermont, June 16-17, 2004.
- Guest Speaker, Munster, Germany, August 4-6, 2004.
- Guest Speaker, 37th Congress Mexican Society of Pediatric Surgery, CD. Juarez, Mexico, September 2004.
- Guest Speaker, Lecturer 9th Central European Congress of Coloproctology, Serbian Association of Colorectal Surgeons, Belgrade October, 2004.
- Guest Speaker, San Lucas Hospital PUCRS, Porto Alegre, Brazil, October 15-16, 2004.
- Guest Speaker, Clinica Alemana, Chile, November 2-5, 2004.
- Guest Speaker, Treatment and Management of Children with Stoma, Milano, Italy, January 2005.
- Guest Speaker, Association of Mexican Military Doctors Oaxaca, February 2005.
- Guest Speaker, Neonatology Grand Rounds, Denver, April 2005.
- Guest Speaker, “Present and Future Management of Anorectal Malformations,” Academic Symposium, Riley Hospital for Children, Indianapolis, Indiana, June 3-4, 2005.
- Guest Speaker, “Luck and Serendipity- A History of Surgical Technique,” Surgical Grand
Rounds, Wright State University, Dayton, Ohio March 1, 2006.

- Guest Speaker, “The Newborn Management of Anorectal Malformations for Pediatrics,” Surgical Grand Rounds, Children’s Medical Center, Dayton, Ohio, March 1, 2006
- “Increased Heritability of Certain Types of Anorectal Malformations.” Presented at the American Pediatric Surgical Association 37th Annual Meeting, Hilton Head, South Carolina, May 21-24, 2006
- Guest Speaker, “Reoperation of Anorectal Malformations” British Association of Paediatric Surgeons, The Royal College of Surgeons Presented July 18 – 21, 2006
- Guest Speaker and Co-Chairman The 13th International Paediatric Colorectal Club, Helsinki, July 15-17, 2006
- “Reoperations in Hirschsprung’s disease” Presented at the American Academy of Pediatrics National Conference and Exhibition, Atlanta, Georgia, October 7-12, 2006.
- “Postsagittal approach for genitourinary pathology” Presented at the American Academy of Pediatrics National Conference and Exhibition, Atlanta, Georgia, October 7-12, 2006.
- Key Note Speaker, VACTERL Network, “Surgical procedures of Children with Bowel Issues” Covington, KY, June 29, 2007
- Guest Speaker, Paediatric Colorectal Club York, United Kingdom “Management and Outcome in Cloaca” and “Complication of Stoma Surgery” York St. John’s University Lords Mayors Walk York, United Kingdom July 14-16, 2007

VISITING PROFESSOR

- Visiting Professor at Mexican Societies and Hospitals 341 times as of July 1985
- Visiting Professor, Colombian Society of Pediatric Surgery. March 9-13, 1978
- Visiting Professor, Ecuadorian Society of Pediatric Surgery, October 2-4, 1979
- Visiting Professor, University of California at Davis, Sacramento, California, January 4-7, 1981
- Visiting Professor, Argentinan Society of Pediatric Surgery, April 20-22, 1981
• Visiting Professor, Primary Children's Hospital, Salt Lake City, Utah, November 2-4, 1981
• Visiting Professor, University of California Medical Center, Children's Hospital, San Diego, California, July 9-11, 1981
• Visiting Professor, The Children's Hospital Medical Center, Boston, Massachusetts, January 28-30, 1982
• Visiting Professor, University of Texas Medical School, San Antonio, Texas, February 1-3, 1982
• Visiting Professor, Los Angeles Children's Hospital Surgical Division, Los Angeles, California, February 24-27, 1982
• Visiting Professor, Henrietta Engleston Children's Hospital, Emory University, Atlanta, Georgia, June 22-26, 1982
• Visiting Professor, Case Western Reserve University and Rainbow Children's Hospital, Cleveland, Ohio, June 20-26, 1982
• Visiting Professor, Walter Reed Hospital, Division of Pediatric Surgery, Washington, D.C., August 12-16, 1982
• Visiting Professor, Hospital for Sick Children, Toronto, Canada, November 1-4, 1982
• Visiting Professor, East Tennessee State University, Department of Surgery, Johnson City, Tennessee, November 4-7, 1982
• Visiting Professor, National Children's Hospital, Washington, D.C., November 8-12, 1982
• Visiting Professor, Children's Mercy Hospital, Kansas City, Missouri, November 13-16, 1982
• Visiting Professor, Children's Hospital Medical Center, Boston, Massachusetts, April 27, 1983
• Visiting Professor, Medical University of South Carolina, Charleston, South Carolina, May 9-11, 1983
• Visiting Professor, Columbus Children's Hospital, Columbus, Ohio, May 12-13, 1983
• Visiting Professor, Children's Hospital, Norfolk, Virginia, June 23-24, 1983
• Visiting Professor, Hershey Medical Center, Hershey, Pennsylvania, June 27-29, 1983
• Visiting Professor, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania, July 14-15, 1983
• Visiting Professor, Long Island Jewish Medical Center, New Hyde Park, New York, July 16, 1983
• Visiting Professor, Children's Hospital of San Diego, San Diego, California, August 22-25, 1983
• Visiting Professor, Mount Sinai Hospital, New York, New York, September 27-30, 1983
• Visiting Professor, Children's Hospital of Eastern Ontario, Ottawa, Canada, October 30-November 1, 1983
• Visiting Professor, Instituto Nacional de la Salud. Ciudad Sanitaria de La Seguridad Social. Clinical Infantil, La Paz, Madrid, Spain, November 27-30, 1983
• Visiting Professor, Massachusetts General Hospital, Boston, Massachusetts, April 3-4, 1984
• Visiting Professor, Hartford General Hospital, Hartford, Connecticut, April 9, 1984
• Visiting Professor, The Children's Hospital Medical Center, Boston, Massachusetts, August 1-2, 1984
• Visiting Professor, University of Connecticut, Hartford, Connecticut, August 6-8, 1984
• Visiting Professor, Winthrop University Hospital, Mineola, New York, August 9, 1984
• Visiting Professor, The National Children's Hospital, Washington, D.C., August 13-14, 1984
• Visiting Professor, Wilhelmina Children's Hospital, Utrecht, The Netherlands, September 20-26, 1984
• Visiting Professor, Vrije Universiteit, Children's Hospital, Amsterdam, September 26-October 1, 1984
• Visiting Professor, Ospedali Riuniti Di Bergamo, Bergamo, Italy, October 2-4, 1984
• Visiting Professor, Hospital Israelita Albert Einstein, Sao Paulo, Brazil, November 27-30, 1984
• Visiting Professor, Children's Hospital, Vancouver, B.C., Canada, January 13-16, 1985
• Visiting Professor, Henrietta Engleston Hospital for Children, Atlanta, Georgia, January 21, 1985
• Visiting Professor, Children's Hospital of Birmingham, Birmingham, Alabama, January 24-26, 1985
• Received 7th Annual Robert E. Gross Award, Robert E. Gross Symposium, Houston, Texas, February 16, 1985
• Visiting Professor, Princess Margaret Hospital for Children, Perth, Australia, April 12-17, 1985
• Visiting Professor, Christchurch Hospital, Christchurch, New Zealand, April 29, 1985
• Visiting Professor, Hospital Infantil San Juan De Dios, Barcelona, Spain, July 23-26, 1985
• Visiting Professor, Children's Hospital Medical Center and Massachusetts General Hospital, Boston, Massachusetts, January 8-9, 1986
• Visiting Professor, Babies Hospital, Columbia Presbyterian Medical Center, New York, New York, January 14, 1986
• Visiting Professor, Hartford Hospital, Division of Pediatric Surgery, University of Connecticut, Hartford, Connecticut, January 17, 1986
• Visiting Professor, The Children's Hospital of Buffalo, Buffalo, New York, February 20-21, 1986
• Visiting Professor, Children's Orthopedic Hospital & Medical Center, Seattle, Washington, February 24-28, 1986
• Visiting Professor, Henrietta Engleston Hospital for Children, Atlanta, Georgia, March 12, 1986
• Visiting Professor, New Jersey Medical School, Newark, New Jersey, March 17, 1986
• Visiting Professor, The University of Iowa, Iowa City, Iowa, April 16-19, 1986
• Visiting Professor, The Albany Medical College of Union University, Albany, New York, May 25-26, 1986
• Visiting Professor, Los Angeles Children's Hospital, Los Angeles, California, June 15-18, 1986
• Visiting Professor, Massachusetts General Hospital, Boston, Massachusetts, August 8, 1986
• Visiting Professor, Walter Reed Army Medical Center, Washington, D.C., August 22, 1986
• Visiting Professor, Yale University, New Haven, Connecticut, August 19, 1986
• Visiting Professor, National Institute of Pediatrics, Mexico City, Mexico, September 8-12, 1986
• Visiting Professor, Henrietta Engleston Hospital, Atlanta, Georgia, October 9-11, 1986
• Visiting Professor, Brooke Army Medical Center, San Antonio, Texas, November 4-6, 1986
• Visiting Professor, the Prince of Wales Children's Hospital, Randwick, Australia, November 24-26, 1986
• Visiting Professor, Mater Children's Hospital, Brisbane, Australia, November 27-29, 1986
• Visiting Professor, Washington University Medical Center, St. Louis, Missouri, December 10-12, 1986
• Visiting Professor, Milwaukee Children's Hospital, Milwaukee, Wisconsin, January 14-17, 1987
• Visiting Professor, National Institute of Pediatric Surgery, Mexico City, Mexico, February 9-18, 1987
• Visiting Professor, Children's Hospital of British Colombia, Vancouver, British Colombia, February 24, 1987
• Visiting Professor, Royal Manchester Children's Hospital, Manchester, England, March 20-25, 1987
• Visiting Professor, Institute of Child Health, University of London, London, England, March 27, 1987
• Visiting Professor, Vancouver Children's Hospital, Vancouver, B.C., Canada, April 23-25, 1987
• Visiting Professor, Japanese Society of Pediatric Surgeons, Kobe, Japan, May 24-June 3, 1987
• Visiting Professor, University of South Alabama, Mobile, Alabama, July 10-11, 1987
• Visiting Professor, Course on Anorectal Malformations, Austrian Association of Pediatric Surgeons, Saltzburg, Austria, August 1-10, 1987
• Visiting Professor, Walter Reed Army Medical Center, Washington, D.C., August 21, 1987
• Visiting Professor, Cali, Colombia, South America, September 5-12, 1987
• Visiting Professor, National Institute of Pediatrics, Mexico City, Mexico, September 13-16, 1987
• Visiting Professor, Ain-Shams University, Cairo, Egypt, October 4-9, 1987
• Visiting Professor, 7th Congress of Asian & Pacific Federations of ACS, Taipei, Taiwan, November 3-8, 1987
• Visiting Professor, Sapir Medical Center, Kfar-Saba, Israel, January 18-24, 1988
• Visiting Professor, Hospital Infantil La Paz, Madrid, Spain, March 1-5, 1988
• Visiting Professor, Postgraduate Institute of Medical Education & Research, Chandigarh, India, March 6-12, 1988
• Visiting Professor, Hospital de la Misericordia, Bogota, Colombia, April 20-23, 1988
• Visiting Professor, Hospital del Nino, Caracas, Venezuela, April 18-20, 1988
• Visiting Professor, National Institute of Pediatrics, Mexico City, Mexico, May 23-24, 1988
• Guest Speaker, 50th Anniversary PEMEX Medical Services, Mexico City, Mexico, May 24-27, 1988
• Visiting Professor, University Hospital, Edmonton, Canada, June 23-24, 1988
• Visiting Professor, University of Connecticut, Hartford, Connecticut, July 14, 1988
• Visiting Professor, Sophia Children's Hospital, Athens, Greece, September 26, 1988
• Visiting Professor, Course on Anorectal Malformations, 12th Brazilian Congress Pediatric Surgery, Fortaleza, Brazil, October 6-14, 1988
• Visiting Professor, XVII Congress of Chilean Association of Pediatric Surgeons, Course on Anorectal Malformations, Valdivia, Chile and Temuco, Chile, November 19-25, 1988
• Visiting Professor, Ospedale General Regionale, Treviso, Italy, December 5-10, 1988
• Visiting Professor, University of Puerto Rico, San Juan, Puerto Rico, January 11-15, 1989
• Visiting Professor, Course on Anorectal Malformations, 7th Congress Asian Surgical Association, Kuala Lumpur and Penang, Malaysia, February 16-25, 1989
• Visiting Professor, University of Connecticut, Hartford, Connecticut, March 10, 1989
• Visiting Professor, Course on Anorectal Malformations, Universita Degu Studi de Parma, Parma, Italy, March 20-25, 1989
• Visiting Professor, British Council Course on Neonatal and Pediatric Surgery, Royal Manchester Children's Hospital, Manchester, England, July 10-14, 1989
• Visiting Professor, Kinderkrankenhaus S. Marien, Landshut, West Germany, July 14-18, 1989
• Visiting Professor, Rainbow Children's Hospital, Cleveland, Ohio, November 15-18, 1989
• Visiting Professor, Course on Anorectal Malformations, Ostra Sjukhuset, Goteborg, Sweden, November 27-December 6, 1989
• Visiting Professor, Hackensack Medical Center, Hackensack, New Jersey, December 21, 1989
• Visiting Professor, National Institute of Pediatrics, Mexico City, Mexico (Follow up of Research Protocol - "A Functional Evaluation of Imperforate Anus Patients After Primary Posterior Sagittal Anorectoplasty Repair"), February 16-28, 1990
• Visiting Professor, Course on Anorectal Malformations, Sponsored by Project Hope, Krakow, Poland, March 10-17, 1990
• Symposium, Boston, Massachusetts, March 23 & 24, 1990
• Visiting Professor, Course on Anorectal Malformations, Turkish Association of Pediatric Surgeons, Istanbul, Turkey, April 16-28, 1990
• Visiting Professor, Course on Anorectal Malformations, Rambam Medical Center, Haifa, Israel, April 22-28, 1990
• Visiting Professor, Department of Surgery Grand Rounds, Children's Hospital & Medical Center, Seattle, Washington, May 16-18, 1990
• Attended 21st Annual Meeting, American Pediatric Surgical Association, Vancouver, British Columbia, Canada, May 19-22, 1990
• Visiting Professor, Kaiser Permanente Medical Center, Anaheim, California, May 23-25, 1990
• Visiting Professor, Babies Hospital, Columbia Presbyterian Medical Center, New York, New York, June 28, 1990
• Visiting Professor, Children's Hospital of Michigan, Detroit, Michigan, July 18-19, 1990
• Visiting Professor, Babies Hospital, Columbia Presbyterian Medical Center, New York, New York, August 27, 1990
• Visiting Professor, XXVII World Congress of the International College of Surgeons, Congress of Brazil, Sao Paulo, Brazil, September 7-13, 1990
• Visiting Professor, Tampa General Hospital, University of South Florida, Tampa, Florida, September 20-22, 1990
• Visiting Professor, Universiteit van Amsterdam, Amsterdam, The Netherlands, November 28-30, 1990
• Visiting Professor, University Medical Center Steglitz, Berlin, Germany, December 1-5, 1990
• Visiting Professor, Children's Hospital, Denver, Colorado, January 14-16, 1991
• Visiting Professor, Baylor University Medical Center, Dallas, Texas, March 21-23, 1991.
• Visiting Professor, Course on Anorectal Malformations, Archbishop Makarios III Hospital, Nicosia, Cyprus, April 16-20, 1991.
• Visiting Professor, Course on Anorectal Malformations, Opesdale Generale Regionale Hospital, Treviso and Universita' Degli Studi di Messina, Sicily, Italy, April 20-28, 1991.
• Visiting Professor, Course on Anorectal Malformations, Hospital del Niño, Villahermosa, Tabasco, Mexico, June 24-28, 1991
• Visiting Professor, Hospital de Misericordia, Bogota, Colombia, South
• Visiting Professor, Spokane Children's Hospital, September 26-29, 1991
• Visiting Professor, Children's National Medical Center, Washington, D.C., October 17-20, 1991
• Visiting Professor, Department of Surgery Grand Rounds, Sinai Hospital of Baltimore, "The Evolution and Recent Advances in the Management of Anorectal Malformations", November 16, 1991
• Visiting Professor, Department of Surgery Grand Rounds, Children's Hospital of San Diego, San Diego, California, November 19-23, 1991
• Visiting Professor, National Workshop on Anorectal Malformations, Postgraduate Institute of Medical Education & Research, Chandigarh, India, November 24-December 2, 1991
• Visiting Professor, Philippine College of Surgeons, Manila, Philippines, December 3-9, 1991
• Visiting Professor, Course on Anorectal Malformations, Chang Gung Memorial Hospital, Taiwan, ROC, December 9-16, 1991
• Visiting Professor, Berne, Switzerland, January 23-25, 1992
• Visiting Professor, St. Peter's Medical Center, New Brunswick, New Jersey, February 6, 1992.
• Visiting Professor, C.S. Mott Children's Hospital, Ann Arbor, Michigan, February 7-8, 1992
• Visiting Professor, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania, February 13, 1992
• Visiting Professor, Virginia Commonwealth University, Children's Medical Center, Richmond Virginia, February 21-22, 1992
• Visiting Professor, Babies Hospital, Columbia Presbyterian Medical Center, New York, New York, March 12, 1992
• Visiting Professor, Course on Anorectal Malformations, sponsored by Project Hope, Krakow, Poland March 15-22, 1992
• Visiting Professor, Henrietta Engleston Hospital, Emory University, Atlanta, Georgia, April 17-19, 1992
• Visiting Professor, Hospital Infantil, Bucaramanga, Colombia, S.A., April 18-May 3, 1992
• Visiting Professor, Course on Anorectal Malformations, National Institute of Pediatrics, Mexico City, Mexico, May 29-June 5, 1992
• Visiting Professor, Ochsner Medical Institutions, New Orleans, Louisiana, July 10-11, 1992
• Visiting Professor, Department of Surgery, Academisch Ziekenhuis Nijmegen, Nijmegen, The Netherlands, July 16-21, 1992
• Visiting Professor, Children's Hospital, Denver, Colorado, August 20-22, 1992
• Visiting Professor, Course on Anorectal Malformations, Kenyatta National Hospital, Nairobi, Kenya, October 30-November 7, 1992
• Visiting Professor, Children's Hospital, Denver, Colorado, January 29-31, 1993
• Visiting Professor, Children's Hospital of Pittsburgh, Pittsburgh, University of Pittsburgh, School of Medicine, Pittsburgh, Pennsylvania February 12-13, 1993
• Visiting Professor & Guest Speaker, Grand Rounds, Portland Medical Center, Portland, Maine, February 20-21, 1993
• Visiting Professor, Course on Anorectal Malformations, The General Infirmary at Leeds, Leeds, U.K., July 16-20, 1993
• Attended, British Association of Pediatric Surgery, Manchester, U.K., July 21-24, 1993
• Visiting Professor, Tucson Medical Center, Tucson, Arizona, August 6-8, 1993
• Visiting Professor, Children's National Medical Center, Washington, D.C., September 3-4, 1993
• Visiting Professor Course on The Surgical Treatment of Anorectal Malformations, IV
Congress of the Arab Association of Paediatric Surgeons, Dubai, U.A.E., October 21-29, 1993
• Visiting Professor, Course on the Surgical Treatment of Anorectal Malformations, Association of Argentinean Pediatric Surgeons, Mendoza, Argentina, October 30 - November 6, 1993
• Visiting Professor, Medical College of Georgia, Augusta, Georgia, March 18-20, 1994
• Visiting Professor, Beilinson Medical Center, Tel Aviv, Israel, April 10, 1994
• Visiting Professor, Ospedale Infantile, Torino, Italy, April 28-20, 1995
• Visiting Professor, Course on The Surgical Treatment of Anorectal Malformations, Children's Hospital, Vije Universiteit, Brussels, Belgium, May 4-10, 1994
• Visiting Professor, Baton Rouge, Louisiana, June 10-12, 1994
• Visiting Professor, Course on Surgical Treatment of Anorectal Malformations, PEMEX Hospital, Mexico City, Mexico, June 15-17, 1994
• Visiting Professor, Unita Locale Socio Sanitaria, Treviso, Italy, June 23-25, 1994
• Visiting Professor, Japanese College of Surgeons, Kobe, Japan, June 28-29, 1994
• Visiting Professor, Osaka University Hospital, Osaka, Japan, July 30, 1994
• Visiting Professor, Keio University, Tokyo, Japan, July 2, 1994
• Visiting Professor, Course on the Surgical Treatment of Anorectal Malformations, Samsun Medical Center, Seoul, Korea, and Wonju College of Medicine in Wonju, Korea October 27-November 1, 1994
• Visiting Professor, The Chinese University of Hong Kong, Prince of Wales Hospital, Santin, Hong Kong, November 2-7, 1994
• Visiting Professor, Landshut, Germany, January 3-5, 1995
• Visiting Professor, Hospital Universitario "Dr. Antonio Maria Pineda", Barquisimeto, Venezuela, Jan 30-Feb 3, 1995
• Visiting Professor, Babies Hospital, Colombia-Presbyterian Medical Center, New York, New York, February 16, 1995
• Visiting Professor, Buffalo Children's Hospital, Buffalo, New York, February 17-18, 1995
• Visiting Professor, SUNY Health Science Center, Syracuse, NY February 24-25, 1995
• Visiting Professor, Children's Hospital of Orange County, Orange, California, March 6-10, 1995
• Visiting Professor, Montefiore Medical Center, Bronx, New York, June 19, 1995
• Visiting Professor, Japanese Society of Pediatric Surgeons, Yokohama, and Tokyo University Medical Center, June 26-19,1995
• Attended Neonatal Surgery Seminar, Manchester, U.K., July 19-21, 1995
• Attended British Association of Pediatric Surgeons, Sheffield, U.K., July 24-29, 1995
• Visiting Professor, Hartford Medical Center, Hartford, Connecticut, August 19-20, 1995
• Visiting Professor, Fifth Congress of the Arab Association of Paediatric Surgeons, Course on the Surgical Treatment of Anorectal Malformations, Alexandria, Egypt, October 11-153, 1995
• Visiting Professor, Course on the Surgical Treatment of Anorectal Malformations, King Hussein Medical Centre, Amman, Jordan, October 16-21, 1995
• Visiting Professor, Orange County Children's Hospital, Anaheim, California, January 17-19, 1996
• Visiting Professor,*Course on Anorectal Malformations, Hospital General Universitario "Gregorio Maranon," Madrid, Spain, March 15-24, 1996
• Visiting Professor, 29th Annual Meeting of the Pacific Association of Pediatric Surgeons, Singapore, May 12-15, 1996
• Visiting Professor, Children's Hospital of San Diego, San Diego, California, May 23,
1996
• Visiting Professor, Rainbow Children’s Hospital, Cleveland, Ohio, June 28-30, 1996
• Visiting Professor, Hospital General Universitario “Gregorio Maranon,” Madrid, Spain, August 1-4, 1996
• Visiting Professor, Basler Kinderspital, Basel, Switzerland, August 29, 1996.
• Visiting Professor, and Guest Speaker, 32nd National Congress of Italian Pediatric Surgeons, Torino, Italy, September 26-28, 1996.
• Visiting Professor, Group Hospitalier Necker-Enfants Malades, Paris, France, November 19, 1996
• Visiting Professor, Klinken der Stadt Koln, Cologne, Germany, December 12-15, 1996.
• Visiting Professor, Children’s Hospital, Greenville, South Carolina, February 13-16, 1997
• Visiting Professor, Medical College of Georgia, Augusta, Georgia, June 12-14, 1997
• Visiting Professor, LKA Kinderchirurgie, Salzburg, Austria, June 26-28, 1997
• Visiting Professor, Sociedade Paulista de Cirurgia Pediatria, Sao Paulo, Brasil, June 30 to July 2, 1997
• Visiting Professor, King Hussein Medical Center, Amman, Jordan, July 25-26, 1997
• Visiting Professor, The University of Texas Medical Branch at Galveston, Galveston, Texas, August 8-10, 1997
• Visiting Professor, Academisch Ziekenhuis Nijmegen, Nijmegen, The Netherlands, August 21-23, 1997
• Visiting Professor, Course on Surgical Treatment of Anorectal Malformations, The General Infirmary at Leeds, Leeds, United Kingdom, September 16-21, 1997
• Visiting Professor, Azienda Ospedaliera “S. Maria Degli Angeli,” Pordenone, Italy, September 21-24, 1997
• Visiting Professor, King Hussein Medical Centre, Amman, Jordan, April 13-15, 1998
• Visiting Professor, Ostecheizer Kinderspital, St. Gallen, Switzerland, April 20, 1998
• Visiting Professor, Basler Kinderspital, Basel, Switzerland, April 21, 1998
• Visiting Professor, and Guest Speaker, II Curso Intensivo Sobre Tratamiento Quirurgico de las Malformaciones Anorectales, Hospital General Universitario “Gregorio Marañon,” Madrid, Spain, May 6-8, 1998
• Visiting Professor, Azienda Ospedaliera S. Maria Degli Angeli, Pordenone, Italy, July 16-18, 1998
• Visiting Professor, Universite Catholique de Louvain Cliniques Universitaires Saint Luc, Brussels, Belgium, October 21-15, 1998
• Course Organizer, American College of Surgeons Fall Meeting, Specialty Session, “Pediatric Surgery: Congenital Anorectal Malformations,” October 27-29, 1998
• Visiting Professor, King Hussein Medical Centre, Amman, Jordan, March 11-14, 1999.
• Visting Professor, University of Tel Aviv, Shneider Children’s Hospital, Tel Aviv, Israel, March 14-20, 1999
• Visiting Professor, Hospital Nacional de Niños, San Jose, Costa Rica, March 25-28, 1999
• Visiting Professor, Azienda Ospedaliera, Istituti Clinici di Perfezionamento, Milan, Italy, June 23 to June 27, 1999
• Visiting Professor, Academisch Ziekenhuis, Vrije Universiteit Brussel, Brussels, Belgium, July 17-19, 1999
• Visiting Professor and Guest Speaker at the XXXII Congreso Nacional de Cirugia Pediatrica, of the Sociedad Mexicana de Cirugia Pediatrica, “Atencion Neonatal del recien nacido con ano Imperforado,” “Colostomia,” “Anorectoplastia Sagital Posterior,” “Reoperacion de ano imperforado,” “Movilizacion urogenital total,” “Cloaca,” “Advances en Incontinencia Fecal.” Zacatecas, Mexico, September 8-16, 1999
• Visiting Professor, Hospital Bambino Gesu, Rome, Italy, December 2-4, 1999
• Visiting Professor, Klinikum Mannheim, Mannheim, Germany, December 6, 1999
• Visiting Professor, Fredrich-Schiller Universitat, Jena, Germany, December 7, 1999
• Visiting Professor, “Tratamiento actual de las malformaciones anorectales,” and “Cirugia in vivo,” Hospital “Teresa Herra”, A Coruña, España December 9-10, 1999
• Visiting Professor, St. Christopher’s Children’s Hospital, Philadelphia, Pennsylvania, January 6-8, 2000
• Visiting Professor, LKA Kinderchirurgie, Salzburg, Austria, January 14-18, 2000
• Visiting Professor Nurnberg, Germany. December 4-7, 2000.
• Visiting Professor, Vincenza, Italy. December 8-9, 2000.
• Visiting Professor Anorectal Malformation Course, Three Day Workshop, Guadalajara, Mexico. January 22-24, 2001
• Visiting Professor, 34th Annual Meeting Pacific Association of Pediatric Surgeons, 11th Council Meeting, World Fereration of Associations of Pediatric Surgeons, Kyoto, Japan, April 4-8, 2001.
• Visiting Professor, Cosenza Italy, January 17-21, 2002
• Visiting Professor and Guest Lecturer 22nd Annual F.L. Raffucci Memorial Lecture. Universidad De Puerto Rico, February 6-10, 2002.
• Visiting Professor Thomas Jefferson University - duPont Hospital for Children Delaware. April 17, 2002.
• Visiting Professor, Pacific Association of Pediatric Surgeons (PAPS), San Diego, California - Coe Medal Recipient - May 2002.
• Visiting Professor - Meeting Lecture to Parents of Children with Anorectal Malformations, Munich, Germany, May 25, 2002.
• Visiting Professor Klinikum Oldenburg - Oldenburg, Germany May 27-28, 2002.
• Visiting Professor Austin Pediatric Surgery Association, Austin, Texas, June 21, 2002
• Visiting Surgeon, Brazilian Association of Pediatric Surgeons - Operating Course. Brazilian Academy of Pediatric Surgery, October 31st - November 7, 2002.
• Visiting Professor, Hospital de la Misericordia, Bogota, Colombia, December 5-9, 2002.
• Visiting Professor, The Hospital for Sick Children, Toronto, Canada, February 27-18, 2003.
• Visiting Professor, XV Internacional De Urologia Pediatrica, Il Curseo De La
Asociacion Andaluza de Urologia Para Residentes. XV International Course of Pediatric Urology, Malaga, Spain, April 1-3, 2003.

- Visiting Professor, Third Annual Spring Pediatric Urology Renez-Vous, Vermont Children’s Hospital, Burlington, Vermont, May 3, 2003
- Visiting Professor, BAPS 50th Annual International Congress, Portugal, July 15-18, 2003
- Visiting Professor, The Children’s Hospital, Denver Colorado, August 7-10, 2003.
- Guest Speaker and Visiting Professor, Sociedad Mexicana de Cirugia Pediatrica, Cancun, Mexico, September 11-12, 2003.
- Visiting Professor, Nuevo Hospital Maternao-Infantil, III Curso Intensivo sobre Tratamiento Quirurgico de Malformaciones Anorrectales, Madrid, Spain, October 12-21, 2003.
- Visiting Professor, St. Joseph Hospital, Berlin, Germany, November 2-8, 2003
- Visiting Professor, Bogota, Colombia, December 2003.
- International Pediatric Colorectal Club Meeting 11th Meeting May 22-23, 2004, North-Shore Long Island Jewish Medical Center.
- Visiting Professor, Girona Spain, June 1-3, 2004.
- Visiting Professor, National Congress of Urology, Oviedo, Spain, June 4th, 2004.
- Visiting Professor, 8th Annual Colodny Lectureship in Surgery, University of Vermont, June 16-17, 2004.
- Visiting Professor, Munster, Germany, August 4-6, 2004.
- Visiting Professor, 37th Congress Mexican Society of Pediatric Surgery, CD. Juarez, Mexico, September 2004.
- Visiting Professor, San Lucas Hospital PUCRS, Porto Alegre, Brazil, October 15-16, 2004.
- Visiting Professor, Clinica Alemana, Chile, November 2-5, 2004.
- Visiting Professor, Symposium, International Conference for the Development of Standards for the Treatment for Anorectal Malformations 17-20 May 2005, Nettetal, Germany.
- Visiting Professor, Treatment and Management of Children with Stoma, Milano, Italy, January 2005.
- Visiting Professor, Association of Mexican Military Doctors Oaxaca, February 2005.
- Visiting Professor, Neonatology Grand Rounds, Denver, April 2005.
- Visiting Professor and Surgeon, Our Lady’s Hospital for Sick Children, Dublin, Ireland July 9, 2005
- Visiting Professor and Surgeon, St. Louis Children’s Hospital, St. Louis, Missouri, August 9-10, 2005.
- Visiting Surgeon, Schneider Children’s Hospital Long Island Jewish, Long Island, New York, October 10, 2005
- Visiting Professor, Catholic University Hospital, Porto Alegre, Brazil. October 16-20, 2005.
- Visiting Professor, Hospital Santa Casa, Porto Alegre, Brazil. March 10, 2006.
- Visiting Professor, Bellinzona, Switzerland. March 27-30, 2006.
- Visiting Professor, Padvoa, Italy. March 31-April 3, 2006.
• Panelist, Colorectal Symposium, IPEG Annual Meeting, Dallas, Texas. April 26, 2006.
• Visiting Professor, Universidad de Cd. Juarez, Mexico City, Mexico. May 13, 2006.
• Visiting Surgeon, Hospital Buzzi, Milan, Italy July 22, 2006
• Visiting Surgeon, Madrid, Spain July 24, 2006
• Visiting Surgeon, Hospital Mutua de Terrassa, Barcelona, Spain July 25, 2006
• Visiting Professor, “Neonatal management of anorectal malformations”, Luck and Serendipity”, “idiopathic constipation”, and Evolution in the management of anorectal malformations” University of California, Irvine Department of Surgery Division of Pediatric Surgery. Pediatric Grand Rounds and Surgical Grand Rounds, Orange, California, January 24-26, 2007.
• Visiting Surgeon, San Jose, Costa Rica March 6-11, 2007.
• Visiting Professor, “Advances in the management of anorectal malformations” and “Therapeutic principles in low anorectal malformations” 8th European Congress of Paediatric Surgery Turin, Italy May 16-19, 2007.
• Keynote Speaker, VACTERL conference, “Spectrum of Anorectal Malformations” Covington, KY, June 30th, 2007
• Visiting Professor, Pediatric Surgery Workshop Al Wasl Hospital, Dubai, United Arab Emirates. November 26-28th, 2007.

PUBLICATIONS

8. Perez FL, Peña A, Rodriguez AE: Surgical treatment of gastroesophageal reflux issues (hiatus


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111. Levitt MA, Peña A. Letter to the editor: “High anorectal malformations in boys: Need for
122. Peña, A., Krieger Migotto, M. Practical Aproach to the Management of Anorectal Malformations -2004

BOOKS

41. Peña A, Hong AR. Anorectal Malformations: Surgical Directives Pediatric Surgery. Editor: Peter Mattei, Lippincott Williams & Wilkins. Section VII, Ch. 73, pp413-420 2002.
53. Levitt MA, Peña A. Complications after the Treatment of ARM and Redo operations. Ch 24 In:


61. Peña A, Sher M: Pediatric Hirschsprung’s, Anorectal malformations and other Conditions. Textbook of Colon and Rectal Surgery. Springer Verlag, Chapter 51. [In press].


64. Peña, A; Elicevik M, Levitt, MA Reoperations in Hirschsprung disease 42: 6, 1008 – 1014, 2007


VIDEOS


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