Lester W. Martin, MD

Interviewed by
Brad W. Warner, MD

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Cincinnati, Ohio

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Preface

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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.

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ABOUT THE INTERVIEWER

Brad W. Warner, MD

Dr. Warner was the final pediatric surgery fellow selected by Dr. Lester Martin at the University of Cincinnati Children’s Hospital. Dr. Warner completed his MD degree at the University of Missouri in Kansas City and was a resident in general surgery at the University of Cincinnati. During his residency, he completed a two-year research fellowship with Dr. Josef Fischer in metabolism and nutritional support. During this time, he also completed a fellowship in extracorporeal membrane oxygenation with Dr. Frederick Ryckman at the Cincinnati Children’s Hospital.

Having completed his fellowship at Cincinnati Children’s in 1991, Dr. Warner became faculty at the Cincinnati Children’s Hospital where he spent the next 16 years, ultimately rising to the rank of full Professor of Surgery. During Dr. Warner’s tenure, he was the director of the extracorporeal membrane oxygenation program and directed his own NIH-funded laboratory, directed toward understanding the regulation of intestinal adaptation following massive small bowel resection.

In July 2007, Dr. Warner left Cincinnati Children’s to become the Apolline Blair St. Louis Children’s Hospital Professor of Surgery and Surgeon-in-Chief at St. Louis Children’s Hospital at Washington University School of Medicine in St. Louis. On the day of his interview with Dr. Martin, Dr. Warner was having a going-away reception and Dr. Martin was able to attend.
Interview of Lester W. Martin, MD

DR. WARNER: This is Brad Warner, professor of surgery at the University of Cincinnati College of Medicine and program director at the Cincinnati Children’s Hospital interviewing Dr. Lester Martin on June 5, 2007, in my office here in Cincinnati. Dr. Martin was gracious enough to come from his retirement, currently in Florida, to come up and be here for my reception celebrating my time here at Cincinnati Children’s Hospital and my moving on to be chief of pediatric surgery at the St. Louis Children’s Hospital in Washington University.

It’s on, and we’ll get started. So why don’t we just start out by you telling me how you got from Missouri to a pediatric surgical fellowship with Dr. [Robert E.] Gross?

DR. LESTER: I had my first two years of medical school at the University of Missouri when it was a two-year school, two basic science years. And everyone had to transfer somewhere else for their third and fourth years. Most of the students transferred to Washington University in St. Louis, which was an excellent school. There were only twenty-six in our class at the University of Missouri. Three, including myself, transferred to Harvard [Medical School] for the third and fourth

DR. WARNER: So you were an excellent student in medical school?

DR. MARTIN: There were three of us that applied to Harvard. I applied sort of as a joke because Harvard had never taken more than two, but for our year they accepted three. And so in medical school at Harvard, I rotated to the Children’s Hospital Boston].

In fact, I had a job at the Children's Hospital in the blood bank every third night. The hospital was just across the street from the dormitory, and I could sit in my room at night and study and take calls for the blood bank. All we did was a type and simple cross match, A, B and O. We’d get the same type, and then we’d cross match. If they didn’t clot, the child got the blood. To do a cross match would take me twenty minutes. I got three meals, and a small salary.

DR. WARNER: And this was throughout your entire two years?

DR. MARTIN: Yes. And I got acquainted especially with the surgeons, when they’d come rushing up to the blood bank to get some blood usually for a child undergoing emergency surgery.

DR. WARNER: And was it the surgeons that were actually coming to the blood banks, themselves?
DR. MARTIN: The surgical residents.

DR. WARNER: I see.

DR. MARTIN: Or the fellows—well, they didn’t have regular clinical fellows then, just pediatric surgical residents. There were a few that were in a special fellowship, doing mostly research. John Kirklin was one of them. I recall one night when John was waiting at the blood bank with the patient’s blood sample and as I proceeded to do the cross match, he calmly explained, “This child really needs blood in a hurry because one pupil is bigger than the other one, and the child is beginning to lose consciousness, and they’re getting him on the operating table right now.” [Laughs] He’d tell me about every patient, and it was a real thrill to me.

DR. WARNER: I bet.

DR. MARTIN: There were two medical fellows in the blood bank. Anyway, all three of them, the two fellows and the chairman all won the Nobel Prize.

DR. WARNER: The two others with you in the blood bank.

DR. MARTIN: No, I was a medical student working as a technician. They were able to grow the polio virus on human tissue foreskin from outpatient circumcisions performed by surgical residents. Fred [Frederick C.] Robbins and Thomas [H.] Weller were the fellows, and their chief was John [F.] Enders. They successfully grew the polio virus on foreskin. [Laughs]

DR. WARNER: This was not your foreskin!!

DR. MARTIN: [Laughter] Foreskin from circumcisions done by surgical interns. I was a senior resident in charge of the clinic. It was my responsibility to deliver the specimens to Dr. Enders’ laboratory.

DR. WARNER: OK.

DR. MARTIN: But it happened that I knew them personally, and when John Enders was offered the Nobel Prize, he allegedly answered, “I’ll accept it on one condition I have two very bright fellows that did all of the work. I just directed them. And they have to share it with me.” All three of them received the Nobel Prize.

DR. MARTIN: And so anyway, those were people I got to know at the blood bank.
DR. WARNER: Sure.

DR. MARTIN: And all the surgical residents just came for blood. Alexander Bill from Seattle and Bill [H. William] Clatworthy [Jr.] and the residents and I can go on and on, but it was a real neat job. I enjoyed it, and I was invited to join the surgical residents for their early morning work rounds.

DR. WARNER: Just on your own time.

DR. MARTIN: On my own. I’d just go with them, make rounds at six thirty in the morning. [Laughs] I got hooked on pediatric surgery. I chose an elective a month in pediatric surgery as a fourth year student. Dr. Gross was another reason I chose pediatric surgery because he was just an outstanding surgeon, clinician, and teacher.

DR. WARNER: So tell me about Dr. Gross.

DR. MARTIN: For that month, the month on pediatric surgery, Dr. Gross, it turned out, was on vacation. So I just followed Luther Longino who was the chief resident at the time. I just followed him around, and scrubbed with him every day. He was a super teacher. On my last day there, Dr. Gross came back to work. I had told Luther how I had enjoyed his teaching but how disappointed I had been that I hadn’t been able to scrub with Dr. Gross, and he said, “You just hop in his hip pocket and you stay there all day long. Whatever he does, you go with him.” [Laughs]

DR. WARNER: Wow.

DR. MARTIN: And his first operation was a hernia repair followed by an orchidopexy for an undescended testicle, and next was a vascular ring, and next was a Wilms tumor, and we finished by 1:00 pm. Then we went to the lunch room and had lunch together. It was just the greatest day in my entire four years of medical school.

DR. WARNER: So from there, you matched in what surgical residency?

DR. MARTIN: I matched in surgical residency at Cornell [University Medical College] at New York Hospital.

DR. WARNER: How was the match process done at that time?

DR. MARTIN: It wasn’t a match at that time. We just applied, and the hospitals would call us on a certain date, and they couldn’t call until that
date. The calls began after midnight. And it was a shambles. And they’d try to get you to say yes. My first choice was Cornell.

DR. WARNER: Really.

DR. MARTIN: No, my first choice would be Mass General [Massachusetts General Hospital], and next was Cornell, and next would be [University of] Rochester and then next was Salt Lake City [University of Utah]. And so Salt Lake City called me first, right at the stroke of midnight. And I had to put them off for about an hour before I heard from Rochester, then I dropped Salt Lake City and put off Rochester until eight o’clock the next morning. New York Hospital called me right at eight o’clock. I didn’t think I had much of a chance at Mass General so I accepted Cornell.

DR. WARNER: So you had to make a decision within a certain period of time.

DR. MARTIN: Yes. They said, “If you don’t accept it right now, we’re going to call the next person on the list.”

DR. WARNER: Now, did you interview at these places?

DR. MARTIN: I did not go to Salt Lake City, but I interviewed at Rochester. It’s an excellent program, and I really hated to turn it down. But Cornell was most attractive to me at the time of my interview visit. So I accepted.

DR. WARNER: Did your time at Cornell reinforce pediatric surgery for you?

DR. MARTIN: It did. In a negative way. The problem with pediatric surgery there was the pediatricians took care of the patients, and the surgeons did the surgery; it was not clear which service was in charge of determining the need for a nasogastric tube and who was to remove it and what intravenous fluids were to be given and what antibiotic. It was a very unpleasant experience. I recalled that in the month of pediatric surgery at Boston Children’s, such problems had never occurred. I decided to return to Boston at some later date for a year of pediatric surgery and then come back to New York Hospital. I talked to Dr. [Frank] Glenn, the chief of surgery, and he was thrilled at the plan, but Uncle Sam spoiled it. Then things went on. Even though I had served over three years in the military during World War II, I was recalled back into the service for Korea.

DR. WARNER: You went to Korea?
DR. MARTIN: I didn’t go to Korea. I was assigned to a teaching position at Fort Sam Houston, Army Hospital, and I worked at Brooke, got to know the people there. A nice experience. I had a great time.

DR. WARNER: How long were you there?

DR. MARTIN: I was there for a year and a half. Then I went back for the year at Boston Children’s.

DR. WARNER: Was that your chief residency year, then?

DR. MARTIN: I took four years of pediatric surgery.

DR. WARNER: And that’s how long you were at Boston Children's?

DR. MARTIN: Yes. Starting with the very basic year, and then the two-year intermediate, and then the year as chief resident.

DR. WARNER: Wow. And that was the training for a pediatric surgery then.

DR. MARTIN: Yes.

DR. WARNER: Was it four years everywhere?

DR. MARTIN: When I applied, there was only one program, Boston. There was no set amount of time. Some surgeons came for a year, some came for six months, some came and observed. Chick [C. Everett] Koop came as an “observer” for several weeks, but he had already been appointed chief at CHOP [Children’s Hospital of Philadelphia].

DR. WARNER: Really?

DR. MARTIN: He was there. That’s how I first met Chick.

But there was no formal training program in pediatric surgery at that time. The only pediatric surgical organization was a group that got together with the pediatricians at the annual meeting of the [American] Academy of Pediatrics. It began prior to my time, with three pediatric surgeons. Dr. Oswald Wyatt from Minneapolis, Dr. [William E.] Ladd from Boston and Dr. Herbert E. Coe from Seattle. Then the group doubled in size with the addition of Dr. Thomas Lanman, Dr. Robert Gross and [Orvar] Swenson all from Boston. Then came Dr. Koop from Philadelphia and Dr. [Willis] Potts from Chicago. Koop had started a nine month training program and Dr. Potts a one year program. Herbert E. Coe was a pediatrician from Seattle who, after several years of practice, travelled to Boston for pediatric surgical
experience with Dr. William Ladd, then returned to Seattle to practice pediatric surgery.

DR. WARNER: With Dr. Bill?

DR. MARTIN: No, it was before Sandy [Alexander] Bill. Sandy Bill was chief resident in pediatric surgery in Boston when I was a third year medical student. Anyway, the group would get together once a year at the meeting of the [American Academy of] Pediatrics usually at the Palmer House, which was the beginning of the American Academy of Pediatrics Section on Surgery (the first pediatric surgical organization).

DR. WARNER: What did you do at those meetings when you got together? Was it a lot of dinners and social time, or—

DR. MARTIN: Very little social. Surgeons would present their problem cases for discussion and consultation.

DR. WARNER: Wow. Like the Lilliputian [Surgical Society].

DR. MARTIN: Like the Lilliputians “Albatross session.” That’s how the Lilliputians got started because this was so popular. Surgeons would bring their X-rays and the story of their problem cases, which were discussed. Experience and advice flowed freely from the audience. There were no time limits. The meeting was completely informal, and sometimes lasted into the evening.

DR. WARNER: So it was not completely well organized, then.

DR. MARTIN: No, no formal papers at all. It grew into case reports after a few years, and then it got larger, and then they finally decided to have an Albatross one-day session and have formal papers another day. When the Surgical Section meeting grew more formal and the presentations were in demand for publication, the Albatross day was omitted but because of its popularity with the membership it was moved to the Lilliputians meeting.

DR. WARNER: Is that right? So this is the real history of the development of the AAP Surgical Section.

DR. MARTIN: Yes. It became a section during the late 1940s or 1950s. There were, I believe, 16 organizing members. My diploma in 1957 was number 31.

DR. WARNER: Wow.
DR. MARTIN: And I was secretary of the association for six years. And Larry [Lawrence K.] Pickett was president for six years.

DR. WARNER: Really?

DR. MARTIN: He ran it, and I was his secretary for six years.

DR. WARNER: My goodness. Well, tell me how, then, you got to Cincinnati? How did that work out?

DR. MARTIN: In March of my year as chief resident, Dr. Gross gave me a few days off to look for somewhere to go when I finished training three months later.

DR. WARNER: That was it for the year, I bet.

DR. MARTIN: Yes, yes, and I was going to visit Kansas City, Dallas, Oklahoma and Denver. I was offered an exciting position on the faculty of the University of Kansas Medical Center in Kansas City [Kansas] and George Dorman invited me to join him in private practice in Dallas where he was the only pediatric surgeon for the entire Dallas/Fort Worth area. In Oklahoma, I was offered a position as chief surgeon at the Children’s Hospital [at OU Medical Center] of Oklahoma with a faculty position at the university. My trip to Denver was cancelled because of fog, which lifted after 24 hours, permitting my return to Boston on schedule. It had been a fruitful trip. Kansas City seemed like the most desirable, but it was not ideal.

The Children's Hospital in Kansas City, Missouri, [Children’s Mercy Hospital] was a little brown stone front brick building with three operating rooms all with open windows and fly swatters in each room. Flies were seen in each operating room. There was no air conditioning. The nurse said they had plans to build a new children’s hospital someday. The department of children's surgery over at the University of Kansas, where Frank Allbritten was department chairman, was in a nice, new, modern building. I’d be a member of the department of general surgery, and along with Fred [C. Frederick] Kittle and some other outstanding surgeons there that—the names have sort of slipped my memory at the moment. My main headquarters would be University of Kansas, and then I would work part time over at the Children’s Mercy Hospital Missouri, about five miles from the University of Kansas.

When I got back to Boston, there was a note in my mailbox from Dr. Gross. Said, “Call me.” He was a man of few words. [Laughter] So I caught up with him in the operating room, and he said, “Marshall Lee is leaving Cincinnati.” Dr. Lee was a general surgeon on the university staff who had taken up pediatric surgery as an interest, and he and Paul Sutton, who was
general surgeon in private practice, came to Cincinnati the year I was born and did the pediatric surgery “as a hobby.” And Marshall Lee had left to become medical director of the John Hancock Life Insurance Company in Boston. So I visited him in his Boston office to find out why he left. He was polite and courteous, and he told me of the problems that he had encountered in Cincinnati. His days were taken up—he had to do general surgery to make a living. And he said, “You can’t make a living in pediatric surgery.”

Paul Sutton used to tell me when I went out to visit, he said, “Two young people get together, and they’re going to get married and have a baby, sometimes not exactly in that order, and they don’t have any money. The young man gets himself a job somewhere, a minimum-wage type job, and they save up enough money to pay the obstetrician. The pediatrician—they can put that on time, by so much a month. And if the baby has to have surgery, there just is nothing left for it. It’s all for free.” (As it turned out, about 85 percent of it was free.) But there were 85 pediatricians in Cincinnati, and there were 172 surgeons on the staff at the Children’s Hospital and none who limited their practice to pediatric surgery.

Paul Sutton volunteered to do the clinic surgery for free. But 171 surgeons were clamoring for operating room space. There was one operating room. They “were building another one.” In fact, they opened two more before I arrived but one was a tiny room for tonsillectomies. And then there were two rooms by the time I arrived. Years later, I was told that [A. Ashlee] Weech who was the head of the department of pediatrics had gone to Bill [William A.] Altemeier in the department of surgery and said, “We need a pediatric surgeon. You’ve got to find one. If you don’t find one, I’m going to.” And he said, “In Pittsburgh the pediatricians went out and hired a pediatric surgeon by the name of Bill [William B.] Kiesewetter. They paid him $25,000 year. We’re going to do the same thing unless you can find someone.”

Well, the surgeons were all against it. They didn’t want to give up a section of general surgery. I didn’t know this at the time. But with 85 pediatricians and nobody doing just pediatric surgery, I thought that was an opportunity. I could make it work somehow.

DR. WARNER: Wow. That’s amazing.

DR. MARTIN: So I called Frank [Allbritten] and reneged on the appointment there. Three days before I left Boston, Dr. Gross called me in and offered me a job to stay in Boston at the Children’s Hospital [Boston]. [Laughs]

DR. WARNER: Why did it take him so long to decide?
DR. MARTIN: I said, “Dr. Gross, I’m flattered, absolutely flattered that you’ve given me this offer.” He was giving me a good salary, basic salary of I think it was $20,000 a year, and I’d be in charge of the research lab and have an unlimited private practice with some teaching responsibility. And it just sounded like an answer to a maiden’s prayer, but I said, “I’m psyched up for Cincinnati. My furniture is all in the moving van. We’ve moved out of our house already, and I’m due to start work there,” I think the next week. “I just don’t see—the wife and I are both psyched up for Cincinnati.” He said, “Well, give it some thought and come back and talk to me in a couple of days.” [Laughs]

I went home and talked it over with Joan. The atmosphere there at the time was not very good. There was a lot of acrimony in the department of surgery. I had had a great time. The year as chief resident—I think it was the best year of my entire career.

DR. WARNER: Really?

DR. MARTIN: Just everything was superb. And I had a group of friends on the staff that were just absolutely outstanding and easy to get along with. All seven of us took our boards at the same time, the year I was chief resident. So we all got together and studied together and had a pathology section and all that, so it was a super year. I really enjoyed it. And if he had offered it to me a month earlier, I would have taken it in a heartbeat.

DR. WARNER: Think of what pediatric surgery in Cincinnati would be like had you stayed in Boston.

DR. MARTIN: They would have found someone. But it worked out.

DR. WARNER: Did you interview before you came to Cincinnati for the job?

DR. MARTIN: Oh, yes. Oh, yes. Dr. Altemeier wouldn’t give me an answer for the longest time. I came out in April for the first interview, then the second trip a month or so later involved multiple interviews with individual surgeons, division directors in surgery and in pediatrics, a luncheon meeting with Dr. Sutton. Dr. Altemeier insisted I stay at his home where I met his wife and their children. He was most courteous to me in every way; but each time I called about an appointment, he would ask me to call again within a few days.

DR. WARNER: Yes.
DR. MARTIN: Finally I had to tell him that I had my furniture on the moving van and that it was on the way to Kansas City unless he could give me an appointment, in which case I’d call North American Van Lines and have them drop my furniture off in Cincinnati.

DR. WARNER: Wow.

DR. MARTIN: And he hemmed and hawed and wanted me to call him back the next day. I said, “Dr. Altemeier, it’s the greatest opportunity in the world. It’s one of the finest departments of surgery in this entire country, if not the world.” One of the top—it had that reputation. It was absolutely superb. “And the pediatricians at the Children’s Hospital—it’s an answer to my prayers. And I would love to go to Cincinnati, but I’ve got to make a decision, and I’m going to have to make a decision today. I can’t go home and tell my wife that it is still undecided. In two more days, our furniture will be in Kansas City.”

He finally said, “Well, yes. Why don’t you have them leave the furniture in Cincinnati?”

DR. WARNER: I know that you have some great stories of your very first day in Cincinnati, when you came on. Tell me about that.

DR. MARTIN: The biggest event of the first day—I came in, and nobody was expecting me. I went to the hospital administrator, and he knew nothing about me coming. No office. I was supposed to have an office and a secretary. Nobody knew anything about it. And I felt absolutely lost, and I wasn’t sure what I was going to do. I said, “Well, I think I’ll look around the hospital. I haven’t even been to the operating room yet.” And somebody—I’ve forgotten who it was now—was taking me on a tour. And we caught the elevator down to the emergency room. We were going to start on the first floor. No, we walked down. We walked down to the first floor and saw the emergency room, and then we went into the elevator. I said, “The next thing I’d like to see is the operating room.”

When we got in the elevator, there was a pediatrician in the elevator named Harry Shirkey. He said, “You must be the new pediatric surgeon.” I said, “Yes, I’m Dr. Lester Martin.” He said, “Fine, fine. Can you see a patient for me right now?” And he said, “There’s a patient due in the emergency room. I think he has a diaphragmatic hernia.”

DR. WARNER: Wow.

DR. MARTIN: So—

DR. WARNER: Not going directly to the nursery.
DR. MARTIN: We didn’t have a nursery.

DR. WARNER: No NICU [neonatal intensive care unit].

DR. MARTIN: No, no nursery. Not even an incubator. Not of the type we now know. They had these old Armstrong units that the babies were in. And when I saw the child in the emergency room, the infant had stopped breathing and there was no laryngoscope in the ER. I knew how to insert an endotracheal tube without a laryngoscope, but there was no tube in the ER either. No intratracheal tube, no anesthesiologist. They had three nurse anesthetists, all busy giving anesthesia. And so the baby was black—dusky, cyanotic. So I grabbed it in my arms, and Harry Shirkey and I ran up to the operating room, five floors, with the infant and found an intratracheal tube, which I inserted in the infant’s trachea for administration of oxygen. They never did find a laryngoscope. The baby turned pink and started kicking and fussing. At that point, the nurse anesthetist arrived and we moved into an operating room and I proceeded to repair the diaphragmatic hernia. The infant was pink and was breathing spontaneously and it was all right by the next morning. But he didn’t make it in the long term.

DR. WARNER: Really?

DR. MARTIN: I must admit that it made a dramatic arrival to Cincinnati.

DR. WARNER: What a way to splash into your new job.

DR. MARTIN: I had to use a chest tube for closed underwater drainage, but the tube could only exit from the Armstrong unit by looping it up over the top of the unit and then down into a gallon jug of water, just a regular gallon jug. It wouldn’t work. So I went down to the machine shop in the basement and got a hammer and a cold chisel and knocked a hole in the end of the Armstrong unit, pulled the chest tube out through the hole then into the water jug and it worked! [Laughs]

DR. WARNER: So you did your own repairs on the cribs?

DR. MARTIN: Then you won’t believe what happened! [Laughs] By the time I got the baby settled in, I received a call from Dr. John Sanker, another pediatrician, regarding an infant four months old coming to the ER vomiting blood. It turned out she had massive esophageal varices. And so I quickly manufactured a makeshift Sengstaken tube from a Foley catheter and either because or in spite of my efforts, the bleeding stopped. With her second bleed several months later I ligated the varices. The next bleed came
at the age of seven years. By then her vessels were large enough for a porto-
 systemic shunt. She finished college with no further problems.

DR. WARNER: This was your second patient.

DR. MARTIN: That was the second patient. All in one day, my first
day at Children’s Hospital. [Laughs] And I still had no office, no secretary,
no hospital privileges, no contract and not even a written note to attest to the
fact that I was welcome in Cincinnati.

DR. WARNER: Oh, my gosh. That’s unbelievable.

What did your wife do when you moved to Cincinnati?

DR. MARTIN: She had three little girls, and another one was born a
month after we arrived. [Laughs]

DR. WARNER: So she kept fairly busy.

DR. MARTIN: She was busy. We had one automobile. When she
needed the car, she drove me into work in the morning and would come get
me that night.

DR. WARNER: What were your hours like then?

DR. MARTIN: I usually got home before midnight. Came in, made
rounds about six o’clock in the morning. Actually, initially the patients were
mostly complicated cases: the diaphragmatic hernias, esophageal varices,
meconium ileus—I got all of those because they were going to die anyway;
biliary atresia—they all came to me. Esophageal atresia—I think all of them
came to me after I arrived. It was six months before I operated on a patient
with an inguinal hernia.

DR. WARNER: Really? When did you start taking out all the appendixes in
Midwest?

DR. MARTIN: [Laughs] Appendectomies continued to be done by the
general surgeons for quite a long time. I saw no reason to try to intervene,
because they did a good job. Inguinal hernias, I can’t say that for. It was
customary for the surgeon to make a long incision and close the skin with silk
stitches, then a bandage with tape then a diaper. Wound infections were
common and the hospital stay averaged over a week.

DR. WARNER: How long were children staying in the hospital after a
hernia repair done by you?
DR. MARTIN: I kept them overnight. Well, actually, they came in the night before. I operated the next morning, and they went home the next day.

DR. WARNER: Wow.

DR. MARTIN: “No stitches and no bandage and home the next day,” created quite a stir and considerable controversy, especially among surgeons.

DR. WARNER: Were you using collodion then?

DR. MARTIN: Using collodion, yes, to seal and waterproof the wound.

DR. WARNER: Really. Did that come from Dr. Gross?

DR. MARTIN: Yes, that came from Boston. Well, I managed to find some collodion in a drugstore here; they didn’t have it in the hospital.

[Laughs]

DR. WARNER: Really? And we still use collodion today.

DR. MARTIN: Do you?

DR. WARNER: Yes.

DR. MARTIN: It’s great stuff.

DR. WARNER: It really is.

Who were your greatest influences in terms of pediatric surgery in your career? You mentioned Dr. Gross, obviously.

DR. MARTIN: Dr. Gross, and there was another surgeon there by the name of Tom [Thomas] Lanman, whom you probably never heard of. I have his photograph on my wall at home. He was due to be chief of surgery at Children’s. Dr. Ladd was just retiring at that point, and Dr. Lanman was supposed to take over. He was a modest yet very proud man. President [Franklin D.] Roosevelt had declared war on Japan and World War II was coming. Dr. Lanman decided to go into the service where he spent several years. With Dr. Lanman away, Dr. Gross and Dr. [Orvar] Swenson were the only two candidates for the position. Nobody seems to know exactly how the appointment occurred, but next morning, Dr. Gross was said to be in Dr. Ladd’s office, informing Dr. Ladd’s secretary of her new duties.

DR. WARNER: So he was a significant influence in your career.
DR. MARTIN: Yes. Swenson didn’t seem to enjoy teaching, so I never really got to know him. Dr. Gross gave him the rectal clinic to run.

DR. WARNER: Is that what they called it then?

DR. MARTIN: Yes. It was called the rectal clinic.

DR. WARNER: Wow. That’s a complete HIPPA violation now.

DR. MARTIN: He went to the rectal clinic to continue his studies regarding Hirschsprung’s disease. When I was a student, he had operated on 30 children with Hirschsprung’s, and his operation was a great success. He presented his work at the American Surgical Association meeting in 1948. When I was an intern in 1949 at New York Hospital, the operation hadn’t been done there yet.

DR. WARNER: Throughout your career in pediatric surgery, who were some of the pediatric surgeons whom you really have learned the most from, that you really admire?

DR. MARTIN: Well, let me see, Dr. Robert Gross, Luther Longino, Nicholas Stahl. Nick was the unsung hero there. He didn’t do a lot of writing or a lot of research; he just taught the residents. He would have the chief resident make rounds, and he’d just sort of come along as a spectator. He wouldn’t try to dictate anything. But he’d stop at a bedside, and when the chief resident would start to move on, he’d stop and stand there when he had something to say. And he’d wait, and everybody would come back because they knew Nick had a pearl. And he’d come out with some of the most tremendous diagnoses and bits of information which we all cherished.

DR. WARNER: Wow.

DR. MARTIN: One child had come in with an unexplained pancreatic abscess and had had a previous abscess in the left chest. Then there was another admission for portal hypertension and esophageal varices. He was only about six years old. He’d had several operations, including a left lower lobectomy for lung abscess, another for drainage of a lesser sac abscess, and another for left chest empyema. Nick stopped at the bedside of that patient. He said, “You know, I think we could put all these things together and make some sense.” He said, “I think this child could have a congenital duplication coming off the small bowel somewhere, maybe the duodenum, going up through the lesser sac into the chest, and it’s not draining well. There’s refluxing in it. And that would explain the lobectomy that was done because of lung abscess. It would explain the portal hypertension.” And he just put it all together. And everyone thought Nick had really flipped at this point. [Laughs]
DR. WARNER: I bet.

DR. MARTIN: It turns out that’s exactly what the child had. It was finally operated on, in two stages, and all the duplication removed.

DR. WARNER: Did he do it?

DR. MARTIN: I think I did one of the last—most of it was before I was chief. I think we got the final part of the duplication out when I was chief resident.

DR. WARNER: That’s really amazing.

DR. MARTIN: He was one of the unsung heroes there. The teaching was shared by Dr. Gross, Dr. Stahl and Dr. Longino. All were superb teachers. They shared the daily teaching rounds for surgical residents, interns, students and frequently a guest—many of whom were from overseas.

DR. WARNER: What about after you finished your training, during your career, pediatric surgeons whom you really greatly admired?

DR. MARTIN: Oh, one of them whom I really admired was the general surgeon at Children’s here in Cincinnati, who started practicing here the year I was born, and I was introduced to him by Bill Altemeier. We had lunch at the Vernon Manor when I came out for one of my visits. We had just finished dessert, and Dr. Altemeier said, “Paul [Sutton], Dr. Martin is thinking of coming to Cincinnati and limiting his practice to pediatric surgery.” Dr. Sutton sat there for a minute and didn’t say anything. He was smoking his pipe at that point. A little puff of smoke went out of his pipe the wrong way. I’ll never forget that. “Well, Bill, I wish him the very best if he does. But one thing, you’re going to have to pay him a salary because he can’t make a living doing only pediatric surgery.” He said, “I do it as a hobby.” He said, “I hardly ever send a bill to pediatric patients because they don’t have any money.” Nobody had insurance. If they did, insurance didn’t cover infants until they were two months old.

DR. WARNER: Really?

DR. MARTIN: One of the pediatricians—I think it was Sutherland, James Sutherland. He and his wife were both physicians and on the staff here as pediatricians, and he was influential in starting the neonatal unit. He went to Columbus to lobby the legislature, himself, about, “babies are really people. They’re humans when they’re born. Why doesn’t insurance cover them?” The answer was, “Aw, it’s just too expensive. They have all these things wrong at birth.”
He kept harping on it and kept harping on it, and he did it all by himself—he wanted me to go with him, and I said, “I’d love to. If we can get a time, yes. If we can get a time when I can break free, I’ll be glad to go up and help you lobby.” And he’d bring it up at grand rounds. Every place he could get an ear, he’d bring it up. And I’d help him. Get people to talk about it. I tried to help push for it. And eventually he got what he wanted, insurance—a law so that the insurance companies had to cover babies from the time they were born.

DR. WARNER: And that was for the state of Ohio?

DR. MARTIN: For the state of Ohio.

DR. WARNER: How was Ohio relative to other states? Was it fairly behind or progressive?

DR. MARTIN: I don’t really remember. I really can’t answer that.

DR. WARNER: These are great stories, Dr. Martin.

What was your vision for surgery when you came to Cincinnati, for children? Did you ever, in your wildest dreams, imagine that you would build one of the premier training programs and one of the larger groups in this city?

DR. MARTIN: Well, that was my goal, and I thought it could be done.

DR. WARNER: That was it right from the start.

DR. MARTIN: Because Boston Children’s was a success, CHOP was a success, and Children’s Memorial [Hospital] in Chicago was a success. Now, Cincinnati had this huge research foundation, eighty-five pediatricians, and only one pediatric surgeon. I was a member of the department of surgery as an assistant professor and was not permitted to recruit another pediatric surgeon for 12 years, which delayed my plans considerably.

DR. WARNER: What did you think was the most important thing that you did to accomplish that goal?

DR. MARTIN: I worked hard and was the handmaiden for the pediatricians, and I gained the pediatricians’ support. And it goes back to why the pediatric surgeons went to the [American] Academy of Pediatrics to form the Surgical Section. The pediatricians appreciated what we did. The general surgeons didn’t appreciate it, and the specialties hated us. And we experienced problems getting recognition on the national scene. General surgery would not give us recognition of any kind at the board level.
DR. WARNER: Did pediatric surgeons have the stature within general surgery?

DR. MARTIN: No. The stature came through the executive committee of the Surgical Section of the American Academy of Pediatrics. We would talk about the future of pediatric surgery at every meeting. It was a major issue. The pediatric surgeons out in private practice looked to the executive committee to do something. Finally, they demanded it. They told us, “You’ve got to organize something, or we’re going to organize ourselves.” They needed recognition; a board of pediatric surgery, a certificate of proficiency, or something in writing to certify their additional training in pediatric surgery. The training programs needed to be regulated. There were 24 training programs which suddenly sprung up in the United States with length of training being from six months to four years. Some surgeons listed themselves in the telephone books as pediatric surgeons even though they had had no formal training and little experience.

On three occasions over a period of five years, the executive committee of the Surgical Section of the AAP approached the American Board of Surgery asking for some form of recognition, only to be denied each time. The fourth approach to the American Board of Surgery was successful.

Several significant developments helped change the outcomes.
1) A representative group of pediatric surgeons assumed the responsibility of compiling a list of requirements for training programs in pediatric surgery.
2) A method of inspection of programs for approval was arranged.
3) Copies of these documents were circulated to the membership. Programs were inspected and nine of the 24 were approved. The others all closed voluntarily. There were no lawsuits, even though nobody had legal authority to do all this. It was all purely voluntary.
4) The American Pediatric Surgical Association was incubating as a second freestanding organization with bylaws and rules and regulations similar to those of other surgical societies.
5) Considerable change had occurred within the membership of the American Board of Surgery.
6) The Journal of Pediatric Surgery was born with monthly publication of papers presented at each of the two major pediatric surgical societies.
7) Discussions were being arranged for certification of pediatric surgeons.
8) This fourth presentation was delivered by Harvey [E.] Beardmore, surgeon-in-chief at the Montreal Children’s Hospital and professor at McGill University. Harvey was a highly respected surgeon in both the US and Canada, and a good salesman.
9) And last, but not least, all candidates for the certificate of proficiency in pediatric surgery must have full training in general surgery and be
certified (or be eligible for certification) in general surgery plus two years of pediatric surgery in an approved pediatric surgical training program.

DR. WARNER: Tell me, now, you have made a lot of terrific contributions to pediatric surgery and specifically here in Cincinnati but also internationally. You've done a huge practice of cleft lip and palate. You know, you've had some significant experience with Hirschsprung’s disease and modification of established techniques, but one of the ones that's close to my heart is your ileal pouch anal pull-through procedure for ulcerative colitis and polyposis. I know that that was originally presented by Dr. [David C.] Sabiston many years ago in a dog study, but then it really was resurrected by you and Dr. [Josef E.] Fischer and I guess Dr. [William K.] Schubert, the gastroenterologist here. Tell me how you really started with that, and tell us a little bit about the history of that procedure that you developed.

DR. MARTIN: Well, in that particular procedure, the patient demanded it. I had one patient way back—oh, I’d been here about a year, I guess, and Harry Shirkey—pediatrician—came down to the dining room while I was eating lunch one day and said, “There’s a patient upstairs with ulcerative colitis. I think he needs an ileostomy or something.” He said, “He’s in pretty bad shape. You have time to finish your lunch.” I thought, “Oh, golly.”

DR. WARNER: [Laughs]

DR. MARTIN: I finished my lunch, and went to the unit to find the patient had just died. He was a teenager, and for three years he steadfastly would not consent to have an ileostomy.

DR. WARNER: You mean colectomy and ileostomy.

DR. MARTIN: It was the ileostomy that he objected to.

DR. WARNER: Just an ileostomy?

DR. MARTIN: The thought of a bag on his side for his bowels to move into for the rest of his life was unacceptable to him. A bright kid. High schooler. And I thought about it, and it really bothered me. The first patient I did with ulcerative colitis had toxic megacolon with perforation of the colon and peritonitis. He had to have surgery, so I did a simple colectomy and an ileostomy. The next one—it was late like that. There just had to be a better way. There was a manuscript in the *Annals of Surgery* in 1957 reporting complications from operations on ulcerative colitis in children. They averaged four major complications for every patient that was operated on for ulcerative colitis, and the death rate was around 50 percent.
DR. WARNER: Wow.

DR. MARTIN: In those days ulcerative colitis could be cured by surgical removal of the colon, but the patient would, for the rest of their lives, have to glue a bag onto their side to collect their bowel discharge which was watery and smelly and discharged without control throughout the day and night.

Most of the patients were teenagers who would not consent to this plight. We as surgeons just had to find a better way to cure this devastating disease. I’d heard about a procedure that Dr. [Franco] Soave was doing in Genoa, Italy for Hirschsprung's disease. I had met Franco so I called him. The operation was not appropriate for ulcerative colitis but it gave me some ideas. I also found three other reports of attempted sphincter-saving operations during the latter half of the 19th century, but they did not help me much. I did gain helpful ideas from a report published by Mark Ravitch and David Sabiston in 1948. Their operation was developed in the experimental surgical laboratory and later abandoned after attempting it on five patients. In the same year (1948), Dr. Orvar Swenson reported his monumental operation for Hirschsprung’s disease. It preserved anorectal continence following removal of the aganglionic rectum and major portion of the left colon. If the entire colon was removed, however, the results were less than ideal in a high percentage of patients because of frequent stools, perineal excoriation and stool soiling. But Dr. Orvar Swenson was the first to prove to the world that the sphincter-saving concept was now a reality that could work successfully in patients with Hirschsprung's disease.

So the stimulus to develop a better operation came from the teenage patients who gave their lives to make their point. The idea to preserve the muscular layer of the rectum to preserve the sensation of fullness came from Dr. Franco Soave, who pioneered the technique of the mucosal proctectomy. The concept of preserving the proprioceptive sensation of a full rectum came from a Dr. Black, a general surgeon of the Mayo Clinic in his publications in 1934. He also described the need to preserve the transitional mucosa overlying the columns of Morgagni since herein lies the sensory limb of the reflex arc which controls the contracture of the internal sphincter.

The concept of the “S” shaped reservoir and how to construct it came from a general surgeon from Texas who described his technique for using the jejunum to construct a new stomach following total gastrectomy for patients with stomach cancer.

Four previous authors published their own failed attempts to construct or preserve anorectal continence so that future surgeons could evaluate their methods and avoid making the same mistakes.
Dr. Swenson proved the concept of preserving the anorectal sphincter mechanism.

Dr. Rupert Turnbull perfected the technique of the ileostomy and taught us much of what we now know about the many aspects of the devastating nature of ulcerative colitis. The operation could hardly have been carried out with any degree of success without modern day support from total parenteral nutrition, steroids to bring the severe inflammatory process under control pre-operatively and of course the wide choice of broad spectrum antibiotics.

DR. WARNER: Tell us about the first operation. How long did it take?

DR. MARTIN: The first several operations were performed in the experimental surgical laboratory on animal subjects. The most daunting part of the operation was the mucosal proctectomy, which, as it turned out, was disarmingly easy in animals. After I felt comfortable doing the operation, we moved to the first patient, a 12-year-old boy with bloody diarrhea 18 to 20 times daily for close to one year and 20 pound weight loss. The mucosal proctectomy was difficult and blood loss was excessive because of the overwhelming inflammation of the mucosa. In the middle of the case, I regretted that I had ever undertaken it, but after replacing four pints of blood and eight hours of operating, I felt that the procedure had been a success.

DR. WARNER: Was that a straight pull-through?

DR. MARTIN: It was a straight pull-through without a pouch and without an ileostomy. He recovered after one relatively minor complication: I had placed a drain inside the rectal cuff alongside the anastomosis, bringing it out through a perineal stab wound. On the fourth post-operative day, I noted brownish drainage from the drain site which cultured enteric organisms, but it healed spontaneously. He went on to college and graduated with an engineering degree. The last time I talked to him he was married and had two children.

For the next patient, we devoted eight weeks to pre-operative measures to reverse the acute inflammatory process with total parenteral nutrition: Nothing by mouth, intravenous steroids; rectal steroid suppositories; intravenous antibiotics and plenty of rest, relaxation and encouragement regarding the progress of the treatment. The bloody diarrhea stopped and the rectal mucosa returned to near normal appearance. The operation still was not easy, but was easy as compared to the first patient. Blood loss was minimal with no replacement required. We followed this routine for the next 14 patients prior to reporting the experience.
A major problem with the straight direct anastomosis was that most patients experienced a period of approximately six months of perianal excoriation due to frequent stools containing digestive enzymes. Stimulated by favorable reports by [Alan G.] Parks of England and [Tohru] Utsunomiya of Japan using a reservoir of the “S” of “J” configuration, we included the construction of a reservoir as a part of the operation.

DR. WARNER: How did you start working with Dr. Fischer? Because you two were quite a team.

DR. MARTIN: I kept getting calls from adults who wanted the operation, and I didn’t have facilities to do the operation on adults. Dr. Bill [William] Culbertson had a patient by the name of Rosemary whom he had done a sub-total colectomy on fifteen years before. She had an ileostomy and had accepted that it would be permanent. He asked me one day if I thought I could do this operation on his patient, Rosemary. She was married and had two children. She was thirty-five. I said, “Sure, if you scrub in with me and have the patient on your service.” Because I hadn’t operated on adults for years. I could diagnose a complication in children over the telephone, but I did not feel comfortable assuming full responsibility for completely different complications which can occur in adults during their postoperative phase. We arranged for the patient to be admitted to the hospital on his service and we would do the operation together. Rosemary did beautifully, recovered in record time, and had full control with the first bowel movement she had had for 15 years. She was “forever grateful.”

And then Dr. Bob [Robert] Hummel had a couple of patients I did with him. And Dr. Dick [Richard] Welling had several at Good Sam [Good Samaritan Hospital] and I did them with him until he felt comfortable doing them without me. Shortly thereafter, Dr. Josef Fischer came from Boston to be our new department chairman of surgery. He had written a book on inflammatory bowel disease but had not done this operation. He wanted to learn the details of how to do the operation, so we started as a team with the plan that I would fade away after he felt comfortable doing the operation without me. As it turned out, we both enjoyed the relationship until several years and 200 patients later I retired and Dr. Fischer moved to Boston to become department chairman at Harvard [Medical School].

DR. WARNER: Well, nowadays it seems that we are operating on larger and larger children.

DR. MARTIN: Yes.

DR. WARNER: What do you think about doing bariatric surgery in children?
DR. MARTIN: Initially I didn’t want to get involved in it. There are some conditions I’ve tried to avoid. I’ve tried to avoid pregnancy and its complications in the pediatric patient. Initially I regarded childhood obesity as a pediatric disease. I’ve since changed my mind, because the pediatrician is saddled with the problem and needs occasional surgical help.

Dr. Joe [Joseph] Cox became interested in bariatric surgery, so I encouraged bariatric surgery referrals be directed to him. [Laughs]

DR. WARNER: So he did some—

DR. MARTIN: Oh, he did several operations, and attracted many referrals prior to recurrence of his illness.

DR. WARNER: Now, you’re also distinguished for having done a fair bit of surgery over at the Cincinnati Zoo [and Botanical Garden].

DR. MARTIN: [Laughs]

DR. WARNER: Tell us about how you got into being an advanced veterinary surgical consultant.

DR. MARTIN: Well, I started out to be a veterinarian. I actually had two years in veterinary school.

DR. WARNER: You did?

DR. MARTIN: Before medical school. I didn’t think I could afford medical school. It was too expensive. I grew up in an unproductive area in southern Missouri, where people didn’t fare very well during the Depression. My family didn’t do too great, either. They had a little farm and a house, and we had plenty to eat, but I couldn’t afford the expense of medical school. I thought I wanted to be a veterinarian, but after two years of vet school World War II came along and I found myself in the US Army for three years. I didn’t do much to help my country win the war, but I wore a uniform and did what they told me and I saluted and said, “Yes, sir.” [Laughs] But anyway, I didn’t get killed and I received four years of the G.I. Bill, which paid for medical school. It was a dream come true.

DR. WARNER: So how did you hook up at the zoo?

DR. MARTIN: I was the only full-time surgeon at Children’s Hospital and I had set up an experimental surgical laboratory at the hospital where I did animal surgery every Wednesday. Also my credentials included two years of veterinary school. One of the neonatologists, Paul [H.] Perlstein, was interested in the zoo and actually was a consultant for the newborn nursery
at the zoo. When he encountered a surgical problem he called me for advice. One day he called about a baboon that had an unsightly umbilical hernia. Animals could not be placed on exhibit unless they’re perfect physically. This was a lowland gorilla worth $250,000. Paul knew that I had a special operating room for animals and he also knew that I did a lot of free surgery and he had seen my patients following surgery for umbilical hernia and knew they did not have a visible scar. The zoo veterinarian anesthetized the patient at the zoo with the help of Dr. Ted [Theodore W.] Striker, our Children’s Hospital chief of anesthesiology and transported the gorilla asleep to my laboratory operating room. The rest was just another free operation.

DR. WARNER: [Laughs].

DR. MARTIN: So umbilical hernia was the first one, and then next came the inguinal hernias, and the crowning blow was when a white tiger baby choked when first fed and Paul assumed that it had a TE [tracheoesophageal] fistula, but examination under anesthesia proved the problem instead to be a congenital cleft palate, which I repaired with a pharyngeal flap.

DR. WARNER: Oh, my gosh.

DR. MARTIN: [Laughs].

DR. WARNER: Did you bronch him and do an esophagoscopy and all?

DR. MARTIN: Oh, yes. And all he had was a cleft palate. Fortunately there was another one in the litter that we could put to sleep so we could examine it [laughs] to see that this was different. [Laughs]

DR. WARNER: Otherwise how would you know?

DR. MARTIN: That’s right.

DR. WARNER: What about the post-operative care?

DR. MARTIN: Carol Schottelkotte, the daughter of the announcer [Al Schottelkotte], was the caretaker at the zoo nursery and she fed him with a medicine dropper.

DR. WARNER: That’s a name from the past.

How was it to do experiments with animals when you were doing investigation? Did you have to have institutional approval?

DR. MARTIN: No.
DR. WARNER: Where did you get your animals?

DR. MARTIN: There were places where one could buy them. Some of the dogs came from the dog pound. They were going to put them to sleep and get rid of them, so we took them. And then the other places would sell them to us for a reasonable sum. On one occasion I refused to accept a beautiful, big English pointer as a donor for liver transplant. [Laughs] So they took him back without any comment.

DR. WARNER: Gosh.

DR. MARTIN: Pigs proved to be good for experimental work and at the time were less expensive and easier to obtain.

DR. WARNER: How did you squeeze that into your schedule?

DR. MARTIN: That was every Wednesday morning right after clinic. Sometimes I’d have to cancel, if some emergency would come in, but usually Judy would go to the lab to prepare the patient, put the animal to sleep and draped and ready for me to make the incision. When we became involved with liver transplants, Judy would make the incision and mobilize the donor liver, then if I was delayed she would start the recipient. She was an excellent surgeon.

DR. WARNER: Wow.

DR. MARTIN: She and one of my daughters one summer worked together, and, gee, it was like having two experienced residents in the lab.

DR. WARNER: I was going to ask if you were able to take any of the fellows—

DR. MARTIN: They were usually busy with clinical responsibilities, but if their schedule permitted they would join us.

DR. WARNER: What sorts of things were you doing?

DR. MARTIN: We perfected the pull-through operation for ulcerative colitis. We worked out the details of the operation for kidney transplants and liver transplants. We attempted to create a model for NEC which was not successful. I’ve forgotten several of the proverbial “dead horses.”

DR. WARNER: Before patients?
DR. MARTIN: Before patients, yes. And [Lou Gonzales] had the lab at the Veterans Hospital [Cincinnati VA Medical Center], since he was chief of surgery there. Most of our original kidney transplant work was at the VA where we perfected the technique. Lou also went to Denver to study with Tom [Thomas E.] Starzl for two weeks before we did the first patient. It was the first in Ohio. Incidentally, we had to finance all our research from our own private practice, except for a small budget which Dr. Gonzales obtained at the VA Hospital.

DR. WARNER: Really?

DR. MARTIN: I tried getting grants and all that, and I found that I could make better use of the time by doing surgery.

DR. WARNER: Yes.

END OF TAPE 2, SIDE A

DR. WARNER: Looking back over your career, what would you say are some of the things that you’re the most proud of, your greatest triumphs?

DR. MARTIN: I guess the greatest satisfaction that I’ve had is training young surgeons, especially pediatric surgeons.

DR. WARNER: [Laughs]

DR. MARTIN: I grew up on a farm, and I was interested in horses, especially thoroughbreds. One of our daughters became very interested in horses and learned to ride and care for the horses. One of the old sayings in the thoroughbred business is that with every foal that hits the ground, the owner looks at it and says, “My God, I think that’s gonna be another Man o’ War.” [Laughs] But in the three years it takes to get ready for the Derby, only one out of several hundred will make it, but there’s always another crop coming on next year.

DR. WARNER: Yes.

DR. MARTIN: And it’s like training pediatric surgeons. Every one that comes along, “He’s going to be another William Ladd.” [Laughs] It’s so interesting and so gratifying to see them mature, to become icons themselves in pediatric surgery. That is the most gratifying part of my entire career.

DR. WARNER: That’s fantastic.
DR. MARTIN: There have been a few that have really turned out to make significant contributions to the field of pediatric surgery and become leaders and actually icons in the field, that’s number one. And number two is to have a part in building a children’s hospital and building a department of surgery with teaching, research, administration and patient care—all directed to improving the quality of care for children world wide as well as locally.

DR. WARNER: Absolutely.

DR. MARTIN: And I guess number three is the satisfaction of doing surgery.

DR. WARNER: Taking care of patients.

DR. MARTIN: Yes.

DR. WARNER: That’s fantastic.

DR. MARTIN: Research is great, but my part of research—I’ll go back a little bit. When Dr. Gross offered me the job to stay at Children’s in Boston and be in charge of the surgical research laboratory, I said, “Dr. Gross, I’m not much of a scientist.” He answered, “You have written four papers, and you’re still in your residency. I’m not a scientist.” He added, “I just find a clinical problem and then work out a solution to it.” He said, “That’s all you need to do in surgical research. You can’t go back and reinvent the wheel.” He put it all in great perspective to me.

DR. WARNER: That really is, I think, the cornerstone of what we as physicians should try to accomplish in our research. It’s to take a clinical problem and try to solve it.

DR. MARTIN: We as physicians have a background of the science to combine with the clinical experience to help us visualize the solution of clinical problems utilizing the gold mine of information which the basic scientists have provided us with.

DR. WARNER: Yes.

DR. MARTIN: And we have got a great advantage because of the clinical problems which we experience almost daily.

DR. WARNER: Yes, yes. It’s the ability to translate that and apply the techniques and knowledge that bridge those gaps.

DR. MARTIN: Yes.
DR. WARNER: That’s what’s key.

DR. MARTIN: Exactly. And surgeons benefit the most because problems are referred to them to correct and often they encounter someone who dies because there are problems still which we cannot fix.

DR. WARNER: Yes.

DR. MARTIN: One lies awake at night, thinking, “How can I fix that? How can you operate on the inside of a heart?” [Laughter] And now that’s commonplace. Transplanting a heart to another patient.

DR. WARNER: Right.

DR. MARTIN: I mean, those things, when I was a medical student, you didn’t even think of. But primarily surgeons have made all those big advances. Everyone keeps saying this: “Oh, there are no more places to go. It’s all been discovered.” It’s not true. I heard that quote when I was a medical student.

DR. WARNER: Dr. Martin, have you had any things that you’ve done along the way, looking back at your career, that you would have done differently? Any regrets of anything?

DR. MARTIN: If I had known the type physician I was going to be, I would love to have had some training in management. Where I felt deficient, for example, was when an anesthesiologist and a clinical surgeon would get in an argument, and it was my duty to settle it. My first impulse was to take them and knock their heads together, but that’s not the way to do it. Solving of conflicts, and a little bit of training along that line would have been greatly beneficial to me. I learned things the hard way.

DR. WARNER: I can imagine, yes. What are your thoughts now about the way the pediatric surgical fellowships have evolved? Do you think that we are getting so sub-specialized now that we’re no longer doing the types of ENT procedures or urology or fetal interventions, that the field is becoming too big? And what should we do to improve things for pediatric surgeons?

DR. MARTIN: I asked Dr. Gross one time what he thought his trainees should do when they came out of his program, because there we did ENT. We did all the urology, just like regular general surgery. We did the thoracic, just like regular general surgery. It was just part of the same thing. All the head and neck and plastic. We had a separate plastic surgeon who taught us to repair cleft lips and palates. I asked Dr. Gross, “What should we be able to do?” He said, “We’re giving you basic training here in all these
fields.” He said, “When you get out on your own, you sort of fit yourself into the community, respond to where the needs are.” And I think that was good advice.

I agree that the training programs should continue to provide a broad training experience.

DR. WARNER: Yes. What do you think about the fast-track plan? You know, they’re talking now about doing less general surgery and more pediatric surgery and making the overall training less.

DR. MARTIN: Well, I’d be opposed to that. My concept is that pediatric surgery is general surgery confined to a pediatric age group where additional training and experience are required. The basic principles of surgery apply equally to pediatric and adult surgery.

DR. WARNER: So you feel that the work-hour restrictions have really more of a negative impact than positive.

DR. MARTIN: There are two issues which must be kept separate: One is the quality of the learning experience; the other is the need for cheap labor. Trainees should receive a reasonable compensation, but at the same time they must expect to perform certain services billable by the employer and supervised by the senior surgeon. In answer to your question, the answer is “no.” I feel that there should be certain work hour restrictions but the trainee must understand the training purpose is to equip them for a professional career, not to be hourly labor. Their number one responsibility is to the patient. The faculty oversee and supervise their work. Their degree of patient care responsibility is dependent upon their capability. The institution simply provides the environment. What the trainee learns is their own responsibility.

DR. WARNER: Yes.

DR. MARTIN: There needs to be a compromise. I think if they’re going to make it a 40-hour week, then I think the program has to be extended for more years.

DR. WARNER: Yes.

DR. MARTIN: But there can be a compromise there. The compromise is something that has to be settled.

DR. WARNER: What, in your surgical career, do you recall as being perhaps one of your greatest triumphs? Whether it be a case or contribution or something that stands out as just a phenomenal experience.
DR. MARTIN: Just off the top of my head and on the spur of the moment, the contribution that has really done the most for mankind is the surgery for ulcerative colitis, which I developed here in Cincinnati. I was asked to give a talk at the American Gastroenterological Association in New Orleans one time, when I first started doing this operation, and the gastroenterologist who preceded me on the program gave some statistics. He concluded that there were 250,000 patients in the United States with ulcerative colitis that would benefit from any good operation that could be developed for them to cure their disease and leave them with rectal continence. That sort of struck a chord with me. I thought, “Don’t send them all to Cincinnati.” [Laughter]

I think that’s probably it, then. The others, including the operation for total colon Hirschsprung's, are things that I feel good about, but what has done the most good to the most people I think is the operation for ulcerative colitis. Prior to then, a colectomy and an ileostomy would cure the disease, but they had to have a bag on their side for the rest of their lives for collection of bowel movement.

DR. WARNER: Right.

DR. MARTIN: And this has got to be better. And from the standpoint of quality of life, that’s been a great contribution.

DR. WARNER: What have been barriers for you in your career here in Cincinnati to developing the program that ultimately exists?

DR. MARTIN: My inability to convince some of my seniors that something new would be beneficial.

DR. WARNER: I see.

DR. MARTIN: I was fired for the first kidney transplant Lou Gonzales and I did. It was the first pediatric successful kidney transplant to be done in Ohio or any adjoining state.

DR. WARNER: You were?

DR. MARTIN: Mm-hm.

DR. WARNER: Here at Children’s Hospital?

DR. MARTIN: No, not the hospital, by the department of surgery.

DR. WARNER: Really? And on what grounds?
DR. MARTIN: I was instructed to not permit the news media to hear of it. The operation began about 4:00 pm and concluded near midnight. The word somehow had leaked to the newspapers and about 10:00 pm, reporters with cameras attempted to break into the operating room, at a very critical part of the operation. I had the recipient prepared with the abdomen open. Dr. Gonzales was just completing the removal of the mother’s kidney. Time was critical. I don’t remember what I said, but it was far from polite and they left immediately. The operation was a success; the headlines in the *Cincinnati Enquirer* the next morning proclaimed the success of this “great medical breakthrough in Cincinnati” with our names but no reference to the department of surgery of the medical school.

DR. WARNER: Right.

DR. MARTIN: But my boss in the medical school was just resistant to this happening. He’d given permission, but I had to finagle a little bit to get permission from the department of pediatrics and the department of surgery and from the dean’s office, all those things. And I sort of had to go to the right person at the right time, and they’d approach the other one and say, “Well, they’ve all approved it.”

DR. WARNER: My gosh.

DR. MARTIN: Then I got an answer, “Well, I won’t stand in your way. I won’t condemn it. But you don’t have my backing.”

DR. WARNER: But the hospital, itself, has been incredibly supportive.

DR. MARTIN: Yes, they had because the hospital was run by pediatricians, and the pediatricians all gave me support.

DR. WARNER: Yes, absolutely.

DR. MARTIN: I was tolerated by the surgeons and most of the specialists tolerated me.

DR. WARNER: Who was your first partner in practice?

DR. MARTIN: I wasn’t allowed to have a partner for the first 12 years. Joe Cox was our first trainee in pediatric surgery. He grew up in Eaton, Ohio. When he finished, I told him I could give him a job. I kept my fingers crossed behind me when I told him that.

DR. WARNER: [Laughs.]
DR. MARTIN: And for him to look around to see if he could find anything better, and he looked around and came back and said he’d like to stay in Cincinnati. And I said, “Okay, you just keep doing surgery, just like you are now except I don’t have to supervise you anymore; but I’m always here if you need me.” The department of surgery eventually approved his appointment to the faculty.

DR. WARNER: Wow.

DR. MARTIN: And he was the first one.

DR. WARNER: Was Dr. [John] Noseworthy the second?

DR. MARTIN: No, Jens [G.] Rosenkrantz was the next one. That’s a long story that I really can’t go into, but Jens Rosenkrantz grew up in Indian Hill, and he had a lot of influence in the Cincinnati area. He graduated from Harvard Medical School and completed pediatric surgical training at Boston Children’s Hospital.

DR. WARNER: Yes.

DR. MARTIN: He was the second, and then, with my encouragement, an old friend Bill [William R.] Richardson had come to Cincinnati in private practice of pediatric surgery. The four of us shared emergency call as well as the teaching responsibilities for several years. Dick [Richard] Stevenson and Fred [Frederick C.] Ryckman both trained with us here and were recruited to join our group.

DR. WARNER: Mm-hm. It helps to bring someone in like that who has a lot of talent.

Here at Cincinnati, what has been the greatest impact of things that have made contributions to the care of children in your career? Is it anesthesia, the personnel they’ve been able to recruit? Is it the nursery? What do you think has been the major impact for pediatric surgical care?

DR. MARTIN: Oh, gee, there are so many things. The development of the intensive care units, the parenteral nutrition, antibiotics, department of radiology. I guess the supporting departments are probably where the biggest impact is, radiology and the laboratories. They all add up to better care for our patients. When I first came here, to get a blood sugar on an infant required five ccs of blood.

DR. WARNER: You were doing a lot of blood transfusions then.
DR. MARTIN: [Laughs]. You just had to operate without it. There have been so many advances like that in every way. Computerization—and it’s just been a great age to live in.

DR. WARNER: You’ve really gotten into computers, yourself, recently, haven’t you?

DR. MARTIN: Yes.

DR. WARNER: That’s great. Now, in your spare time—I know that you didn’t have much when you were really developing the program here, but you ultimately did get into breeding cattle?

DR. MARTIN: Yes.

DR. WARNER: When did you get into that? And tell me a little bit about that.

DR. MARTIN: Oh, I grew up on a farm. When I went to high school, I had a vocational agriculture course in high school for four years. That was part of the training. I was going to be a farmer. And I had cows and sheep and a small farm. Then I went off to college and medical school and resumed this interest after I retired at the age of 75. I started a herd of Hereford cattle on a farm between Cincinnati and Columbus. I used the modern techniques of artificial insemination and embryo transfer. I raised some fine cattle, won several awards and had one national champion, but just about broke even financially. I realized beforehand that it’s a lifetime endeavor if you’re really going to make very significant contributions in the field. I enjoyed it and got a lot of satisfaction from it. My impact on the industry, however, was infinitesimal because there are so many other people in the field who are doing the same thing I was and have been doing it all their lives.

DR. WARNER: But that’s remained as a hobby?

DR. MARTIN: It was a hobby. I’m out of it now. At my age, it’s time to move on.

DR. WARNER: It’s tough.

DR. MARTIN: So I’ve put all that aside.

DR. WARNER: Switching gears here, one interest of mine has been necrotizing enterocolitis. Have you really seen any differences in how we manage or diagnose NEC now compared to when you first started discovering NEC?
DR. MARTIN: I can’t answer that question very well, Brad, because I’ve been away from it long enough that I don’t even know what you’re doing anymore. [Laughter]

DR. WARNER: Honestly, I must say I don’t think that it’s very much different.

DR. MARTIN: I suspected that, but I didn’t want to say it.

DR. WARNER: When you come back for conferences—and I know that you do that infrequently, but we see you coming for teaching conferences—has anything struck you that made you think that we were reinventing the wheel. In other words, we’re starting on the same path of something you did many years ago and you can forecast that we’re going to end up the same way?

DR. MARTIN: There’s a little bit of that, but by and large it’s advancing. There have been incredible advances in technology, research, prenatal surgery, minimally invasive surgery, organ transplantation, open heart operations, stents in coronary arteries, precise and previously unheard of neurosurgical techniques, cures for leukemia and other forms of cancer. I could go on and on. Yes, there are times when, for example, at a conference a subject will come up that makes me think, “Gee, I thought we solved that twenty, thirty years ago, forty years ago.” But those occasions are rare. At most every conference which I attend, I’m impressed by the great discoveries and new techniques and methods available today.

DR. WARNER: [Laughs] Is there anything you want to tell me about that I haven’t asked you yet?

DR. MARTIN: You have done an excellent job of putting your finger on all the important questions.

DR. WARNER: I’ve really tried. I just have to say that in my lifetime, I think it’s been probably a golden gift to have been your last fellow here at Cincinnati and really to have been working with you during my residency. I feel that I’ve latched onto someone who’s really great, and I really, really appreciate that.

DR. MARTIN: I’ve followed your career with interest and admiration.

DR. WARNER: Well, thank you.

DR. MARTIN: And I think you’ve really accomplished a tremendous amount in the times that you’ve been here, and I think you’ve got a great
future ahead of you in St. Louis. I wish I could give you more advice on the basis of my experience here. I’ve tried to.

DR. WARNER: You certainly have.

DR. MARTIN: I certainly wish you well out there. Expect some stumbles. And some alligators around the corners.

DR. WARNER: Yes, absolutely.

DR. MARTIN: [Laughs]

DR. WARNER: I think that’s true everywhere. I really do. But really, looking back at what you’ve accomplished here in Cincinnati, and looking out my window at all of these huge buildings now, I think our success has been based on many things, but one of those pillars I think is outstanding surgical care.

DR. MARTIN: Also one thing that we have, we’re blessed with here is an excellent board of trustees of the hospital. The members are leaders in the community, each with expertise in their various fields, all dedicated to Children’s Hospital. For example, for our first satellite unit we thought we needed at least 10 acres of expensive land. The board instead purchased 40 acres, and before construction started, they sold 20 acres off for enough to pay for the entire 20 acres left.

DR. WARNER: Isn’t that something?

DR. MARTIN: They’re just astute business people.

DR. WARNER: Very visionary.

DR. MARTIN: And you have an administrator now, Jim [James M.] Anderson, who has just been superb to work with.

DR. MARTIN: Yes. Excellent person. He really is.

Well, it’s been an unbelievable experience for me, personally, to have been here in Cincinnati for twenty-five years, and to have worked with many of the people whom you’ve mentioned. It’s really been a fantastic experience over all. It’s one large family, and everybody supports each other.

DR. MARTIN: Right.

DR. WARNER: Well, Dr. Martin, thank you for your time.

DR. MARTIN: Well, it’s been enjoyable.
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