Dr. F. Gregory Connell—First President of the Wisconsin Surgical Society

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Dr. F. Gregory Connell died May 29, 1968, at the age of 93. The story of medicine during the first half of the Twentieth Century is the story of his life. To the practicing physician he was a shining example, to the student of medicine an idol, to the profession a legacy.

Doctor Connell was born in Milwaukee Jan. 12, 1875, the son of Dr. M. E. Connell, who served as superintendent of Milwaukee County Hospital and was an associate of Dr. Nicholas Senn. Doctor Connell's mother was also a Doctor of Medicine and was the founder of the first nurses' training school in Wisconsin. Living in this medical environment, Doctor Connell attended Wauwatosa High school from 1888 to 1892. Because of the influence on his later life, this period was a very important one.

Dr. Nicholas Senn had an excellent laboratory and, in association with Dr. William MacKee and the elder Doctor Connell, carried out a series of animal experiments. Many of these were relative to rejoining the gastrointestinal tract. It is of interest to note that one of Senn's methods for testing the security of the anastomosis was to fill the bowel with hydrogen and test the inflammability of the gas escaping from the wound.

Doctor Senn attracted many famous visitors to his laboratory. From visitors such as Bayard Holmes, Charles Parkes, Christian Fenger, Harvey Reed, and

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Thomas Manley, Doctor Connell collected autographs. He liked to tell of Prince Von Esmarck and the pomp surrounding the visit of this Austrian physician.

In a paper by Doctor Senn entitled "Enterrhaphy," published in 1893, he listed among the many ways to rejoin the intestine, a suture of Dr. M. E. Connell. Doctor Greg Connell told me that at this time every surgeon had his own suture and the success or failure, most often the failure, was attributed to the suture—never the surgeon. The senior Doctor Connell's suture, developed with the aid of Doctor Connell's mother, had been described and presented at an AMA meeting in Milwaukee in 1892. It was described as a continuous right angle stitch penetrating all coats with the knots and suture buried deeply between the coated surface.

A New Zealand surgeon, Doctor Maunsell, at the same time presented a similar suture differing only in the placement of the knot. Doctor Connell felt that his father's suture did not "catch on" primarily because of the seton action it was thought to have.

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In 1899 the Philadelphia Medical Journal published the original article, including drawings, describing Doctor Connell’s method. The drawings clearly illustrated the trick of inverting the knot which was to nullify the seton action. In spite of this being a prize winning essay, it was adopted by only a few close friends. A second paper was presented to the surgical section of the AMA’s 52nd annual meeting in 1901. Doctor Connell presented the same suture, this time in conjunction with a criticism of the great Doctor Halsted’s method. Doctor Halsted emphasized a new layer, the submucosa. Doctor Halsted said: “The crude views of Jobert and Lembert as to the construction of the wall of the intestine have been universally accepted by surgeons up to the present time. The peritoneal coat is believed to be thick enough and sufficiently strong to hold a stitch and the existence of the submucosa gives strength and it should be sutured penetrated but not perforated.” By using the correct proportions of the needle and bowel layers, Doctor Connell showed it was impossible to penetrate without perforating the submucosa layer.

It was unusual to criticize Halsted but this brought popularity to Doctor Connell and his suture. He was soon asked to speak on the subject again in Detroit and the suture was accepted. After the suture was accepted Doctor Connell said, “My modification proved unnecessary.”

In 1900 Doctor Connell won the Senn Medal for an essay on “Exstrophy of the Bladder.” This paper was judged anonymously by Drs. Keen, Ochsner, and Rodman. Only two other surgeons, Doctors Crile and Halsted, ever received this medal.

In 1902 Doctor Connell became ill with what was thought to be tuberculosis and moved to Salena, Colo. for his health. Here he served as a railroad surgeon and certainly did not rest. Publishing several papers in the five years he spent there, he married Isabella Stickney from Milwaukee and fathered two children, Jane, now Dr. Jane Card of San Francisco, and Charles of Wilmette, Ill. Mrs. Connell.

Reproduction of a page from an article published in the Journal of the American Medical Association in which Doctor Connell criticized Doctor Halsted’s sutures and proposed his own as preferable.

After high school, Doctor Connell attended the University of Wisconsin for one year. He transferred to Rush Medical School and graduated three years later in 1896. After medical school he attended the University of Illinois postgraduate school for one year and then served one year internship at the Alexian Brothers Hospital in Chicago.

Following his internship he returned to the University of Illinois where he served as assistant to Drs. Christian Fenger and Dean Bevan. One of his duties was to act as a prospector, dissecting the cadaver for the professor’s class the following day. His partner as prospector was Ernest Hemmingway’s father. In later life Doctor Connell corresponded with Hemmingway, who seemed appreciative of Connell’s criticism of his writing.

While serving as an associate professor at the University of Illinois Medical School and an attending surgeon at Cook County Hospital, Doctor Connell began presenting his views to the medical world. Subsequently he published more than 90 papers on various medical subjects, the earliest being a modification of his father’s suture. This modification was described as a method of ending up with the knot inside the bowel.

The Nicholas Senn Medal awarded Doctor Connell.
whom Doctor Connell fondly referred to as Issy, was of great assistance to him in his medical work. She was an artist and did most of his illustrating.

In Colorado, he was able to obtain one of the earliest sphygmomanometers in the country and spent time taking blood pressure readings up and down Pikes Peak, an example of his zest for research.

In 1907 he returned to Wisconsin as an associate of Dr. C. W. Oviatt, who was a student of Doctor Senn and also a pioneer surgeon in Wisconsin. This association was short. He carried on as solo surgeon in Oshkosh. A clue to his breaking up his association with Doctor Oviatt was in a paper I found in his file. The paper was entitled "Hernia Repair" by Dr. C. W. Oviatt. Doctor Connell had crossed out Doctor Oviatt and scribbled, "by Dr. F. G. Connell."

Why he did not develop a group practice, as most of his friends did at the time, cannot be answered. Most likely he could not afford to let the management of a group interfere with what he enjoyed so much, medical research. In reference to groups, he often said, "get engaged but never married."

Doctor Connell was a very independent man and completely ignored anyone who had little to offer. He cultivated, instead, the friendship of giants in the financial, medical, and literary world.

He traveled extensively and spoke intimately of foreign medical centers as well as of those in this country.

He carried on a vast correspondence and saved most of it in a filing system of his own, utilizing large used manila envelopes. Going through these is like going through "Who's Who in Medicine." Even in his late 80s, he read most of the surgical literature, underlined what he thought important and clipped these articles for his file system.

Doctor Connell served as president of the State Medical Society of Wisconsin in 1923. He was very active in the American College of Surgeons, National Society for Advancement of Gastroenterology, and Western Surgical Society. He was the first president of the Wisconsin Surgical Society and a founder member of the Wisconsin Surgical Travel Club.

He served as a delegate to the AMA and was the recipient of the State Medical Society's Council Award in 1947. In World Wars I and II, he served as advisor to the Surgeon General.

In Doctor Connell's later years he became most interested in peptic ulcers and felt the answer to be the removal of the acid-bearing part of the stomach, leaving the antrum, the alkaline-producing portion. He called this fundectomy. This proved unsuccessful both in principle and reality; yet years later Dr. Owen Wangensteen went through the same procedure, the sleeve resection. Doctor Connell was gratified when Doctor Wangensteen first published this with good results.

In Doctor Connell, medicine had an extraordinary man who practiced surgery in a small town, yet held his head level with the giants of the medical world.

His greatest assets were his sense of humor and his ability to say the right thing at the right time. If he were to send a message back today, it would probably be similar to a letter he wrote to a friend, who had sent him a manuscript of his memoirs for comments and editorial judgment. He wrote, "Dear Victor—I have read, 'Doctor Do Tell' and find it most interesting, amusing and historically valuable. I have one suggestion to make, you should include one death."

Monographs by F. Gregory Connell, MD

1. Intestinal Sutures, Philadelphia M J (Jan) 1899.
2. Exstrophy of the Bladder, JAMA (Mar 9) 1901.
3. Progress of Surgery, The Pleura, Univ. of Ill, 1900.
4. Intestinal Sutures, all knots inside, Medicine (Apr) 1901.
5. The Knot Within the Lumen in Intestinal Surgery, JAMA (Oct 12) 1901.
6. Gastrointestinal Perforations and Their Diagnosis, JAMA (Mar 4) 1903.
7. The Effect of Altitude Upon Pneumonia, Amer Medicine (June 12) 1903.

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The Subcutaneous Injection of Paraffine for Correction of Deformities of the Nose, *JAMA* (Sept 19, 26) 1903.


17. Definition and Classification of Gastric Hemorrhage, *Medical Record* (Jan 7) 1905.


23. Loose Bodies of the Knee Joint, *Amer Surg* (Feb) 1906.


27. Radical Cure of Varicocele and its Results, 1907.


Defining Milieu Therapy

GENE M. ABROMS, MD, University of Wisconsin Medical Center, Madison, Wis: Arch Gen Psychiat 21: 553–560 (Nov) 1969

Modern milieu therapy (therapeutic community) represents a significant advance over the late 18th century moral treatment methods. Whereas moral treatment represented an advance, it achieved its results by adopting the simple humanistic principle that treating patients as responsible human beings is effective in getting them to act that way. Taken out of their chains, treated kindly, given work to do, and decisions to make patients did do better than when they were treated as animals in cages.

But in addition to upholding these humane values, modern milieu therapy possesses an effective technology for promoting behavioral modification. The armamentarium of techniques include the somatic therapies (phenothiazines, antidepressants, lithium salts, and electroshock treatments), the behavior therapies, individual psychotherapy, the group processes (psychodrama, family or couple therapy, and sensitivity training), hypnosis and suggestion techniques, communications analysis, and role-playing. There is general agreement that each has at least a limited sphere of therapeutic potency.

What is unique about milieu therapy is that it constitutes a metatreatment. It should be regarded as a general method for providing these specific techniques in an effective manner. This involves constructing a stable, coherent social organization which provides an integrated, extensive treatment context. The aim of the organization is to make certain that a patient’s every social contact and his every treatment experience are synergistically applied towards realistic, specific therapeutic goals. These goals are learning to control or set limits on the main kinds of pathological behavior (destructiveness, disorganization, deviancy, dysphoria, and dependency), and to develop basic psychosocial skills (orientation, assertiveness, occupation, and recreation). Evaluating milieu therapy involves determining how well it accomplishes these goals of providing limits and skills. Its organizational structure can also be evaluated in terms of its quality as a social system. But looking at its structure in relation to its main therapeutic function, one can appreciate that the milieu requires the consensus-making machinery characteristic of democratic social arrangements: a set of forums or meetings that encourage participation in information-sharing, decision-making, decision-execution, and interpersonal conflict-resolution. Although these democratic institutions are valuable in their own right, their main justification in the milieu is their role in facilitating the specified aims of treatment.

RENEAL VEIN THROMBOSIS

A Roentgenographic Diagnosis

GENE P. WEGNER, MD; ANDREW B. CRUMMY, MD; TIMOTHY T. FLAHERTY, MD; and FLORENCIO A. HIPOMA, MD, University of Wisconsin Medical Center, Madison, Wis: JAMA 209:1661–1667 (Sept 15) 1969

Renal vein thrombosis is not a rare occurrence, and spontaneous recovery occurs more frequently than clinically suspected. The classical clinical picture in the adult and infant is but one aspect of the clinical spectrum of renal vein thrombosis.

A morphologic staging is proposed to help clarify the response of the kidney to renal vein occlusion, and to stress the role that collateral venous development plays in determining this response.

Since it is a difficult diagnosis to establish clinically, and is histologically similar to membranous glomerulonephritis, the roentgenographic appearance, particularly the angiographic features, of renal vein thrombosis, are emphasized. Correlation of the clinical and roentgenographic findings allows the diagnosis of renal vein thrombosis to be made regardless of the stage of the disease.

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