Pioneer Perfusionist Interview: Calvin Scott

Mark Kurusz: Today is January 24th, 2012. My name is Mark Kurusz, and I'm here today to interview Calvin Scott, former president of AmSECT. And we're very happy that Calvin has graciously allowed us to come to his home and conduct this interview. Calvin, it's really good to be here to visit with you today. And I'd like to go through a few questions at the beginning of this interview on your background and how you really got into the field of perfusion. How did you become a perfusionist, Calvin?

Calvin Scott: Well, actually, as far as background is concerned, I was a pre-med student as several numbers of the perfusionists were, and I didn't make it into med[ical] school. And I got into laboratory technology primarily to keep my interest up so if that opportunity did come to go to med[ical] school, I would not have lost my interest, but it didn't work out as far as getting into med[ical] school was concerned. After having been in perfusion and all the things that occurred there, I feel that there was really no great loss. Perfusion's not like medicine, but it isn't too far from it with all the things that we have done. And when I say we, I mean, all of us who were in perfusion at some period of time. I know we've done some grand and glorious things, whether we want to claim credit for it or not, it has happened.

Mark Kurusz: Yes. What years did you practice clinical perfusion, Calvin?

Calvin Scott: Well, I started training in 1960, 1961, and I guess after about two years, and then back in those days, we had a cardiologist who came from another—well, this was at the Veteran's Administration in Los Angeles. And, of course, at that time, the discipline was very new, and there was a cardiologist who had read up, boned up—I guess he figured he knew all the whereofs and whereas of perfusion at that point. So, he, I guess, was really a mentor for me, and he showed me how to set it up, and I would set it up, oh, for about a year. And then bit by bit, he'd let me do a little bit more. And after about two years, I guess, the Chief of the service made the announcement. "Well, I don't think we're going to need Dr. whatever…", I can't think of his name right now, "…and Scotty is going to take over."

Mark Kurusz: Great.

Calvin Scott: Well, I appreciated the confidence, and, of course, I kind of got the jitters because when you're running around doing errands for somebody, and then the next thing you know, you're sitting in the hot seat, that's a different story.

Mark Kurusz: Sure.

Calvin Scott: That's a different story.

Mark Kurusz: Was all your on-the-job training conducted in the OR, or did you have any animal experience?

Calvin Scott: Yes. And we duplicated what we did in the OR with the animals. And back in those days with the equipment that we had and the scheduling that we had being with the VA, one of these hospitals that had surgery going on almost every day—once a week was our schedule. And, of course, we worked in conjunction with UCLA. UCLA had a combined residency training program in several fields with the VA. And, so, including, we didn't do too much working with their heart team, but if certain problems or certain issues [were] to come up, we would go over. And when I say that I think of one issue that UCLA was, I think, pretty well-known for is that cardioplegia that we were doing in those days, which was instituted by Dr. Gerald Buckberg.

Mark Kurusz: Yes.

Calvin Scott: Now there are a lot of changes that have been made since then that all of you youngsters out there would know about, but I think Dr. Buckberg was one of the pioneers in that field.

Mark Kurusz: Yes.

Calvin Scott: And again, to answer your question, actually, my entire perfusion, I started, I guess, about 1963 or 1964, and I retired in 1985.

Mark Kurusz: I see.

Calvin Scott: I was in it roughly about 25 years, 20 to 25 years. Now along with that, I was one of the older persons to get into perfusion. You've got a whole slew of youngsters who are coming in now, some fresh out of college, some fresh out of high school.

Mark Kurusz: Yes.

Calvin Scott: And, of course, I had been out of college, out of high school, married with a child and that sort of thing. The years were there. I think I was, what, close to 40 years-old, about 35 [years-old] or so when I got into perfusion.

Mark Kurusz: And being an adult hospital, what were your most common procedures back in the 1960s—were they valvular?

Calvin Scott: They were valvular, both aortic and mitral were the main valves. And, of course, as time went on, we knew about other things, and the surgeons would take a shot at things. Now mapping was one of those, I think, well, that's what we refer to it, but maybe your youngsters have another term for it now, but back in those days it was mapping.

Mark Kurusz: To treat arrhythmias.

Calvin Scott: Right.

Mark Kurusz: Yes. And, of course, when coronary artery bypass grafting came into vogue, I'm sure you ended up doing quite a bit of those in the 1970s and 1980s.

Calvin Scott: Yes, we did.

Mark Kurusz: Who were some of the surgeons that you worked with, Calvin?

Calvin Scott: Well, I started off, the person who was in charge of the program at the VA, Dr. John Burrows, who was a graduate of the school in Baltimore.

Mark Kurusz: Johns Hopkins?

Calvin Scott: Johns Hopkins, thank you. And he had other surgeons who assisted him in those beginning years because they were in the process then of training residents who were at UCLA. And they would come over and maybe spend two or three months in the thoracic department at the VA. Now, also I might say that…I mean the institutions were very close together. It was practically across the street. When we weren't involved in a heart procedure as such, they would go back over to UCLA and get involved with the other thoracic surgeries that they were doing at that time.

Mark Kurusz: Yes. I imagine, like many of us in the early days, the relationship between the perfusion team and the cardiac surgeon was very close. Did you collaborate with Dr. Burrows other than operating the heart-lung machine when he had any new ideas for surgical procedures?

Calvin Scott: Indeed, we did. And of course, as I said, you asked me who were some of the surgeons I worked with—Dr. Burrows, he was the beginning one. And we had a lab, and we would go over and operate on these dogs, just [the] same procedure that we would use on humans, even to the point where we had dogs that would be donors for the blood that we used. And, of course, we used lots of blood in those days, which is, well, we didn't know any better. And that was the procedure to follow. And, of course, as time went by, we gradually cut down on that and used other things. But yes, whenever Dr. Burrows would come up with an idea about something, he'd talk to us about it and then we'd get in the lab and try to see what we could do with it, work it out. He designed a machine that was supposedly going to be a pulse duplicator. It never got off the ground. And, of course, the open-heart program, particularly in those early days, it still is, not to think of it lightly, but it was a very expensive program and procedure. And, of course, the VA wasn't quite used to all those expenses. And then Dr. Burrows was a very vocal person. He didn't care who you were, the higher you were in the hierarchy or whatever, the louder he spoke. And he was there, and they said, this man must be crazy. They said, "Let's get him what he wants to just get him out of our hair." And, so, he did get a lot of things done—of course, he left the program, and he was succeeded by Dr. Richard K. Hughes. And then from [Dr.] Hughes came Dr. Joseph S. Carey, who we became very close and very, very good friends, like an extended family. Joe was a bachelor when he started, then he got married, and I went to his wedding, and he was kind of surprised at that, but

appreciative in a sense because his wife lived in New York. And, of course, going to New York was really a big thing because I don't have deep pockets. Didn't have deep pockets then and don't have them now, but nevertheless, I was able to scrounge up enough to get to his wedding, as well as visit my relatives who were there. And then Joe and his wife had five children, and I was around for all of those births. Three have gotten married now, and two of the three have started their families. The daughter has three children and one of the... He had three boys and two girls, one girl still isn't married. And the interesting thing about it, and I chuckled, his oldest son has not gotten married, and he has gone into medicine. He's in the program at USC in Los Angeles. They all have settled in California. Joe originally was, his dad has been in the Army, and he traveled quite a bit and had done some work in, I think it was South Africa. I don't know exactly, but he was there that long as he had a brother who had a practice there, and he'd go and visit with him. But Dr. Carey's work mainly was with the VA, and he did quite a bit and did a lot of, well, not a lot, but whatever ideas he had, he would consult with his team, and we'd take it from there.

Mark Kurusz: Well, let's go back just a bit to what job you had before you were recruited to be on the pump team, Calvin. What hospital experience did you have prior to that?

Calvin Scott: Well, prior to that, well, actually prior to going to California, I was working with the Department of the Army at Fort Benning, Georgia, in a hospital as their lab tech. And I did that and was able to make a transfer up to making the decision to move to California. I was able to transfer my records as such from the Army to the VA since they were both government institutions, basically, and I didn't lose any credits or anything of that sort—of course, it didn't gain anything either as such at that time. And I guess I had been at the VA some three or four years when they really got started with the open-heart program. And I spoke with Dr. Burrows, who was in charge at that time, and told him I understood he was looking for personnel. And at that time, the main method of training was OJT. I think there was only perhaps maybe one school who offered a systemized training program, and that was Ohio State, from what I understand.

Mark Kurusz: Yes.

Calvin Scott: And the rest, of course, others have come along since then, and well, the world has turned all the way around since they planned it or whatever, since those days. And all for the better, I think.

Mark Kurusz: Sure.

Calvin Scott: That was the way that went.

Mark Kurusz: Besides the hands-on training where you basically preceptored and learned the job on-the-job, did you have any textbooks or what sort of material did you use, or did you rely on communicating with other perfusionists back in the 1960s?

Calvin Scott: Well, actually, we used, for the most part, some physiology books because those of us who are in perfusion realized it encompasses all of that. And Dr. Burrows was very, very concerned about our reading up on and reviewing, regardless of what we might have gotten somewhere along the line, but I can't recall on that. I mean physiology, and, of course, some bacteriology, [but] it wasn't as in-depth as you would get in a medical school, but he would suggest various chapters first to review for what we were doing.

Mark Kurusz: Yes. As you think about the surgeons that you worked with, Dr. Carey was mentioned, you worked with him for a long time. And who…

Calvin Scott: I finished up with Dr. Carey.

Mark Kurusz: Pardon me?

Calvin Scott: I say I finished up my practice with Dr. Carey.

Mark Kurusz: Of all those that you worked with over the years, Calvin, who would you say had the most positive impact on your career?

Calvin Scott: Well, I would have to say, really Dr. Carey because I was with him longer than any of the others, but, on the other hand, I can't deny Dr. Burrows who got me started in the program.

Mark Kurusz: Sure.

Calvin Scott: And I got a lot from him.

Mark Kurusz: Well, that's a good background, I think, as we go on with this interview, Calvin. I'd like to now shift gears a bit and talk about some of your career highlights. During that time, obviously, there's been tremendous technological changes as well as changes in technique. What stands out as maybe the top one or two or three changes that you saw during your career?

Calvin Scott: One of the greatest things that really impressed me and was an impact, was, and I guess it was Travenol, the Travenol disposable bag oxygenator, put it that way. What had happened now, they had made a film, as most manufacturers would not do when coming out with a new product. And I think it was done at Texas Heart, I'm not too sure. But anyway, when the case was over, I think it was one of the nurses, took this bag, just grabbed it up and threw it in the trash. And I said, look at there. That's for me, that's for me. Well, actually, at the time, Travenol, I guess, had gotten a jump start on most of the other...Well, there weren't too many manufacturers really in those days, they were, oh, everybody was out there struggling, trying to learn. And you heard among the older perfusionists, you might hear the story that such and such person came out of that garage with their product in hand and to my lab to introduce it. And I had that experience with [Jim] Bentley—he brought his...and that's what we wound up

using as a disposable oxygenator. Now, back again to the Travenol, before we could get hooked up with them, so to speak, other people were coming. Bentley had his, and there was, I don't know who else was on at that time. But Bentley came by out of his garage to our lab and talked to us and worked with us actually. And another interesting person, well, of course it wasn't...Well, I think his company finally got into oxygenators, but his last name was Collins, he was one of the founders of Cobe Lab[oratories]. And he started out with sort of a garage presentation, but his main force at that time was supplies, tubing, and mainly tubing for…

Mark Kurusz: Like a custom pack?

Calvin Scott: Well, a custom pack, but for the machines that we were using to hook into the patient and monitor, EKG machines...

Mark Kurusz: Oh, okay.

Calvin Scott: …and those kinds of things. Now, and the other thing about that person was, AmSECT was coming onto the scene, and it wasn't, oh, maybe five or six years-old. And I remember him saying precisely, and he followed through, he said, "Scotty, you need to have a meeting with a dinner, and we'll sponsor it for you." I said, "Really?" I didn't know too much about those kinds of things. And well we were all just getting started. So, we had the dinner, he sponsored it and…

Mark Kurusz: Wonderful.

Calvin Scott: …it was great. And so, of course, he just took off, not necessarily from that experience, but he was out there building a business and he built it. And it was known as Cobe, and they were just outside of Denver at one point. Now, I don't know where, I think they've changed the name, but I still think they're in the same location.

Mark Kurusz: I believe that's true, I think that Sorin took them over.

Calvin Scott: I think that's the name. Of course, all that happened after my time, so to speak. I don't know. And, of course, the persons who founded it, I think they sold out, they're somewhere relaxing in whatevers, in California.

Mark Kurusz: Sure, sure.

Calvin Scott: Whatever.

Mark Kurusz: Prior to the disposable era, you had to use reusable oxygenators and equipment and hand-cut the tubing?

Calvin Scott: Exactly. And the one thing I can say about that is it strengthened my hands and fingers because we had to use that to tighten screws and that sort of thing, because once you

got set up, you didn't want to put pliers or anything like that on it. You could tighten it enough. And I learned to do that, to tighten the connectors. And, then of course, as with the advent of disposables, all that went by the wayside.

Mark Kurusz: Sure.

Calvin Scott: And I can remember Dr. Hughes was partly responsible for this. Now they probably were doing it in other hospitals, but we were having a terrific time with infections, and it was perplexing to everybody. And Dr. Hughes was consulting with his colleagues and whatnot and couldn't quite find out what it was. He said, "Okay, we're going to sterilize the whole operating suite." And what he did before we'd have a case, the cleaners would go in with some type of disinfectant and do the walls and the tables and the whole bit, and nobody was allowed in that room until after the surgery. Well, and then he also designed what they call a pass-through box because specimens were going out to other areas, to the labs and that sort of thing when we were operating. And, so, they had a pass-through box for that to try to keep out the infection. But the one thing that they called him on, when I say they called him, the hospital engineers, he wanted to put a cover on the floor and saturate them. They said, you can't do that, that's not it. He didn't have anything to show. He said they overruled him on that, but anyway that was one of the things that he did. Secondly, he insisted that all the nurses wear pants.

Mark Kurusz: Oh.

Calvin Scott: Now, as I said, they may have been doing it elsewhere, but they hadn't been doing it in that area as far as I know. And what had happened, one of the circulating nurses was flipping around and operating in a skirt, [and] got caught in the pump. And back in those days, we had pumps. Some pumps were made to the side of the console, some were on top. And then that, of course, brought about different ways to protect the pumps from such things that's happening to them. I don't think that was a great catastrophe, but it scared everybody half to death.

Mark Kurusz: Sure.

Calvin Scott: Couldn't wear skirts in [the OR] because it stopped the pump.

Mark Kurusz: Oh.

Calvin Scott: And this was the arterial pump. There wasn't a...

Mark Kurusz: Oh, gee. Got everybody's attention.

Calvin Scott: Yeah, absolutely. They said, all right. Of course, some of the ladies say, oh great, because when they get to stooping and squatting and all that sort of thing with pants on, they didn't have a problem.

Mark Kurusz: Yes.

Calvin Scott: And some of them didn't care even with their skirts or whatever they were wearing in those days, but the pants really turned out well. And, of course, I don't think you can go in an operating room anywhere now and not find the female personnel wearing pants.

Mark Kurusz: Sure, sure. Obviously, the transition from reusable equipment to disposable was a huge change. Are there any other technological innovations or even practice innovations that stand out in your mind as being particularly important?

Calvin Scott: Well, yes. I think in relation to the priming of the, I don't know just what's used these days, but we began to reduce the…but back in those days we would be using whole blood that we would convert with heparin, and I think calcium chloride we used for that. And I can remember on an occasion, and I had gotten to the point, having worked with this cardiologist right from the beginning, he told me what to measure, the amount of heparin to put in the bottles to be placed in the pump. And, of course, regardless of what he said or when he said it, I always go back. I said, "You said such and such thing?" "Yeah." Well, he misunderstood me, because the dosage was two milligrams of heparin, and I think six of the calcium chloride. Well somehow or another, I guess I said 20, and he said, "Yeah." So, we had a whole bunch of bottles with 20 milligrams of heparin in it, and when it came time to convert from the heparin, it wasn't working. And he said, "Well, let's review this then." Dr. Burrows was in charge in those days. So, we got the patient through, but that was a scary occasion. Now on another occasion, a question came up. This question came up in, I think at one of the AmSECT meetings, one of the after meetings when we used to sit around and chew the fat about what we'd done and what's going on. And somebody popped up with, well now, what would you do if you had a patient that was allergic to fish, and you had perfused him and got ready to convert him, and, of course, of conversion of drug—I think it was protamine.

Mark Kurusz: Yes.

Calvin Scott: And protamine was a fish derivative. What would you do? Somebody said, well, we used a protamine, and we didn't know, we just used protamine, and he survived, or she survived or whatever. I don't think I ever got the right answer to that for my own benefit, of course. There had to have been something that would work because, well, of course, two things enter here. There are not that many people who would be allergic to fish. And on other hand that they would get protamine to convert them from the…

Mark Kurusz: Yes. What was your…As you think about the cardiopulmonary industry, as you noted earlier, there were very few players in the early days, but then it expanded. How would you view them? What was your view of the industry in terms of sponsoring meetings or just dealing with the sales reps on a daily or weekly basis, Calvin?

Calvin Scott: Well, my thing was dealing with the reps as the companies developed, and, of course, reps would come in almost out of the wall. And they'd come in and say "Hi," and "We

got this…" and boom, they were gone. My thing was, the key thing in this rep business was service. I said, "Oh." I said, "I have to be honest with you. As far as I'm concerned, all your products are the same, put them in the bag, shake them up, they all fall out together. And I don't think one is extremely…", of course, reps didn't like to hear that, but I said, "Personally, I just don't think one is that much better than the other. And the one, what you see me using is because that rep gave me service. When I needed something, I got it." And if I didn't need something, they just bring things up that you might want to use this at some point in time.

Mark Kurusz: Sure.

Calvin Scott: Service. And I don't know whether that prevails today or not. I have been out now since 1985, what's another 20 years or so, a lot of things have, oh, I know, have happened since that time, as well as it happened before that time.

Mark Kurusz: Sure. Once you finished your training and were really working steadily as a perfusionist, did you ever get involved with training anybody else on the job or even having a mentoring relationship with other fledgling perfusionists?

Calvin Scott: Yes, I did. As a matter of fact, at the VA, I was chief, cook, bottle-washer, whatever. And then finally I got one of the persons who had worked in the OR as a scrub tech. Said he thought he'd like to... He'd been there for a number of years. And he said, "I'd like to get involved in your program if there's an opening." I said, "We'll make an opening." And we did. So, I guess he was probably my only trainee, and we worked together for, oh, maybe about ten years. And it worked out very well.

Mark Kurusz: Wonderful. What sort of resources did you use to train him?

Calvin Scott: Well, the lab was the main thing because we had the lab, and we were duplicating procedures. And the lab was what we were doing in the operating room. And plus, he had his skills that he developed being a scrub tech were excellent. I mean, he could get in and operate on those dogs just like the surgeon and close them and all that sort. And he may not have been, I won't say he was that good on the anatomy, as such, but he knew. When I say that, he probably didn't know the names of everything, but he knew what went where and what had to be done.

Mark Kurusz: Sure.

Calvin Scott: And his patients, which was basically the dogs, most of them survived. As a matter of fact, there was a saying in the lab community because in the lab, there were several labs doing various asundry things. And most of their dogs would expire. And, of course, that was something that they more or less had expected, because they were trying to find out about new drugs and whatever else, but our dogs, we were just working on techniques for open-heart surgery. And, of course, unless something went terribly wrong, most of our dogs survived. As a matter of fact, I took one home, and she lived for about ten years.

Mark Kurusz: Wonderful.

Calvin Scott: And she sort of developed a reputation. They said, “Next dog you do, I want it.” People would come by and say [that]. So, the experience was rewarding in many ways.

Mark Kurusz: Sure. As you think back on your career in perfusion, are there any cases that stand out in your memory as being particularly memorable, whether they were good cases or bad cases?

Calvin Scott: Well, I have thought about that, just in general. And particularly when I’m reading some of the, well, basically the AmSECT literature, and they’re mentioning cases that have sort of gone by, I’ve taken under consideration. And I just said, well, I can’t recall anything that equaled that or came close to it, not that I said we had the best techniques in the business, but I guess it was because of the volume of work that we did. As I said earlier, we weren’t doing cases every day, well, with the old equipment. Of course, after the expendable equipment came, it made it very simple. All day, all night, if necessary. And you just throw the stuff in the trash, get a new set, set it up, and you’re ready to go. But I can remember some things that happened, but I just don’t remember the details enough to really make a presentation on it.

Mark Kurusz: Sure. I’ve got a two-part question, and that is, what was your individual approach to doing a case? Let’s say a case was posted the evening before. How did you approach a case? And secondly, what did you most enjoy about doing perfusion cases, Calvin?

Calvin Scott: Well, I guess I’ll answer your second question first. The most enjoyable thing I did was the fact that the patients survived. That was... And I might say insert right there, that one of the things I learned about doing perfusion was how much trauma the human body could take and still survive, because, friends, I want you to know that in those early days, we did everything we could, and I’m trying to inspire them, but we didn’t know any better.

Mark Kurusz: Yes.

Calvin Scott: Like the overdoses, overdose of heparin now in that preparing the blood bottles for surgery, that sort of thing, but we were able to bring them back. And your first question again was?

Mark Kurusz: Well, the first question was if they posted a case, how did you prepare for the case?

Calvin Scott: Oh, well, now again, going back to Dr. Burrows, one of the things that he said, and I want to say, “When we schedule these cases, I want you to go up and talk to the patients and tell them who you are and what you do.”

Mark Kurusz: Is that right?

Calvin Scott: Exactly. Yeah. I had to do everybody that way. Even when it changed, I said, Dr. Burrows had me doing this, do you want me to do it? It doesn't make any difference to me. I can and I can't. Now maybe that's not a bad idea. And I guess it must have had an effect. Sometimes I'd go, would only be the patient in the rooms. Other times I'd go, the family would be there or part of the family. And I think it gave them an impression that, hey, these folk ain't bad at all. They're trying to help us out and help us to understand what's going on and that sort of thing. And, of course, I wouldn't go into all the details of the surgery—I just tell him who I was and what I was going to be doing, and that was it. And, of course, if they came back with questions, I'd try to answer them.

Mark Kurusz: Sure.

Calvin Scott: But I enjoyed the communication with the patients and the family. Now after the case was over, I'd go and check, make sure I wouldn't have to set up anything at night and go back in the middle of the night. I'd clear the operating room of my equipment. And, of course, again, with the advent of the disposable equipment, that wasn't a big deal, throw it in the trash and go, so to speak. And then I would go by the rooms where the patients were, they... Oh, what am I trying to say now?

Mark Kurusz: Just to make sure they were recovering on schedule?

Calvin Scott: Well, that, but I was trying to think of the name of the...recovery room, okay. There was a recovery for the heart room. Most of the heart patients went to a certain area, and then the recovery for other patients, but in the recovery room, that's it. Exactly.

Mark Kurusz: Yes. And over your years at the VA, I imagine whether it was with Dr. Burrows or Dr. Hughes or Dr. Carey, you had a team of regular people, nurses, and anesthesiologists?

Calvin Scott: Basically, we did. And at first some of them were reluctant, well, they didn't know what to expect. I have put that in Dr. Burrows's days because, well, he initiated the program. And as I said, the way things were going, we hadn't developed a reputation because we hadn't done enough of losing patients and that sort of thing. That worked out pretty well.

Mark Kurusz: I think one of the things that AmSECT would be interested in is if you have any material from your career that you might want to share, whether it be slides or newspaper articles, any newsworthy items that might be duplicated and collected by AmSECT. Do you have any that you can recall, Calvin?

Calvin Scott: Not offhand. Not from a personal standpoint, perhaps as a team standpoint. I'm afraid I'll have to pass on that one for the moment. Now, maybe I'll dig through my archives as such and see what I can come up with.

Mark Kurusz: Well, that would be terrific.

Calvin Scott: And I have some slides from AmSECT meetings and that, not slides, tapes that we made back in those days from various meetings, and I'll try to scrounge those up and see. Now, when you say AmSECT would be interested, would they want to create a sort of portfolio of these things or…?

Mark Kurusz: I believe so. I haven't really worked out the details, but...

Calvin Scott: Because I would need to get them in there so you could get them prepared in time. I guess you would want to show them at the meeting in March.

Mark Kurusz: Not necessarily, not necessarily. Time's a little short for the meeting in March.

Calvin Scott: Oh, okay. Well, then I'll…

Mark Kurusz: Just to archive the material. Photographs, that sort of thing.

Calvin Scott: Hm?

Mark Kurusz: Photographs of early meetings and anything that you might have would be terrific. I'd like to move on now to the last section, Calvin, and that is something that I've titled "Perspectives, Philosophies, and Reflections." This may be a difficult question, but what do you think are some of the personal, professional attributes that contribute most to a person becoming a good perfusionist?

Calvin Scott: Well, I would say someone who is not self-centered, who's willing to devote the time, regardless of what it is. And I'm sure that rather might be a difficult thing for some of the younger perfusionists now since things that develop where they can get in and get out and never have to do those long hours that most older folks know about.

Mark Kurusz: Attention to detail often comes up.

Calvin Scott: Well, it is. I think that's very important, and being willing, even though I said that they don't particularly have to have these long hours, in the event that something came up, how would they feel about really having at it and getting the job done as opposed to... And even back in my day, said they need to do something about this. We['re] just staying in here too long. I've heard those kinds of [comments], but that's not what it's all about.

Mark Kurusz: Sure, sure. Another fairly general, broad-based question, and that is, tell us what it means to you to have been a perfusionist. Were you happy the way things turned out, starting out in the laboratory and ending up spending most of your time as a clinical perfusionist? What did it mean to you to be a perfusionist, Calvin?

Calvin Scott: Well, it was a very rewarding experience from the beginning, really to the end. Going in, learning about these various [things] and working with various facets that we had to

work with and then seeing the progress that was made over the years and looking back and saying, well, we used to do this, but oh, look at us now, that type of thing. It was one of the things, I don't know whether...I guess perhaps all of us have some sort of an experience of that nature, regardless of what we do. We see improvements made and changes occurring, but I don't think it has quite the impact. When you're working with a human life, that's a different story.

Mark Kurusz: Yes, yes.

Calvin Scott: A lot of different stories. It's not your everyday run of the mill, so to speak. And though you don't get out here and talk about it, you just happen to mention, well, and I get this frequently, "You retired, what'd you do?" "Well, I was VA employee." "Oh well, what'd you do?" And then I'd tell them. "Oh, really?" "Really."

Mark Kurusz: Yes. Yes.

Calvin Scott: And that, in itself, was a reward.

Mark Kurusz: Sure, sure.

Calvin Scott: The fact that they realized that. Someone would say, I never heard of that. And, of course, there are others, oh yeah. I had that myself 20 years ago, two or three years ago, and that sort of thing.

Mark Kurusz: Besides the personal satisfaction as you left OR after a good case, you got heavily involved with some of the continuing education activities, you served as a president of AmSECT. Can you tell us briefly, just a little bit about your involvement at the national level when you were there for some of the very early activities that were important to our field?

Calvin Scott: Well, the stage of the organization when I was president, as I recall, we were having, as most organizations have, even our government is having, with finances. And, of course, we had a person who was in charge of the administrative aspect, of course, no longer there now, but one remark that he made after, well, when I was retiring from my presidency. They said, well, one thing he did, he took care of the debt that we were in. It's not quite as bad as it was. Well, I didn't exactly do it, I had help with the people who were around me, and we were able to persuade them that certain things had to be done, that sacrifices had to be made here and there, and it was done, and we survived.

Mark Kurusz: Sure.

Calvin Scott: The other situations, of course, I enjoyed the fellowship and the meetings that we had. I didn't make, and I don't know whether the present president does or not, but I didn't make many regional meetings except for when I was in my own regional meeting. And even before being president, that was one of the things that I tried to work very diligently with the

people in the California area because we had several hospitals who were really going great. And we had enough people to form a…I mean just in that area alone, to form a good chapter, but as time went on, they just fizzled out. I don't know why they lost interest, but they would come to the national meetings and other meetings that were in the area, but meeting locally, I guess they felt they didn't...I said, we need to know what you're doing. That's what this is all about.

Mark Kurusz: Sure.

Calvin Scott: Share your experiences with us.

Mark Kurusz: Sure.

Calvin Scott: They said, "Well, we haven't done that much." So, what can you say?

Mark Kurusz: Well, during your tenure as president of AmSECT, you mentioned straightening out the finances. Can you tell us who were some of the outstanding personalities that you worked with at the time? Obviously, I don't want to put words in your mouth, but Maddie Massengale was a very strong figure.

Calvin Scott: And she was, and still is in her own way. And, of course, Maddie is one of my dearest friends. We communicate maybe about once a month.

Mark Kurusz: Wonderful.

Calvin Scott: Have done over the years. And, of course, Maddie, as nearly everyone knows, is still as active as she can be. Because like all the rest of us pioneer folk, we have our medical problems now. She's not able to do a lot of things that she probably would like to do, but she's not falling behind. I think she's doing remarkably well under the circumstances.

Mark Kurusz: Wonderful. Any other names that stand out from that era?

Calvin Scott: Well, as Larry Cavanaugh, who later became president, was quite active. Another was, who's no longer with us, Jerry Richmond.

Mark Kurusz: Yes.

Calvin Scott: And let's see... Well, those are the prominent names. Oh, another was...who has expired. Oh, goodness. I can describe him. I see his face just as plain as I see yours. He liked boats, and I guess he was in his glory because he was working out of Long Beach at one time, and he lived down there, and he was able to get on his boat and just go out. And I guess it was a side of a relaxation for him. I don't know, from what I hear about…

Mark Kurusz: Was this Mike Burgess or Bob Pfefferkorn?

Calvin Scott: Pfefferkorn.

Mark Kurusz: Bob Pfefferkorn. Sure.

Calvin Scott: Pfefferkorn is one.

Mark Kurusz: And you were on the American Board [of Cardiovascular Perfusion] at one point weren't you in the early years?

Calvin Scott: Yes, I was.

Mark Kurusz: Working on the examination?

Calvin Scott: Right. And that was an interesting experience. And, of course, one of the main stalwarts in that...Well, I guess you might say there were two, but as far as I'm concerned, one of the main ones was Jim Dearing. And then, of course, Charlie Reed. And Charlie had, in a sense, in the beginning time had to pretty much…All of the impression that I got, and most of us had, was he had Texas Heart [Institute] behind him. Whatever he wanted to do, he could do it. So, then that was another, who was sort of a cohort of Charles was Earl Lawrence, who was quite active.

Mark Kurusz: Yes.

Mark Kurusz: Well, as you think back, Calvin, as we bring this interview to a close, and I'd like to thank you on the record again for taking time out of your day to share your thoughts with AmSECT and the people who will view this after the fact. Do you have any closing thoughts that you might want to express to the young perfusionists of today, who have come into the field from a different background than many of the early pioneers who came from various disciplines, than those entering the field today?

Calvin Scott: Well, one of the things foremost and paramount is what I had mentioned about the trauma that the human body can take and still survive from. Of course, the trauma is not nearly as bad as it was in the earlier days. I think the youngsters have a tremendous, say background, of knowledge. There's a lot personally available to them now, much more than we had when we were coming along. There have been books published about the profession that they can get information from. And I think it would behoove them to look at things that are happening in their own settings. Because I think, sometimes we don't think about these things. If a problem comes up, we're so busy trying to get it solved, that we forget what the really significant portion of that incident is or was.

Mark Kurusz: Yes.

Calvin Scott: So, that's something to be thought of. And I must say also, Mark, though I understand in your position now with what you're doing, but I can remember the days when

you weren't doing this, and you were doing other things, like writing and publishing and that sort of thing, which is really something to be proud of and is a feather in your cap. I've always admired what you have done in those areas.

Mark Kurusz: It's very kind of you to say that. Like you, Calvin, I worked in a setting where we weren't terribly busy, and we had a wonderful medical library. And really, I think I was influenced by the surgeons I worked with. And we just were all learning back in those days. And so, the way we all grew up together was going to the library and reading about this or that. And I'll make a confession to you—I didn't even know how the blood circulated through the heart when I got into the field. So, I had to look up the anatomy of the heart. So, it's been a great interview. I want to thank you again for your time.

Calvin Scott: Well, thank you, and for having considered me.

Mark Kurusz: Well, it's been terrific. And we look forward to sharing this with all the AmSECT folks, and I'll make sure that you get a copy of the raw tape as well as the edited tape…

Calvin Scott: Okay, okay, fine. I'd appreciate that.

Mark Kurusz: …for your personal library.

Calvin Scott: Okay.

Mark Kurusz: Thanks again, Calvin.

Calvin Scott: And thank you.