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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Dr. Newman trained as a fellow with Dr. Randolph from 1984-1986. He was the 27th of the 34 fellows that trained in Washington under Dr. Randolph. He then became an attending surgeon at Children's National Medical Center with Drs. Randolph, Anderson, Guzzetta, and Eichelberger as partners.

Dr. Newman graduated Phi Beta Kappa from the University of North Carolina and received his medical education at Duke University and has been elected to Alpha Omega Alpha. He began his surgical training in the Harvard program at the Peter Bent Brigham Hospital in Boston, rising to the level of Chief Resident and also served as the Arthur Tracy Cabot Fellow at Harvard Medical School.

Dr. Newman is a member of the Board of Commissioners of the Joint Commission on Accreditation of Health Care Organizations. He is a past member of the Board of Governors of the American Pediatric Surgical Association. He is also a past Chairman of the Section on Surgery of the American Academy of Pediatrics. He is a professor of surgery and pediatrics at the George Washington University School of Medicine.
Interview of Judson Randolph, MD

DR. NEWMAN: I am interviewing Dr. Judson Randolph for the oral history project for the American Academy of Pediatrics. This is June 26th, 2007, and we’re in Monteagle, Tennessee.

DR. RANDOLPH: I’m Judson Randolph, being interviewed by Dr. Newman and very proud to be so.

DR. NEWMAN: Dr. Randolph, you had a very distinguished career in pediatric surgery. You came from Tennessee. Tell me about how you first got interested in pediatric surgery.

DR. RANDOLPH: It was a round-about way. I was always interested in interaction with young people. I was very active in the Boy Scouts, and all through that training and merit badges and senior patrol leader and so on, I liked interaction with younger people, and so as I approached my medical school decisions, I thought I wanted to be a pediatrician. But when my group was sent to the operating room, I was taken with surgery. I realized first of all, for probably the wrong reasons, that I was really attracted to surgery. I’d been a mediocre athlete in high school and college, and I got in the OR [operating room], and I said, “Man, these people have got locker rooms and uniforms and a thing they do and an arena they do it with [sic; in] and a team, and you can be as good as you want to be, no matter what you weigh.” And I said, “Surgery is an exciting future.” And that’s how I happened to embark on a surgical career.

During my internship, Dr. [Robert E.] Gross’ book [Gross, R. E. (1953). The surgery of infancy and childhood: its principles and techniques. Philadelphia: Saunders] came out. Although we in those days made very little money and I was being supported by my wife, Comfort, as she was a nursery school teacher, nevertheless I splurged and bought Dr. Gross’ book when I saw it in the hospital bookstore, and I brought that book home. I paid eighteen dollars for it, by the way. And it was the last great textbook by a single author in surgery. And I said, “Well, here you can do it all. You can take care of children and you can do surgery, and that’s what I want to do.”

DR. NEWMAN: Where were you an intern?

DR. RANDOLPH: In Rochester, New York, at Strong Memorial Hospital.

DR. NEWMAN: Tell me about the people that influenced you when you were at Vanderbilt, at the medical school there.
DR. RANDOLPH: When I was a senior, Dr. [H. William] Scott [Jr.] had just come from [Johns] Hopkins [Hospital]. He was young and enthusiastic and a Hopkins resident trainee and graduate, and he was very exciting to those of us interested in surgery. And I thought I wanted to stay in his program at Vanderbilt [University], and he offered me a slot. It was the second year of the match, so things weren’t very fixed in how you applied and did your business with the match, and I went home and had Sunday lunch with my family, and my father, who knew really nothing about postgraduate medical education—he was a newspaper man—and I told him I was going to stay at Vanderbilt for surgical training. He said, “Well, now, let me see. You went to grammar school and high school and college and med school all within about two miles of this place.” He said, “Don’t they have something else out there?”

And so I went right down the next day to Dr. Rollin [A.] Daniel [Jr.], who was our wonderful teacher-friend and thoracic surgeon, and I said, “You gotta get me outta here.” [Laughs] And he had a friend, Earle [B.] Mahoney, at the University of Rochester, who was also a thoracic surgeon, and he called him up and inveigled him into taking me, and so I, without knowing anything more than Dr. Daniel sent me, I went to the University of Rochester, and it was a wonderful year.

DR. NEWMAN: And then you came back?

DR. RANDOLPH: Well, during the year, I purchased Dr. Gross’ book and looked at it, and I told my wife, “I’m going to write this man a letter.” We had literally no money for extras or anything, but she’s the one who said, “No”—and I thought she didn’t want me to go for that kind of training—she said, “You’re not going to write him a letter, you’re going to make an appointment and go see him [at Children’s Hospital Boston].” And then she said, as only a wife could say, “Because you’re a lot better in person than you are on paper.” [Laughs]

DR. NEWMAN: So did you go make an appointment with Dr. Gross?

DR. RANDOLPH: I did, right in December, I think it was, of 1953. And I went, and I had the interview, and I had also the very good fortune that one of his senior residents that he was very fond of, who had just finished the program and gone into the service, was George [W.] Holcomb Jr., who subsequently practiced pediatric surgery in Nashville. Dr. Gross wanted George to come back and be on his staff. And George wrote Dr. Gross a letter on my behalf, so when I got there, Dr. Gross had already been a little bit softened up about this other Tennessee boy.

He unrolled this great big master sheet that he had, and he had a plan that he would bring a junior resident on every two months during the year and send
them on through the year’s rotation, and he did that. He was a very practical man, and he did that so there wouldn’t be a total turnover of the staff the first of July. And so he said to me, “Could you come in March of 1955?” I said, “I can come anytime you would have me.” [Laughs] So he penciled my name in, and I asked him, “Well, now, at the end of my internship, I’ll have eight months before I come to you. What would you recommend that I do?” And Dr. Gross said the most interesting thing to me. He said, “Well, when I finished at Harvard Medical School, I couldn’t get the surgical internship I wanted, so I went into pathology.” And he said, “I had three years of pathology, including the chief residency at the Peter Bent Brigham Hospital.” And he said, “You’ve got a mighty fine man down there at Vanderbilt named [Ernest William] Goodpasture, and I suggest you go down there and spend the eight months in pathology,” which is what I did.

And it was an extraordinary work of the hand of the Lord and Dr. Gross and Dr. Goodpasture because I came home, and the first day I got home, I saw my little brother was sick in the bed. And I asked my mom what was wrong with him, and she said, “Well, the flu is going around,” and the doctor hadn’t been to see him, “but he says it’s just the flu.” And I went in and sat on my brother’s bed, and I put my hand on his abdomen, because I’m a surgical intern, and I put my hand on his abdomen, and he jumped. And then I became uncertain. I said, “You know, I’ve just had a whole year of surgery and seeing people with peritonitis and ruptured appendix and so on, and maybe I’m just making this up, you know?”

But my brother was very sick, and I called an old professor of surgery at Vanderbilt, who lived around the corner from us, and I said, “On your way home, I would be grateful if you’d stop and see my brother.” And he did that and came into the bedroom where my brother was, and he examined him for just a minute. He put his hand on his abdomen and so on, and reached over and picked up the telephone and made an appointment in the OR [operating room] for two hours from then, and shipped my brother right to the hospital, put some fluid in him, and in 1954, he had a ruptured appendix with generalized peritonitis.

DR. NEWMAN: Good gracious!

DR. RANDOLPH: And I think, knowing what happened in those early antibiotic days with generalized peritonitis, I think my brother might have died if I hadn’t just come home the first of July. That had a happy outcome, of course.

The other episode: My dad was the financial editor of the Nashville Banner and he took me downtown with him to go around and see his friends at the banks and in the money houses and so on that he used to write about. “This is my son, the doctor.” You know, he was proud to do that, and we had a
wonderful day together. My dad had been gassed in the First World War, and he had bullous emphysema. Later that fall, he had a spontaneous pneumothorax, and they put a chest tube in, and he got better, and then he had another one, and they decided to try to operate, and there just was very little lung tissue left. And Dr. Daniel, who had sent me off to Rochester and who operated on my father, was unable to save him, and my father died. But I was home, able to be there with my mother and not be traveling back and forth from some other place, so that short eight months in Nashville was a boon. Then I went off to Boston in the end of February in 1955.

DR. NEWMAN: Now, what was it like, joining the service there in Boston? Who was the staff, and where did you fit in? What did the junior resident do?

DR. RANDOLPH: They had a very well-organized service. It had six junior residents, one starting every two months throughout the year, irrespective of the academic year. And then they had four senior residents in pediatric surgery, who were on two-year assignments, and they had much more senior responsibility, did a fair amount of the operating, under supervision. And then there was one chief resident, who would usually become an academic pediatric surgeon on graduation. But the men who finished the two-year senior job very often then finished that assignment and went off to establish themselves as major pediatric surgeons around the country. Bob [Robert J.] Izant, Jr. for example, went first to Columbus [Children’s Hospital] and then to [Rainbow Babies & Children’s Hospital] Cleveland and is one of our very distinguished pediatric surgeons. Mort [Morton M.] Woolley had the two-year job, and Dr. Gross offered him the chief residency, but he wanted to get back to California and go to work. Ted [Theodore C.] Jewett [Jr.] went to Buffalo and didn’t take the chief residency but just went off to work.

And so there were a lot of careers in pediatric surgery launched with that two-year senior residency. It consisted of six months on the ward service under the chief resident, then six months in charge of the outpatient department and the emergency room, then six months of plastic surgery under Dr. Donald [Wieting] MacCollum, where you did the ears and the webbed fingers and the cleft lips and cleft palates and really became quite proficient in children’s plastic surgical needs. And then the last six months was on Dr. Gross’ service, as his personal resident. Remember, in my time—this was 1955—John [H.] Gibbon Jr. had done the first open heart surgery in 1953, so we were just getting going in the open heart situation, not only at Boston Children’s [Children’s Hospital Boston] but Mayo [Clinic] and University of Minnesota and some other notable institutions in the mid-fifties. And so being on that cardiac service in the fifties was one of the most exciting, heady, awe-inspiring times of any resident’s life.
DR. NEWMAN: When you first went to Boston [Children’s Hospital Boston], you were the junior resident.

DR. RANDOLPH: And they called it the pup.

DR. NEWMAN: The pup. What were the duties of the pup in those days?

DR. RANDOLPH: The first two months, you started IVs [intravenous procedures], you took patients to the X-ray department to get whatever was required at that time, to be sure the IV [intravenous line] was in if they needed an IVP [intravenous pyelogram]. Intravenous pyelogram was very much one of our major investigative tools in babies and children in those days because Dr. Gross’ service embraced all of pediatric urology as well as general pediatric surgery and cardiac and plastic. So we just were the hand servants to anybody else. We were the lowest members of the totem pole of taking children who needed special procedures, take them wherever they needed to go. We were just a little above orderlies. [Laughs]

DR. NEWMAN: Did you do any surgery?

DR. RANDOLPH: You didn’t get to do any surgery in the early months of your junior residency, but you did get to do some surgery the last four months, because the first two months you just were the pup, and that was a pretty good system because the older, more senior junior residents and the senior residents would just order IVs [intravenous procedures], and they wouldn’t worry about their having to put them in. [Laughs] So they’d just order whatever the baby needed. And you learned something about starting IVs and starting tiny little needles in the scalp veins and in various places that you learned, and you really got quite good at first of all handling babies, working with nurses, starting IVs, putting tubes down for feeding or for aspiration.

And then you moved to two months in the outpatient [department], where you worked under the senior resident, who was the senior person in the surgical outpatient [department]. And you did a few little manipulations and procedures. I was blessed in that when I moved to the outpatient [department] Lester Martin was my senior resident, and Lester was everybody’s hero. He was good at what he did. He was vigorous. He taught easily and well, and I just wanted to be exactly like Lester after spending two months in the outpatient [department] with him.

Then you moved to two months of neurosurgery, and we had the great and memorable Donald Matson as the neurosurgeon at Children’s Hospital [Boston]. He actually was under Dr. Franc [Douglas] Ingraham, but Don [Donald] Matson was the world’s best, and recognized so, pediatric neurosurgeon. And you worked on his service, so you got to work with him.
And there also was a resident on the neurosurgical program that came over from [Peter Bent] Brigham Hospital. I had the great good fortune to be there in the summertime, and Mrs. Matson was in their summer home with [the] children up in Maine, and Dr. Matson would go up on the weekends, but during the week he was by himself, and on a number of occasions he took me to the country club. He had been a near-Olympic swimmer. He had been a college swimmer, and he almost made the Olympics. And so I, it happens, had spent a lot of my summers running swimming pools and stuff, so I was a pretty good swimmer. And so he challenged me to a race at the swimming pool, and I just touched him out, and so we became very good friends. [Laughs]

And my two months at neurosurgery, I was so captivated by Dr. Matson, I thought maybe I wanted to go into pediatric neurosurgery, but the more I saw of the desperate little children with brain tumors in those days, and they were even doing hemicorporectomies for children with epilepsy, and I just said, you know, this patient material is so discouraging, as it was in those day, that I didn’t think I was fitted for that.

Then the next two months, you spent on the cardiac service, under the cardiac senior resident. That was your first real introduction to Dr. Gross. He was very inspiring. He was a wonderful technical surgeon and very facile, very fast. And we went in one day—and the cardiac resident would often open and close and very often do some of the cases such as coarctations and patent ductus arteriosus and things of that sort, and Dr. Gross would just come and look in and be sure everything was going well, and then he would do something else, like an undescended testicle. He loved to do the undescended testicle operation. He just liked doing that. And he would do other things like that.

Occasionally, as the junior resident on the cardiac service, you would end up being the first assistant to Dr. Gross. And I will never forget that—Dr. Gross liked to do his splenectomy from the right side rather than the left side, and I didn’t know that, so I got scrubbed, and I went in and stood on the right side of the patient, and he came in, and now the left side was only there, so he came in, and then he pointed to Marie [Dresser] and then pointed to me, and she gave me the scalpel. And I was about to do an elective splenectomy with the chief helping me, and I was terrified. [Laughs] I was frankly terrified. And I hadn’t meant to cause it to happen, but he just followed through. And then he helped me and he kept saying, [Imitates Gross: ‘Cut!’ ]” Pushed me right along, and I was cutting deeper and faster than I had any right to be. But some way or other, we managed to get that spleen out, and it was a very exciting day and I’ve never forgotten it.

DR. NEWMAN: Sure. As you finished the junior residency, you then needed to find a way to finish surgery.
DR. RANDOLPH: Well, that’s exactly right, and that was a bit of a scary circumstance. I should mention that the next-to-last assignment in the junior residency was on the children’s ward, and then the final two months of your first year of junior residency was on the infant ward, so you got to see the newborn surgery and that sort of thing. And you are quite right. I had to figure out now how to get three more years of general surgery to finish up, because by now, I had been to Dr. Gross’ office. He often—if he was going to interview you or talk to you for any reason or you made an appointment with him, it often was at seven o’clock or eight o’clock at night, and everything was dark. I don’t think he was photophobic, but he kept the lights way down low in his office.

I went to see him one time and said, “Dr. Gross, I would like to come back as a senior resident.” And I guess my work was satisfactory, and so he had an impression of me that he would accept me back. And he took me—he looked at my schedule and his schedule, and we arranged that I would come back after three years of general surgery, when I would be a finished general surgeon. And so he penciled me in for that time. And now I’m really on my own, trying to figure out: What am I going to do?

I had an opportunity, I thought, to go back to Vanderbilt. I thought that would be good. And at the same time, one of our senior residents, who was finishing up to go back to his job in finishing general surgery, was [W.] Hardy Hendren [III]. He was at the Massachusetts General Hospital, and Hardy arranged for me to go and visit with Dr. [Edward D.] Churchill at the Mass General. So I owe a lot to my friend, [W.] Hardy Hendren [III]. And I went and visited with Dr. Churchill and explained what my situation was, and they occasionally took a resident in the middle years at the Mass General because in the fifties, there were boys—boys only, by the way, at that time—boys going off to research opportunities, boys going to the service, and so they would want to fill in with a person, bring them in in the second year or the third year and finish them off in the five years.

You may know that the Mass General had what was called a block program. They would take eight interns and finish them through five years, and then you were board eligible in general surgery, so that was considered a full surgical education. They would then keep one person as a chief resident.

Well, Dr. Churchill offered me those three years, and of course I was so excited to accept it. And I went to the General, and they were some of the most wonderful, happy years of my life. I made lifelong friends. I got to operate under the tutelage of or assisting some of the great surgeons.

DR. NEWMAN: And who were some of those surgeons? What were their areas of interest?
DR. RANDOLPH: Well, Dr. Leland [S.] McKittrick was one of the great abdominal surgeons in that day; Dr. Claude [E.] Welch, Dr. Marshall [K.] Bartlett, both fantastic abdominal surgeons; Dr. Richard Sweet was a nationally recognized thoracic surgeon and did marvelous chest work. Dr. Grantley [W.] Taylor was essentially a cancer surgeon in those days. He did a lot of breast surgery, a lot of other complicated surgery on malignant disease, well recognized in that regard. And he was a wonderful teacher. There were people there—and then the second tier at the [Massachusetts] General [Hospital] when I was there were people who would become leaders in American surgery, like [William R.] Bill Waddell and George Nardi and [J.] Gordon Scannell and others that you’ve known about and heard about. Bill [William Vincent] McDermott [Jr.], who became a professor at Harvard [Medical School]. And those younger men were such good teachers.

The thing about it that I found and found so fortunate to be at Mass General was they were not only some of the smartest guys I’d ever been around, like George Zuidema, who became a very illustrious American surgeon, but they were nice; they were friendly; they were helpful; they were teammates, and there was never any antagonistic behavior amongst the residents. They all were wonderful friends. It was just an unbelievable environment.

DR. NEWMAN: What was Dr. Churchill like? He was the chief?

DR. RANDOLPH: He was the chief. He was rather remote to men in my level by then because he was finishing his career as I was there, and he had put all these great surgeons—he had brought them in, made them a team—I didn’t mention Oliver Cope, for example. Frannie [Francis] Moore was there before he went to be head at the Brigham. Churchill’s great strength was not only his earlier work as a thoracic surgeon; he had a unique ability to bring people together and to give them assignments and set them free and set them on a course, and that’s what made that great training program there. I think Churchill was really one of the great American surgeons.

I remember we had a grand rounds one day, and he had, in those glass preparations where you could put a large slice of organ for demonstrating pathology—he put it up on the table for us to see, and he said, “Well, boys, there, for what it’s worth, is the first right pneumonectomy for cancer.” And so although Evarts [A.] Graham had done the first pneumonectomy for cancer, Churchill soon thereafter had done the second, and he had done the right, so he was kind of chiding himself, as the first “right” pneumonectomy for cancer, of the lung. He was a grand man and a good teacher.

DR. NEWMAN: As you finished your general surgery training, then you were headed back to—
DR. RANDOLPH:  To Children’s.

DR. NEWMAN: —to Boston, Boston Children’s. But what was it like to be a surgery resident in those days? You didn’t have the eighty-hour work week.

DR. RANDOLPH:  [Laughs]

DR. NEWMAN: Did you get paid well? Did you have a family at that time?

DR. RANDOLPH:  Well, it’s interesting you should mention the hours and pay, because we got very little pay. We got a thousand dollars a year at the [Massachusetts] General [Hospital], and we were glad to be there and glad to get it, and—

DR. NEWMAN: That’s the end of Tape 1.

END OF TAPE 1, SIDE A  [TAPE 1, SIDE B is then blank.]

DR. NEWMAN:  This is Kurt Newman interviewing Judson Randolph on June 26th, 2007, for the AAP history project. This is Tape 2. We were just discussing what it was like to be a surgery resident at the Mass General and then the Boston Children’s, where you got paid a thousand dollars a year and were happy to get it.

DR. RANDOLPH:  Well, that’s right. In those days, most residencies were considered educational opportunities, and so it had, up into the fifties, at least, not been considered necessary to worry about paying the residents a lot of money, and so there was no thing like a living wage. You either were single and you lived in the hospital or if you were married, your wife taught school or did something to support the family enterprise, and usually without children. As far as the hours of effort were concerned, we very often, when we were on emergency and clinic duty, for example, would work thirty-six on and twelve off. And if you were married, as I was, you’d come home and just fall into bed, and you weren’t much of a husband.  [Chuckles]  Your wife just had to work, make the money and say hello now and then. It was tough.

But the educational opportunity was so rich that you just accepted it. That’s what you did in those days. And it wasn’t just at Boston hospitals. As a surgical intern, I got eleven dollars a month.  [Laughs]  Whether I needed it or not. And so, of course, had a room at the hospital, but with a wife—she worked, and we had a little apartment. And that was it.

And the work hours were exhausting, but there was a lot of feeling that if you admitted a patient—remember, in those days, in general surgery, an enormous amount of our learning and training and operating was on the stomach for ulcer disease, and, see, you don’t even have that anymore
because there’s an antibiotic that cures ulcers. We wouldn’t have thought that possible because we admitted these patients who were bleeding badly from a duodenal ulcer or were completely obstructed or had been followed in the clinic with unremitting pain, and so there was a lot of stomach surgery, of a variety of sorts, in those days.

And the residents were allowed to do some of that work on the so-called ward patients. And if we were in the emergency room and we admitted a patient and we had some level of senior responsibility, we wanted to follow the patient, we wanted to bring the patient into the hospital, we wanted to get the patient ready, we wanted to operate on the patient. So maybe we’d be operating on our second day without sleep, but some way or other, with helping each other and so on, we got through it. But there were a lot of times when it was not wise, and the eighty-hour work week of today is brought about because it was demonstrated that after a certain number of hours in the hospital, you were functioning at less than optimum performance.

DR. NEWMAN: When you came back to the Boston Children’s, who was the faculty that you came back to? Dr. Gross was still—

DR. RANDOLPH: Dr. Gross was there, and Dr. Luther Longino [pronounced LAWN-jih-no] was there. He was the one that Dr. Gross had as his second-in-command and who was responsible for the ward surgical service and the general surgical service, since Dr. Gross—I came back in July of 1958, and Dr. Gross was completely involved in cardiac surgery and improving the pump oxygenator and operating on children with cardiac defects. And so Luther Longino was the number two man, and he worked very closely with the chief surgical resident, and he gave the instructions and the plans and everything to the chief surgical resident, and the chief then had a senior resident under him and a junior resident under him, or sometimes two junior residents, depending on the relationship with the [Peter Bent] Brigham [Hospital], who sent junior residents over to be on the service for six months or a year. And so that was the structure of the general surgical service.

We also had a couple of junior faculty who were assigned things like, for a good while, Sam [Samuel R.] Schuster, who later was recognized for his innovative work with omphalocele, but his assignment was to do a lot of the coarctation work because we were admitting a lot of patients with coarctation of the aorta, and that’s basically all he was doing at that time.

DR. NEWMAN: And who were the other senior residents with you when you came back?

DR. RANDOLPH: When I came back, I of course was the fourth senior resident or most junior senior resident, and the others were—let’s see, Hardy
Hendren was finishing up as the cardiac resident, Mort Woolley was there as the next in line, and—I can’t remember at the moment who the next—

DR. NEWMAN: What sort of general surgery was being done at the Children’s at that time? What were the cases that you would—

DR. RANDOLPH: Well we did all the tumor surgery, and there was a lot of that because Dr. [Sidney] Farber had established what was called the Jimmy Fund and the Division 28, where they admitted tumors, children with tumors from all over. And the general surgical service took care of children with tumors, malignant tumors, and we took care of all the newborns with the variety of intestinal malformations and omphaloceles and diaphragmatic hernias. It just seemed like it was full of indexed cases of the sorts that we all believe we are pediatric surgeons for.

DR. NEWMAN: So those were early days of treatment of Wilms’ tumor with radiation?

DR. RANDOLPH: Yes.

DR. NEWMAN: Chemotherapy was coming into play?

DR. RANDOLPH: I was very fortunate in that, having had, I thought, wonderful training at the [Massachusetts] General [Hospital] in general surgery, and that meant surgery of the head and neck, that meant vascular surgery, chest surgery, general, abdominal surgery, when I came back to Children’s [Hospital Boston], it seemed to me that we were just assigned children with malignant tumors as senior residents, chief resident or working with Luther [Longino], and there was no cohesive plan to set up an oncology surgical service. And gradually, as I went through the senior residency, ending with the cardiac residency, then being assigned as chief surgical resident, I became closer and closer with two colleagues, and we ended up really starting what would grow into pediatric oncologic total care. And it was just my great good fortune that the clinical person on Division 28 in charge of the medical aspects and diagnostic aspects of children with tumors that were being referred in—it was Audrey [E.] Evans, who is the wonderful template for every oncologic pediatrician in the world.

And lo and behold, Dr. [Edward Blaine Duncan] Neuhauser, who was a great clinical radiologist and diagnostician, didn’t seem to have any interest in the ongoing progress of radiation therapy for children with tumors, and his younger associate was Giulio D’Angio, who, as we all know, made a career of pediatric oncologic treatment with radiation therapy and has been our great leader in that.
So here we were, three younger people, each with a distinguished chief who was less interested in tumor work than we were, and we sort of banded together, and first thing I knew, I was doing a lot of the tumor surgery, and certainly as the chief resident I did a lot of it. And Audrey Evans was often in the OR behind me, saying, “Why don’t you look under there and look at this?” and so on, and Giulio D’Angio was treating them with radiation therapy. We really got it going as a team. I stayed on at Children’s for two and a half more years on the faculty, and we really developed a strong tumor approach.

DR. NEWMAN: What was it like to be a child with cancer, a family with cancer in those days—say, a Wilms’ tumor with metastases?

DR. RANDOLPH: Yes, I think it was no different than it is this very day. It was frightening. It was unknown. It was scary to have a child who was two or four or six, your precious child having this awful condition, but remember that in the mid-1950s Dr. Farber and, through his clinical associate, Audrey Evans, began to use actinomycin D and have these wonderful results. It was the first beginning of results with chemicals to change the biology of a tumor in a host, and I’ve got X-ray pictures of a child’s chest full of snowballs of tumor, and then being treated with actinomycin D and they just disappeared. We couldn’t believe it. This was in the mid-1950s, and it was the beginning of successful chemotherapy, right there at Boston, under Dr. Farber’s direction. And, of course, Dr. Gross had done the early operations for Wilms’ tumor, and Dr. Neuhauser had done the early radiation therapy, and then they sort of handed it over to others.

DR. NEWMAN: What was it like operating on newborns in those days? Anesthesia probably was a little tricky. You didn’t have the TPN [total parenteral nutrition] or other things we take for granted today.

DR. RANDOLPH: We didn’t have all the monitoring, and we certainly didn’t have TPN, which was brought on in the sixties, but we thought we did a pretty good job. In the first place, we had Dr. Robert [M.] Smith, who is the real granddaddy of pediatric anesthesia, and Bob Smith was gentle, and he was effective, and he was clinically—as an anesthesiologist he’s the best I ever saw. He could just take a little baby and rock that baby off to sleep, slip a little tiny tube down if it needed to be intubated, and then we would operate if we needed to in the chest or the abdomen, and we felt that we had the baby under pretty good control. It was the day of personal attention to a baby under anesthesia, a baby needing an operation, and it was not the day of all kinds of monitors and beepers going off and all that stuff. You had to use a lot of common sense and know that you better give a little more blood. It was, I guess, less precise, but I think we were doing a good job.
DR. NEWMAN: What was it like to be on Dr. Gross’ service at that time, be his resident?

DR. RANDOLPH: Well, it was a heady experience. It really was, because he expected his residents, by the time they got to be on his service, to be finished surgeons who could perform. And not only did you have to get up at 5:30 or something and get there and make rounds on everybody and be sure everything was dusted up and in good shape and know where the trouble spots were—remember, we didn’t have intensive care units in those days. We had a room that we called the pump room, and when they came off the pump, they came up to this room, and it really was a forerunner of an intensive care unit, a post-op intensive care. Had special nurses in there, and the residents were on top of that room constantly.

But when Dr. Gross—I will never forget when Dr. Gross expected his cardiac resident to be able to do a ductus, and you scrubbed. You knew what time you were supposed to be there, the patient was put to sleep. Marie Dresser, who was Dr. Gross’ scrub nurse, was there, and you came in, and you were waiting for Dr. Gross to come in, and he came in with a little mask over his face and said, “Well, let’s get goin”, which meant “you get going.” And so then you were going to open the chest, and in the special way Dr. Gross had of approaching the ductus, which was to divide the third and fourth costal cartilages and then enter the fourth interspace and then fold up the third and fourth rib, and that gave you wonderful exposure right there to the ductus, and then you had to, of course, dissect it all out, know where the recurrent laryngeal nerve was.

And then you had to get the special clamps. And the way Dr. Gross had you put clamps on the ductus was he put four clamps on the ductus, and he put, believe it or not, rubber bands around and around the back end of the clamps so they wouldn’t spring open. That was his way of being sure that when you put that clamp down—this was long before we had the marvelous new vascular instruments, so he had four regular hemostats with rubber bands around the back, where you’d usually stick your fingers in, so that they wouldn’t spring open. And then you sort of pried them open and put them on the ductus, and you put four clamps on the ductus.

Then you took the two internal clamps, the closest in the middle, backed them off very carefully, and then you cut the ductus. And now you had two end, and he wanted them over-sewn with silk on both ends, not just tied off. He wanted it over-sewn with silk. And I can tell you that with the old heart heaving away and your own personal heart heaving away, that it was a heady, wonderful, thrilling, exciting experience.

DR. NEWMAN: I remember a couple of anecdotes. He wrote a book that had a certain number of pages, and there was something about—
DR. RANDOLPH: Oh, yes, the stories about his book are wonderful. First of all, his textbook, his marvelous personal textbook, had at the last page of the appendix, a table of contents, [which] was page no. 1000. That’s just kind of the way he did things.

And then the most marvelous thing about his book, history, I think—he had a favorite resident who had gone up to practice in Portland [Maine], and he wasn’t just a pediatric surgeon, he did general surgery in Portland because it was not easy to be just a pediatric surgeon in Portland at that time. And so this wonderful resident of his did general and pediatric surgery, and he called Dr. Gross up about a year after the book was published, and he said, “Dr. Gross, I have a family up here with a little baby, newborn, who has a sacrococcygeal teratoma, and although Boston is near, they’re very rural people, afraid to come to Boston. I have encouraged them and tried to work it out that they would come. They don’t want to come. They’re going to insist that their baby be operated on here. And I feel badly about that, but I’m the one to do it, of course, and so I need to operate on this sacrococcygeal teratoma, and I just wanted to walk over the steps with you, if you would give me a few minutes here on the phone.”

And so Dr. Gross said, “Well, do you have a copy of my book?” And he said, “Oh, yes, sir. I have a copy of your book, Dr. Gross, and I’ve looked at it from page one to page one thousand, and there’s nothing on sacrococcygeal teratoma in the book.” And so Dr. Gross gave the man the information he wanted. Then he went right over, got his book and started thumbing through it, and sure enough, there was no chapter on sacrococcygeal teratoma. And that night, at Four Winds out in Framingham, [Massachusetts] he went fiddling around in his office, and he found that the completed chapter of sacrococcygeal teratoma had—he had sat it up on that metal thing over the heater, the steam heater, and it had fallen off over the back, and he found it down behind the heater, the chapter on sacrococcygeal teratoma. It never made it into the book. [Laughs]

DR. NEWMAN: So now you’re the chief resident there at the Boston Children’s, and then you were asked to stay on on the faculty.

DR. RANDOLPH: Yes.

DR. NEWMAN: What was behind that?

DR. RANDOLPH: Well, I don’t know. He needed more help, and he apparently thought I had done an adequate job and asked me to stay. He paid me a great compliment. I had borrowed money from my mother-in-law, and we purchased a little house in Wellesley during my senior residency at Children’s, and so we stayed there. Little boys started coming along (we had
four boys), and I was on the faculty at Children’s Hospital, as an instructor in surgery at Harvard Medical School, and I just felt like I was in heaven somewhere.

And things like this would happen: One of the current senior residents or the chief resident would call me up and say, “Well, we’ve just admitted an esophageal atresia to your service, a baby with esophageal atresia, born across the street at the BLI [Boston Lying-in Hospital], and we will have it all tuned up and ready to go at eight o’clock in the morning if you’d come in and help us.” And so, you know, life couldn’t have been better. It was just a young surgeon’s dream. And I would get to see these wonderful cases, work with fine men who were ultimately going to do their own thing, folks like Arnold Colodny, who was a senior resident when I was first on the faculty; [A.] Erik Gundersen of the Gundersen Clinic; Lucian Leape, who as we know has become so instrumental in discovering quality assurance for us around the world—just marvelous young people who just kind of kept coming there to train.

DR. NEWMAN: And who were the other junior faculty with you at the time?

DR. RANDOLPH: Sam Schuster was one. We had a man named Nick [Nicholas McLeod] Stahl, who went ultimately to New York to do pediatric surgery. Luther Longino, of course, was still active at Children’s. He was a wonderful surgeon. No flamboyance at all, very quiet, but he could really get it done.

DR. NEWMAN: In 1964 you made a career move to Washington, DC.

DR. RANDOLPH: I did.

DR. NEWMAN: What prompted that? What was the thinking and the process in moving to Washington?

DR. RANDOLPH: I guess that’s a very personal, interesting part of my life because I was so happy, as I’ve tried to indicate, in Boston with my situation as a junior faculty member and with good relationships with residents and with fellow faculty members at Harvard, and I could have been happy staying there always. And, as a matter of fact, I had some conversations with Dr. Francis Moore, who wanted me to develop my interest in tumors, and he wanted me to take a year off and go to England and study tumor immunology, and he was prepared to have me do that and to help me get that done, so that would have been a very nice career, no question about it: children’s tumor surgery and perhaps a little research into tumor immunology.
I got a letter from a man named Robert Parrott at the Children’s Hospital in Washington [DC] [(now Children’s National Medical Center)]. Now, the Children’s Hospital in Washington did not have an established pediatric surgical service. A couple of general surgeons who were interested in children’s surgery occasionally did cases there, but there were no papers coming out of Washington Children’s Hospital, nothing obvious on the screen of academic pediatric surgery. So I looked at this letter. He asked if I’d have any interest. They were thinking of having a chief of surgery, and I just sort of looked at it, and I threw the letter in the wastebasket. I said, “I don’t think they’ve got a hospital for children in Washington.” And so I didn’t think any more about it.

And about three months later, Ginny Dunn, Dr. Gross’ secretary, said, “There’s a gentleman up here who wants to see you. Are you free? Can you come up?” And I said, “Well, sure, I’ll come up.” And it was Dr. Robert Parrott. I remember meeting him. He walked with a cane because he had had osteomyelitis of the hip as a young person, when he was twelve or so, and he had it treated at that Children’s Hospital [Children’s National Medical Center] in those days and then later became a medical student at Georgetown [University School of Medicine] and then a pediatrician and then a researcher in children’s pulmonary disease. He was well known in that field.

Then they inveigled him to come to Children’s Hospital as director of education and to develop a faculty of full-time people. They raised money for those positions, and he brought in a hematologist, he brought in an endocrinologist, and the pediatricians were thrilled because they wanted these experts so that they could send their patients with problems there. He developed pediatric radiology—and he was developing a strong faculty of full-time people.

Anyway, Dr. Parrott said, “I sent you a letter a few months ago.” I said, “Oh, well, I’m sorry I didn’t answer you. I just really had no interest in leaving this situation.” So one thing led to another, and he prevailed on me to come down and just see what they were doing and whether I could offer some consultation and so on. And I went to this little hundred-year-old hospital in the heart of the ghetto in Washington, DC, but I met some very enterprising, energetic young pediatric specialists, and they all said they needed to have a children’s surgeon come and be their partner. I must say that I gave it some thought, and I went back and I thought how wonderful everything was at Boston Children’s and what a vacuum there was in Washington.

And I think it was the vacuum that finally spoke to me, and I said, “Well, you know, this is the last major city in the United States of America that doesn’t have a strong pediatric surgical presence and pediatric surgical service.” So
I talked it over a lot with my wife, and we decided to give it a whirl. And I came to Washington. Never looked back.

It was hard getting started. It was hard because whereas the pediatricians wanted these experts to help them take care of their children with endocrine problems and hematologic problems and so on, the surgeons were there just operating on the children that had Blue Cross and Blue Shield and so on, and it was an income source for the general surgeons in Washington, who rotated through a service there, and they didn’t want a chief of surgery. So I had a hard time at first, because the surgical community did not want a pediatric surgical—particularly some guy that was young, that was from Boston, that thought he knew something that they didn’t know. [Laughs]

DR. NEWMAN: So there you are, at this Children’s Hospital in Washington, D.C., and you had the idea to start a training program. What was behind that? There weren’t that many training programs in the United States at that point.

DR. RANDOLPH: That was another wonderful opportunity for me that just fell by the grace of the gods into my lap. Dr. Bill [H. William] Clatworthy [Jr.], who was one of our greatest pediatric surgeons ever, both with his own abilities and with his foresight—in 1966 I had been in Washington two years, and in 1966 he prevailed upon the Surgical Section [American Academy of Pediatrics, Section on Surgery] to look at all of the training opportunities in the United States, and he happened to have the wisdom to include Canada, to look at the training programs and see what they were doing, because they were all doing it a little bit differently. And he had the Surgical Section form a committee, which they called the education committee, and it was sanctioned by the American Academy of Pediatrics and was funded in part by the American Academy of Pediatrics—

DR. NEWMAN: That’s the end of this Tape #2. And we’ll be putting on a Tape 3. We need to finish it up.

END OF TAPE 2, SIDE A [TAPE 2, SIDE B is then blank.]

DR. NEWMAN: We were talking about the [American Academy of Pediatrics] surgery education committee with Dr. Clatworthy and Dr. Randolph.

DR. RANDOLPH: I was fortunate in being sort of the designated wingman for Dr. Clatworthy’s committee, which ended up meaning that Bill Clatworthy and I and then sometimes I and someone else would go and review the training programs that were extant in those days. There were twelve of them, and they were in Kansas City and Buffalo and of course Boston and Philadelphia and Chicago and Los Angeles and Baltimore. We had not had a program in Washington, but we had had John [R.] Lilly come and work with me, and that really established our training program, in
effect. So there were a total of thirteen programs, and we looked at the total curriculum of each one of those. Some had cardiac surgery; some did not. Some had urology in their program; many did not.

Dr. Clatworthy and the committee then formulated a two-year program, and we established certain requirements of that program. Eighteen months had to be clinical, but six months could be research. A variety of electives of cardiac, urologic, even orthopaedics, which one of the Canadian programs had, could be part of the makeup, but it was decided that two years would be the total training of a pediatric surgeon. Now, this caused some changes in various places. For example, the Boston program of four years would have to be altered to cooperate with this if it were adopted, and in fact finally it was. So with the help of the AAP and the education committee, thirteen programs were approved for training of young people in pediatric surgery. And this was established in about 1969.

It was a great step forward because it established the practice and the specialty of pediatric surgery as having their training program. It was on the basis of these training programs that Larry [Lawrence K.] Pickett and others approached the American Board of Surgery to see if we could have a sub-board of pediatric surgery. The American Board of Surgery turned down Dr. Pickett and his carefully orchestrated committee, saying, “We don’t believe there should be such a program.”

Several other things then happened. First of all, Steve [Stephen L.] Gans, using the great name of Chick [C. Everett] Koop, established the Journal of Pediatric Surgery. That was up and going and was on the library shelves in the medical centers, and many medical schools around the country and medical centers which hadn’t had pediatric surgery began to realize there was a need. They began to try to find pediatric surgeons, so the graduates of these thirteen programs all had several offers of jobs in various places to help start pediatric surgical services, and so the general surgeons who were on the American Board of Surgery realized that their faculties were having pediatric surgeons added to them, and it really was a viable enterprise.

And then lo and behold, we had the good fortune to have Harvey [E.] Beardmore as a spokesperson for pediatric surgery, and he and Marc Rowe and I were appointed to approach the American Board of Surgery. And Harvey was so eloquent and so intelligent and so full of insight that when he finished his presentation to the American Board of Surgery and said, “We have training programs, we have curricula in most of the medical schools in the country, we have a journal, and we, gentlemen, have a specialty, and we need you to recognize it”—but the American Board of Surgery in 1972 decided to have not a special board. What they chose to do instead was say, “We will develop a certificate of special competence in pediatric surgery to
be added to anyone who takes the exam and passes it after proper training and after passing the American Board of Surgery.”

DR. NEWMAN:  Wow. But you had to take the exam.

DR. RANDOLPH:  Yes, the three of us were given the exam in Philadelphia in the American Board of Surgery offices, and they pulled out all the old questions.

DR. NEWMAN:  Were you worried about failure?

DR. RANDOLPH:  You bet I was! Yes. [Laughs] And we never knew—we just knew that they claimed we passed.

DR. NEWMAN:  And then you had to examine the next group.

DR. RANDOLPH:  Well, that was something else.

The next thing that happened was the American Board of Surgery granted pediatric surgery one position on its board of directors, and the three of our names were sent forward, and the people at the American Board of Surgery voted which they would have. And just because I had been at the Mass General and Jerry [W. Gerald] Austin and John Mannick and some of my friends were on the American Board of Surgery, they chose me to be on the American Board of Surgery as the first pediatric surgeon on the board, and I was immensely honored and certainly proud and pleased. It probably should have been Harvey Beardmore, but anyway, this is the way it came down.

We then were instructed at the next meeting of the APSA, the American Pediatric Surgical Association—and, by the way, the fact that there was an up-and-going APSA was part of the argument to the American Board of Surgery. At the next one, we were to give an oral exam to every pediatric surgeon that wanted to be granted the boards—excuse me, a written exam, not an oral exam. The logistics of an oral exam with just three examiners would have been prohibitive, so the three of us—[Harvey E.] Beardmore, [Marc] Rowe and [Judson] Randolph—constructed a written examination in pediatric surgery, with a couple of hundred questions. It was a monumental, tiresome task.

And then we administered it to [H. William] Clatworthy [Jr.] and [William B.] Kiesewetter and [C. Everett] Koop and everybody that you ever heard of that was a pediatric surgeon, but only two were grandfathered in. One was Dr. Robert E. Gross, and the other was Orvar Swenson. We did not have the temerity to examine those two.

DR. NEWMAN:  [Laughs]
DR. RANDOLPH: But we took on Koop and we took on the rest of the world, and I remember getting up in the front of this huge auditorium with about 250 pediatric surgeons, and the monitors were passing out the exam, and I was giving the instructions, and they all booed me. [Laughs] But then they took the exam, and there were a few failures, and that was hard to deal with. But some then subsequently passed it another time, and others never passed it.

DR. NEWMAN: We had briefly mentioned John Lilly as your first fellow. Tell me how that came to pass.

DR. RANDOLPH: John Lilly, one of the most wonderful, remarkable pediatric surgeons and persons I ever knew, and I was just blessed that he thought that he would like to come to Washington and train with me, and he did so because he had been at Great Ormond Street [Hospital for Children, London]—he trained in California, had been at Great Ormond Street for a year as a registrar, and was to have assumed the position of senior registrar, which is their chief residency, in pediatric surgery at Great Ormond Street, and the guy that was in the job was from South Africa, and it was a time, in the early sixties, when South Africa was under great trouble and trauma and distress and everything else, and so this fellow didn’t want to go home, and he stayed in the job. And Mr. [H. Homewood] Nixon came to John and said, “John, we love you and we’d like you to stay, but we have to keep our senior registrar, and we’d like you to be the senior registrar next year instead of this year.” And John told him to go jump in the lake and caught the boat home and went back to California, and then he wasn’t sure what he was going to do.

But he heard that this young fellow who had trained with Gross was in Washington, so he wrote me a letter, and he had his chief of surgery write me a letter, and they told of John wanting to train in pediatric surgery and having had this little problem, and so I talked with John and read his particulars, which all seemed good, and I said, “Well, you know, John, I think you should come to Washington, take a look at our hospital and our situation and see if you really are interested and we see how each other fits up.”

And he said [chuckles]—this is John Lilly to the teeth—he said, “Dr. Randolph, I want to come to Washington. I want to train with you because you trained with Gross.” He said, “Now, I’m five feet eight. I have curly hair. I wear glasses. Can we do this thing now or not?” [Laughter] So I said to him, “Well, we’re both getting married with a sack over our heads, but come on.”

DR. NEWMAN: [Laughs]
DR. RANDOLPH: And that’s how I hired the first fellow, John Lilly.

DR. NEWMAN: Well, I know that was a glorious fellowship and then partnership for a number of years before he went out to—

DR. RANDOLPH: Denver.

DR. NEWMAN: —Denver. And then [R.] Peter Altman was another of your trainees.

DR. RANDOLPH: He was I think the fifth one. Peter was trained in Boston at Tufts [-New England Medical Center] and was very good. And by now we had a training program that—having watched through the Clatworthy process and seen other training programs, I was able to put together a pretty strong training program in Washington, which included six months with Brian Blades in thoracic and cardiac surgery, and in those days, those early days, my residents, like Bill [William] Tunnell and Bill [William] Moyle and Peter Altman and one or two others, all got their chest boards because of the rotations, first the amount of chests they did at our children’s hospital and then the six months’ chest they did with Blades. And so a number of them got their chest boards. That ultimately was not maintained, but I kept the cardiac rotation in place because I felt it had been so valuable to me and was valuable to any general surgeon operating in the chest, so we had our residents go through the cardiac residency for three months, as part of their two years.

DR. NEWMAN: So after Dr. Altman—he stayed on the staff as well?

DR. RANDOLPH: Yes, yes.

DR. NEWMAN: You had the faculty—Peter Altman, John Lilly—and you were doing the biliary atresia—

DR. RANDOLPH: Yes.

DR. NEWMAN: Lots of new things happening in Washington?

DR. RANDOLPH: Yes, yes. Well, starting open heart surgery was something special, because everybody was critical. They said, “Well, we just have thirty miles to go up to [John] Hopkins [Hospital]. Why would we have an open heart program in Washington?” And that would take longer than we have today to tell you, but there was a wonderful old gentleman named Bill [William] Jameson, who had trained with Charles [P.] Bailey [at Sea View Memorial Hospital] in [Staten Island,] New York, who was a cardiac surgeon in the early going, and he was a handyman, and he built his own
pump oxygenator. It was a Rube Goldberg apparatus he had in his garage in Manassas, Virginia. And he came to see me one day, and he said, “I hear you’re thinking about starting an open heart program. I’ve got a pump. Do you want to try it out?” And so he brought his pump up to the research laboratory at Children’s, and it was the funniest thing. It took me a while to learn where all the tubes went with this guy’s thing, but it really worked. And so we did a handful of dogs in the lab and were using his thing, and I managed to get a grant and buy a brand-new pump oxygenator, and we did that in the lab.

Then I had the problem that we had very mediocre anesthesia. The people in our—they were wonderful doctors. They were all general practitioners who had drifted into anesthesia. I sent our youngest anesthesiologist up to Boston Children’s, and he spent a month with Bob [Robert M.] Smith to learn how you administer anesthesia for a cardiac patient, and then we brought him back. We even did a dog in the operating room to be sure everybody knew where they were standing and what their relationships were and so on.

I had Lew [Lewis] Scott come on board as our cardiologist, and Lew was my dear friend and magnificent cardiologist. He picked out three [patients with] simple ASDs [atrial septal defects] who had to have their heart[s] fixed but would be the simplest thing to do, and in fact I did those, and they went very, very well. And it was at about that time that we realized that Jim [James E.] McClenathan was getting out of the Navy, and he was a cardiac surgeon there, and so we brought him on the faculty. He began to do the lion’s share of the cardiac surgery. I kept doing the baby hearts that needed to be done, and he did the older children, and that’s the way our heart surgery program got going.

DR. NEWMAN: You had another passion, for burn patients and set up a burn unit.

DR. RANDOLPH: Yes, yes, I did set up a burn unit. And in those days we were using silver nitrate, which made everything turn black, but it was wonderful at cleaning up burns and controlling infection. I even—one time, when he was invited to Washington, I had the pleasure of bringing Frannie Moore over to show him my burn unit. And, of course, Frannie’s career had started in 1942 at the Cocoanut Grove [Night Club] fire [in Boston], his real interest in burns and in other aspects of the metabolism of burns. Well, he saw my burn unit, and he thought it was good and gave me an encouraging push, and we started a burn unit. There was no other burn unit for children in that part of the Mid-Atlantic region, so it prospered, and we had nurses who did nothing but burn care. We did an awful lot of children with serious burns, a lot of grafting experience, and our residents participated in that.
DR. NEWMAN: I know in your twenty-eight years of being the chief in Washington, you trained a lot of general surgery residents and fellows, but I know one of your most special trainees was Kathy [Kathryn D.] Anderson.

DR. RANDOLPH: Well, she’s certainly special ‘cause she was a lady. She and Mary Fallat were the two women that ended up on our training program. And I have to tell you that Kathy was responsible for a change in my own thinking. Kathy’s wonderful, genius husband, [W.] French Anderson, who is a great geneticist, came to the NIH [National Institutes of Health] and had a whole big section at the NIH in genetic research. And so Kathy, who had graduated from Harvard Medical School and had a year at Children’s and wanted surgical training, came and talked to me about where she should train.

We decided that the strongest program at the time was at Georgetown [University], and so she went to Georgetown and trained in general surgery. And each year, she would come and tell me how her training was going and that she would be ready for pediatric surgical training in 1970. And each time she would come, we would have a chat, and off she’d go, and I would tell John Lilly, “Well, I’m hearing good things about her, but she’s a woman.” And I didn’t think in those days—I was such an awful dummy that I didn’t think women really probably should be in surgery, and I really didn’t have any expectation of having her on—and training her. And, of course, the problem was that her husband was there, and if she didn’t train in Washington, where was she going to train? I told her to go see [J.] Alex Haller [Jr.] at Johns Hopkins or that maybe she could commute to Boston. That was awful.

Anyway, the person that I picked to be our resident in 1970 called me up the first of June and said he’d been drafted. He was in the Berry Plan program. Well, I wanted to kill him because he hadn’t shared that information with me, and so here I was, the first of June, with no chief resident coming in July. It was really a bad situation. So I called up Kathy, and I sort of crawfished around, and I said, “What are you going to do in July?” And she said, “Well, I’m going to stay here on the faculty at Georgetown.” And I said, “Have you thought any more about pediatric surgery?” And she said, in her little clipped British accent, “Well, of course, that door has been closed to me.”

DR. NEWMAN: [Laughs]

DR. RANDOLPH: And so I started in on, “Well, Kathy, we’ve been thinking about things, and we’re readjusting our schedule of trainees, and I think there may be an opening in July, and I wonder if you’d like to consider it.” This was Friday. And Kathy told me, “I’m going to go home and talk with French about it over the weekend, and I’ll let you know on Monday.”
DR. NEWMAN: Goodness. [Laughs]

DR. RANDOLPH: I said, “Okay.” And Kathy has later confessed to me that she knew immediately she was going to come take that job, but she thought I ought to have to sweat a little bit. And I did. But then she came, and the rest of it—she was a marvelous chief resident. She was a marvelous surgeon, and it started a friendship as well as a professional relationship.

DR. NEWMAN: I know you have a lot of accomplishments I could ask you about. You had the idea for the in-training examination, had the idea for the residents’ conference, very involved with starting the children’s oncology group, all the awards and the Ladd Medal and anything that one could hope for in a career in pediatric surgery, but I wanted to ask you about: Are there any memorable patients that come to mind that have influenced you, or memorable operations as you look back on such a distinguished career?

DR. RANDOLPH: Well, you’re kind to mention those things. I have marvelous memories of little children in various venues. One of my most memorable patients was Elizabeth. I later became very close to her mother and father. She had a Wilms’ tumor, and she was sent to me just before Christmas. I think it was 1965. I had only been there a year. And the Washington pediatrician felt this huge lump and sent her to me, and so she had the usual operation for Wilms’ tumor. Several months later, she showed up with pulmonary metastases, and we didn’t have all the protocols that we have today, so having had the Wilms’ tumor cleanly removed, she then was put on actinomycin D, but we didn’t do anything else, and she showed up with these pulmonary metastases, and we radiated the lung fields. They went down some, and then a large mass recurred, which was unresponsive to actinomycin D or radiation therapy, and it was clear that she needed a chest operation, to see if we could get this large mass out.

I ended up having to take out her entire lung because the mass was enveloping all of her pulmonary vessels and part of her outflow. Anyway, we did take out her lung. Now, mind you, this was in the days when we didn’t have respirators; we had those old pressured Bird [Universal Medical Respirator] things. I had her in an oxygen tent, and she was just kind of hanging on. She had had radiation to her lungs, so this single, remaining lung was having more than it really could do, and we were very worried her. And her mother and father were exhausted after about a week post-op, and I sent them home to have a shower and a supper, and I said, “I’ll stay right here in her room until you come back, and I’ll just take care of her while you’re gone, so you feel comfortable going home.”

They went home. And I was holding her hand and talking to her, and she was awake. She was in an oxygen tent. And she had an IV [intravenous line]
going, and the IV hurt her, so I fiddled with the IV, and I put a little piece of
cotton underneath it and made it comfortable for her, and she kind of smiled,
and then she looked over and me and said, “I love you, Dr. Randolph.” And
then that precious child closed her eyes and died. And it was like a movie
death. It wasn’t a struggle and a cough and a choking or anything. She just
died. I knew it wasn’t proper to try to revive her because of her tenuous
 circumstance, but I’ve never forgotten that little girl telling me she loved me.

There are lots of memories that every pediatric surgeon is blessed with about
children and people that mean a lot to them. Emily had a well-meaning
pediatrician biopsy a little mass above her left breast when she was eight
years old, and he was trying to drain an abscess, he thought, and lo and
behold, it was a mass, so he sent some of it for pathology, and it was a
rhabdomyosarcoma, so he sent her down to me. I operated on her, removed
the mass, saved the nipple and did a careful axillary dissection. That’s what
we were just beginning to do rather than huge amputations. We had stopped
doing the awful amputations that were part of peripheral
rhabdomyosarcoma surgery. We had a protocol by then for
rhabdo[myosarcoma] in the national Children’s Cancer Study Group, and
we put her on it, and lo and behold, she got well. That was at a time when
rhabdomyosarcoma in children had a five per cent survival. And Emily
grew up. She invited me to her wedding. I cried when she came down the
aisle.

I remembered when she was a George Washington [University] student and
she came to me, and [on] the side that we’d operated on, her breast was very
undeveloped, and so I had Lewis Thompson, our plastic surgeon, do a breast
enhancement/augmentation on that breast. He used the current method to
enlarge the breast, and her nipple was healthy, and so she came back to see
me about a year later, and I said, “Well, now, Emily, how is it? How do you
feel about your breast that we’ve operated on?” “Oh,” she said, “I like it
better than the other one, Dr. Randolph.” [Laughs]

DR. NEWMAN: What would you say to young people that are considering a
career? We started out with how you got interested in pediatric surgery and
surgery. What would you say to young people these days that are considering
careers?

DR. RANDOLPH: Well, I think you and I both see the impact of the
various economic arrangements that impact medicine and surgery today, and
that sometimes is discouraging to young people, I think. But as I see people
take up the specialty of pediatric surgery, or other specialties in the current
milieu, I think there’s still plenty of satisfaction in a career in medicine. The
heartwarming experiences between the doctor and a patient are still there. I
like to say that, yes, there are all kinds of new rules and new insurance and
new payment procedures and new arrangements for patient care, but when a
pediatric surgeon takes a baby or a young child into the operating room, there’s no administrator that can get between him and his patient, and it’s just him and the precious child. So that feeling is still there. I am unable to speak with authority about other specialties in medicine or even perhaps some specialties in surgery, but I can’t imagine that there’s any more satisfaction in this world than operating on a child who has a life-threatening circumstance and bringing that child through to a successful conclusion and then stepping back and watching that child grow and become a young adult and a contributing member of society. There surely can’t be more satisfaction in any other practice of medicine than that.

DR. NEWMAN: Thank you, Dr. Randolph. It’s been a pleasure having this interview, and I appreciate your commitment to this project.

DR. RANDOLPH: Well, thank you, Dr. Newman. I appreciate your guiding us through this conversation.
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JUDSON GRAVES RANDOLPH, M.D.

Born:

1927  Macon, Georgia July 19, 1927

Education:

1950  B.A., Vanderbilt University, Nashville, Tennessee
1953  M.D., Vanderbilt University School of Medicine

Military Service:

1945-46  S1/C U.S.N.R., USS Alabama, Pacific Theater

Family:

Married:  Comfort Adams of Nashville, Tennessee June 14, 1952 DECEASED, AUG. 2001

Children:  Somers Fitz, son, May 25, 1956
Garrett Adams, son, July 3, 1958
Judson Graves, Jr., son, December 28, 1959
Adam Gordon, son, November 21, 1960
Susan Comfort, daughter, April 30, 1964

MARRIED:  Joyce Dunn, of Maryland, Oct. 2003

Surgical Training:

1953-54  Intern, Surgery, University of Rochester, New York
1954-55  Assistant Resident, Pathology, Vanderbilt University
1955-56  Assistant Resident, Surgery, The Children's Hospital, Boston
1956-57  Assistant Resident, Surgery, Massachusetts General Hospital
1957-58  Senior Resident in Surgery, Massachusetts General Hospital
1958-60  Senior Resident in Surgery, The Children's Hospital, Boston
1960-61  Chief Resident Surgeon, The Children's Hospital, Boston
Previous Appointments:

1960-61  Teaching Fellow in Surgery, Harvard Medical School
1961-62  Assistant in Surgery, Harvard Medical School
1961-63  Assistant Surgeon, The Children's Hospital, Boston
1961-63  Junior Associate in Surgery, Peter Bent Brigham Hospital, Boston
1962-63  Instructor in Surgery, Harvard Medical School
1963-91  Professor of Surgery, George Washington University, Washington, D.C.
1963-91  Surgeon-in-Chief, Children's National Medical Center
1966-91  Consulting Surgeon, National Institutes of Health, Bethesda, Maryland
1968-91  Consulting Surgeon, Walter Reed Army Medical Center, Washington, D.C.
1970-91  Consulting Surgeon, National Naval Medical Center, Bethesda, Maryland
1975-91  Professorial Lecturer, Howard University Medical School, Washington, D.C.

Present Appointments:

1991-present  Professor of Surgery Emeritus, George Washington University
1993-1997  Professor of Surgery, Meharry Medical College

Certification and Licensure:

1954  Tennessee License for Practice of Medicine #2157
1964  District of Columbia License for Healing Arts #2234
1959  Diplomate, American Board of Surgery
1962  Diplomate, Board of Thoracic Surgery
1975  Certificate of Special Competence in Pediatric Surgery, American Board of Surgery 1975; Recertification, 1982
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Organizations:

Washington Academy of Surgery
American College of Surgeons
American Academy of Pediatrics, Surgical Section
Society of University Surgeons
Society for Surgery of the Alimentary Tract
Society of Medical Consultants to the Armed Forces
Southern Thoracic Surgical Society
American Association for Thoracic Surgery
American Pediatric Surgical Association
Southern Surgical Association
American Surgical Association

Honors, Awards:

Alpha Omega Alpha, Faculty, George Washington University
Honorary Member:
  Alton Ochsner Surgical Society
  H. William Scott, Jr. Surgical Society
  Pediatric Society of Guatemala
  Pediatric Society of San Salvador
  Pediatric Society of Colombia
  British Association of Paediatric Surgeons
Robert E. Gross Award, University of Texas, 1984
Orvar Swenson Medal, Tufts University, 1989
Public Service Award, Foundation for Biomedical Research, 1991
LaSalle Leffall Award, Metropolitan Washington Chapter, ACS, 1997
Distinguished Graduate, Vanderbilt Medical School, 1998
The Ladd Medal, Surgical Section, AAP, 1998

Committee Service to Local Organizations:

Scholarship Committee, George Washington University, 1968-1974
Committees of D.C. Medical Society:
  Medicolegal, 1971-1974
  Ethics, 1977-1981
  Public Information and Education 1982-84
Board of Trustees, American Cancer Society of Washington, 1985-1991
Board of Trustees, Children's National Medical Center, 1972-1984
Medical Consultant, Devore/Stewart Trust Charitable Foundation, 1975-1991
Executive Committee, Washington Academy of Surgery, 1982-1990
  President, 1989
Service to National Organizations:

American College of Surgeons
   Committee on Undergraduate Surgical Education, 1980-1986
   Nominating Committee of the Fellows, 1982-1984
   Governor, 1969-1975
   Council Member, Washington Metropolitan Chapter, 1979-1982
   President, Washington Metropolitan Chapter, 1982-1983

American Board of Surgery
   Director, 1973-1979
   Committee on Pediatric Surgery, 1973-1979
   Examination Committee, 1975-1979
   Senior Member, 1979-present

American Pediatric Surgical Association
   Charter Member, 1969
   Governor, 1980-1983
   President, 1984-1985

American Association of Thoracic Surgery
   Ethics Committee, 1975-1978
   Representative, Council of Academic Societies, 1979-1985

Children's Cancer Study Group, N.I.H.
   Organizing Member, Surgical Section, 1965
   Member, 1965-1991, Chairman, 1968-1974

Surgical Section, American Academy of Pediatrics
   Executive Committee, 1969-1975
   Graduate Education Committee, 1969-1972
   Committee to Assess Quality of Care of Children in Hospitals, 1970-1972
   Chairman, Surgical Section, 1973-1974

American Surgical Association
   Representative, Council of Academic Societies, 1986-1989
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Vanderbilt University
  Board of Trustees, 1980-present
  Academic Affairs Committee, 1981-present
    Chairman, 1985-present
  University Medical Center Board, 1981-present
    Executive Committee, 1985-present

Editorial Assignments:

  Editorial Board, Pediatric Surgery, Year Book Medical
  Editorial Board, Contemporary Surgery, Bobit Publications, 1976-
  1992

Training Grant:

  Children's Bureau #247 "Model Pediatric Surgical Training Program"
  $290,800.00, 1972-1980