Historical Review of the San Francisco Surgical Society

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I remember quite vividly being persuaded by Dr. John Cline to join with him and a few other San Francisco surgeons to form a new surgical club so that we might meet periodically to discuss our mutual problems. On March 15, 1939, John invited 12 San Francisco surgeons to meet for dinner at the Family Club in San Francisco. Most of you who are old enough and had the good fortune to know John Cline must have appreciated his great abilities as an organizer, medical politician and leader. He was president of his class in high school, president of the student body at the University of California, president of the San Francisco County Medical Society, president of this society in 1946, president of the California Medical Association, president of the American Medical Association, and shortly before he died, president of the American Cancer Society. During the summer between his junior and senior years at the University of California he and a classmate, Paul Davies, almost singlehandedly toured this state and raised the money to build the Memorial Football stadium in Berkeley. John was certainly qualified to be the guiding spirit in the formation of a new society.

After our dinner a free discussion took place concerning the advisability of forming a society of general surgeons in San Francisco. All present were agreed that such an organization would be to the advantage of surgery in San Francisco and to the individuals composing the society. The object and proper sphere of activity were discussed. The consensus of opinion was that the primary object of such a society should be the promotion of the art and science of surgery by the free interchange of ideas between its members. It was felt that the meetings should consist of mixed scientific and clinical presentations and that the meetings should be frequent enough to preserve interest but not so numerous as to become burdensome upon the members. The society should be large enough to be representative of San Francisco surgery but should not become unwieldy. The matter of members residing in other cities in the vicinity was discussed, but no conclusions were reached except that only those residing within an area of 50 miles would be eligible. Dr. Thomas Mullen was elected president, Dr. George Rhodes secretary and Dr. John Cline treasurer. The officers elected were to constitute a committee to draft a constitution and bylaws to be submitted at the next meeting.

A second organizational meeting was called on April 20, 1939. Prior to that meeting mimeographed copies of the proposed constitution and bylaws had been distributed to each of the 12 founding members and at that meeting were reviewed paragraph by paragraph. Certain changes and amendments were made, one of which limited the membership to 50 fellows. The matter of enlargement of the society was discussed, and a procedure of nomination by the members present by preferential ballot to obtain 12 additional names was adopted. It was also decided that the previously elected secretary and treasurer should become the vice-president and secretary; hence George Rhodes became vice-president and John Cline secretary-treasurer. Two councilors, Dr. Fred Foote to serve for 1 year and Dr. LeRoy Brooks for 2 years, were elected. Balloting then took place

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upon the names of 19 nominees, 12 of whom were elected and invited to become founding members. As a consequence, the names of 24 surgeons are listed as founders of this organization; however, only 12 participated in the first two organizational meetings. The initiation fee was set at 10 dollars, to include the cost of three dinner meetings.

The original 12 founders had been selected as representatives from the two university hospitals and various private hospitals throughout the city of San Francisco. These were Emile Holman, then chairman of the Department of General Surgery at Stanford University Hospital; Glenn Bell, then chairman of the Department of General Surgery at the University of California; Thomas Mullen, our first president, LeRoy Brooks and Fred Foote from Franklin Hospital; George Rhodes, our first vice-president, from the San Francisco City Emergency Service; John Cline, our first secretary-treasurer, from St. Francis Hospital; Alson Kilgore, the uncle of our distinguished president, and Joseph Meherin from St. Joseph's Hospital; Franklin Harris from Mt. Zion Hospital; Dan Delprat from St. Luke's Hospital; and Carleton Mathewson from San Francisco City and County Hospital. Time has taken its toll. Of the original founders seven are still alive and living in the Bay Area. Glenn Bell, Nelson Howard and myself live in San Francisco, Loren Chandler in Palo Alto, Otto Pflueger in Tiburon, William L. Rogers in Pebble Beach, and Brodie Stephens in Walnut Creek. Good fortune has allowed me to remain alive and active in practice and a senior member of this society. It is noteworthy that, while we have had 41 presidents and vice-presidents, there have been only eight secretary-treasurers, constituting the real backbone of our society. We owe a vote of thanks to these dedicated surgeons who contributed so much to the success of the organization. A special vote of thanks should go to the late Dr. John Cline, our first secretary-treasurer, who was not only the guiding spirit behind the inception of the society but kept it going during the troubled times and absence of members during World War II.

The final organization meeting was held at the Family Club on May 31, 1939. Twenty of the founder members were present. It was at that meeting that the secretary was instructed to notify the *Journal of the American Medical Association; California and Western Medicine; Surgery, Gynecology & Obstetrics; The Western Journal of Surgery;* and the San Francisco County Medical Society of the formation of the society and the names of the officers. Drs. Nelson Howard, Brodie Stephens and William Washburn were appointed as members of the first program committee. Drs. Robert Scarborough, Edmund Butler and Glenn Bell were appointed as a committee to investigate the publication of the transactions of the society in some suitable journal.

The first clinical meeting of the society was held at the Franklin Hospital on November 1, 1939. The program consisted of a thyroidectomy and right colon resection by Dr. LeRoy Brooks and a cholecystectomy by Dr. Dan Sooy. There were case presentations by Drs. Cox and Meherin, demonstrations of slides and specimens of a gastric ulcer by Drs. Brooks and Carr, and a moving picture demonstration of ureterointestinal implantation by Dr. Hinman. Drs. Brooks and Carr followed with a discussion of water, mineral and protein balance in surgical patients. Dr. Emile Holman then presented the report of the evening, dealing with arteriovenous fistula. He was at that time a world authority on the subject, and many of his experimental observations were important in the subsequent development of cardiac and peripheral vascular surgery. Before coming to Stanford in 1926, Dr. Holman had served for a number of years as chief surgical resident under William Halsted at Johns Hopkins in Baltimore. After the discussion of Dr. Holman's paper the matter of an official organ for publication of the proceedings of the society and the papers read before it was considered, but no action was taken. It was not until May 1947 that the *Western Journal of Surgery, Gynecology, and Obstetrics* was designated the official journal of the society.

So our society was born, and it has grown progressively from the original 12 members to 24, then 50 and now 99 active members, 50 senior members, 4 military members, and 18 retired members. It was not until May 1950 that Leonard Heaton, then chief of surgery at Letterman Hospital and subsequent Surgeon General of the Army, was elected as the first associate military fellow.

It might be well at this point to review what surgery in San Francisco was like in the decade before the San Francisco Surgical Society was born and to picture, if possible, the prevailing professional atmosphere in which it was conceived. Perhaps this can best be accomplished by relating some personal observations of the events that eventually created a need for a surgical forum in our community.

In view of the tremendous advances during my past 50 years of surgical practice, I look back with disbelief on the early years of my postgraduate training at San Francisco County Hospital. To say the least, the training was meager but was crowded with a broad and often frightening experience in many facets of general surgery. Most of the adjuncts that today's trainees and practitioners accept as routine to the practice of surgery were not known or were unavailable. The ravages of infection were faced at every turn and the only known means of control were rest, local heat and surgical drainage.

Generalized peritonitis and pyelophlebitis were still frequent complications of appendicitis and, if not fatal, led to wound infections, subphrenic, pelvic and intraabdominal abscesses, and often to persistent

fecal fistulas. The mortality from acute bowel obstruction approached 30 percent. The surgical mortality from Graves' disease, in the absence of antithyroid drugs other than iodine, was so high that patients were often denied surgical intervention. Thyroid storm after surgery was not an uncommon event too frequently fatal. A delay of 72 hours after perforation of a duodenal ulcer was almost universally fatal.

Acute gastric dilatation occurred frequently after abdominal surgery, requiring immediate, agonizing decompression with an Ewald tube. As early as 1922, Matas in New Orleans described the use of intravenous drips and continuous gastric suction in caring for patients after major abdominal surgery, and in 1925, Robertson Ward, a member of this society, recommended continuous gastric drainage in the treatment of generalized peritonitis, intestinal obstruction and acute gastric dilatation; however, these methods were not adopted until years later and became known as Wangensteen suction. Destiny seldom rewards the diligent theoretician or the dreamer; it usually rewards those who translate dreams and theories into practical realities.

Mastoiditis, Ludwig's angina, erysipelas and brain abscess were common emergencies, as was acute empyema. Osteomyelitis, almost unknown today, kept a 32 bed ward full of perpetual headaches and, without the aid of modern antiinflammatory drugs, was nearly always fatal in the patient with uncontrolled diabetes. Fractured hips were treated for months in Whitman abduction body casts, and one of four patients died from postmanipulation emboli or pneumonia. All of the serious complications of tuberculosis, diphtheria and poliomyelitis were rampant, with no known means of control. The iron lung was used constantly, as was the Eloesser flap to drain tuberculous empyema. Syphilis was a common disease and the complications of gonorrhea filled the gynecology and genitourinary wards. Ward L, where the prostitutes were confined awaiting three negative smears, was a pelvic museum to the delight of the knife-happy surgical house officer assigned to that ward. On each ward there was a small laboratory where the rotating interns were the technicians held responsible for routine blood, urine and sputum analysis. They made their own Gram stains and crossmatched blood for the rare blood transfusions on glass slides incubated on the top of the steam radiators. Fluids, not tolerated by mouth, were administered subcutaneously or rectally by Murphy drip. Citrated blood transfusions, while in use, were still considered experimental. Blood was usually given by direct transfusion with the use of large syringes or, more commonly, by means of paraffin-lined Kimpton-Brown tubes.

Anesthesia was the province of nurses and interns and consisted almost exclusively of drop ether or nitrous oxide, provided a spinal or local anesthesia was not the surgeon's choice. Muscle relaxation with ether anesthesia, so important in abdominal surgery, was next to impossible, making abdominal closure a long and tedious task. Wound dehiscence and postoperative incisional hernias were all too common in the obese and elderly, who were particularly prone to postoperative atelectasis and pneumonia after drop ether anesthesia.

Acute burns over more than a third of the body were usually fatal because of the lack of adequate knowledge concerning electrolytes and fluid balance, to say nothing of the ravages of uncontrolled infection without the aid of isolation techniques and modern drug therapy. Chest surgery consisted almost exclusively of collapse therapy for tuberculosis instituted by thoracoplasty, pneumothorax or pneumoperitoneum. Resectional therapy, so dependent on controlled intratracheal anesthesia, was yet to come. Posterior gastroenterostomy was still the accepted surgical management of peptic ulcer. Marginal ulcers were common, often leading to the dreaded gastrojejunocolic fistula, the surgical correction of which carried a 50 percent mortality. Peripheral vascular disease of the legs with impending gangrene dictated a supracondylar femoral amputation.

The City and County Hospital, now known as the San Francisco General Hospital, which originally consisted of four separate services, had been reduced to two, divided equally between Stanford and California Medical Schools for teaching purposes; however, the administration remained solely in the hands of the city health department. This arrangement often led to great conflicts of interests particularly detrimental to the expansion of the house staff in keeping with American Board requirements. The surgical house staff on each service consisted of rotating interns, two house officers in surgery, and a third year surgical resident. The third year residency was available to each service only every other year, alternating between Stanford and the University of California.

At that time, 3 years of postgraduate study were considered by many to be ample surgical training. The third year senior resident was shouldered with unwarranted responsibilities, as were the two second year house officers whose background of surgical experience amounted to a few months' rotation on the surgical wards during the intern year. This meager surgical house staff was not only responsible for all of the emergencies in the Mission Emergency division of the hospital but also for the orthopedic ward, the men's, women's and children's surgical wards, the genitourinary ward, and the surgical patients from the large tuberculosis hospital. By present day standards this seems incredible, but even more startling was the fact that the only existing supervision of this undertrained surgical house staff was a group of physicians in private practice who volun-

teered their services at their convenience and pretty much as their private practice permitted. Drs. Edmund Butler and George Rhodes, both early members of this society, were the city physicians in charge of the Mission Emergency division of the hospital. Emergencies requiring urgent surgery were diagnosed by the third year resident, then held for confirmation until the services of one or the other of the emergency surgeons became available, often causing harmful delay in emergency surgery.

Dr. Emmet Rixford, until 1936 the chief of surgery on the Stanford Surgical Service, made his only visits to the hospital when he conducted his weekly wet clinic on Thursday mornings in the operating room. His patients for surgery were selected by the surgical house officer on duty on the male surgical ward. This house officer was obliged to phone Dr. Rixford promptly at 5 o'clock on Wednesday evening to inform him of the cases selected for the wet clinic on Thursday morning. Dr. Rixford was still of the old school, a master technician when he chose to be, but not completely convinced of that nonsense about asepsis. He would wash his hands hurriedly with soda lime, then don a pair of wet rubber gloves and proceed to illustrate his contemplated surgery with colored crayons on sheets of manila paper hung on the back of the operating room door. He would then wash his gloves in a basin of mercury bichloride, adjust his glasses and proceed with surgery. The second year house officer became completely responsible for the postoperative care of these patients. Little wonder that Dr. Rixford had reason to question why there seemed always to be a dearth of major surgical problems available for presentation at his Thursday morning wet clinics.

On the other hand, the second in command, Dr. Leo Eloesser, was the boss. He would come and go at all hours of the day or night and, while he had a tremendous private practice, he seemed to prefer the County Hospital patients. To the consternation of the house staff, it was his habit to visit his postoperative patients after midnight. He was an accomplished musician, a great linguist, a superb teacher and diagnostician, but not what one might call an accomplished technician. He preferred the Percy cautery (what most of you youngsters might call a branding iron) to the cold knife, particularly when dealing with malignancies of the breast, stomach, large bowel and uterus. It became a dramatic event when the red-hot tip of the Percy cautery would melt off the handle and fall into an open wound. His experience seemed to have prepared him for this event, for almost simultaneously he would recover the tip and drop it into a bucket on the floor, change his burned glove and proceed with a new cautery.

Most graduates of this inadequate system of surgical training, which prevailed throughout the country, were simply added to that tremendous pool of general practitioners who vigorously defended their rights to operate. This fact enormously hindered the work of those more fortunate young surgeons who were the product of training programs patterned, for the most part, after the system of surgical training designed by William Halsted. This type of program had taken root in a number of university hospitals, including the University of California and Stanford in San Francisco. Unfortunately, only a chosen few had access to these prolonged periods of training outlined, for the most part, mainly for those interested in academic careers. I, like many others, because of the lack of adequate training facilities in San Francisco, looked elsewhere. After completing 5 years of training in the Middle West and in Europe, I returned home in 1933 and accepted a full-time position on the Stanford teaching staff at the County Hospital. To my consternation, I found that very little had changed since the time of my departure. At the time it was not clear to me why, with such an abundance of clinical material available, the surgical training at the County Hospital did not meet the standards I had encountered elsewhere. I was determined to bring this about.

Fortunately, the surgical atmosphere that had prevailed in San Francisco since World War I was beginning to change. While San Francisco still remained the major referral center for all of northern California, dominated by the surgical giants of the old school, attrition was beginning to take its toll. Times were changing, not only in San Francisco but throughout the country. There was a beginning influx of highly trained young surgeons, the products of institutions that had adopted adequate periods of surgical training.

Dr. Edward W. Archibald, a distinguished Canadian surgeon, in his presidential address before the American Surgical Association on April 6, 1935, first publicly acknowledged that the time had come when surgery in the United States would be benefited by establishing a qualifying body to examine candidates to determine their fitness, after a reasonable education, to practice surgery. It was hoped that, by requiring more exacting and longer training of doctors wanting a surgical career and by holding examinations of those meeting the requirements, the large volume of surgery done by those with inadequate training and experience could be reduced.

After Dr. Archibald's address, the American Surgical Association took the initiative to appoint a committee of six members, with Dr. Evarts Graham of St. Louis as chairman, to consider a plan by which this could be accomplished. They were to respond at the 1936 annual meeting of the association. With this as a beginning, the first organizational meeting of the American Board of Surgery was held in the Palmer House in Chicago on June 9, 1937, to consider the elevation of standards of the practice of surgery and to increase the hospital facilities for the training of surgeons.

The details of the organization of the American Board of Surgery is an interesting saga in itself but will not be discussed here, except to note that it was decided that the Board should consist of 13 members to be allocated as follows: 3 members each from the American College of Surgeons, the American Surgical Association and the Surgical Section of the AMA; and 1 member each from the New England Surgical Society, the Pacific Coast Surgical Association, the Southern Surgical Association and the Western Surgical Association. It was also proposed that those to be certified should be divided into two groups: (1) the founders group, and (2) those certified by examination. The founders group would consist of active and senior members of the aforementioned national surgical organizations named and, in addition, professors and associate professors of surgery in approved medical schools in the United States and Canada.

The certified members would be expected to present themselves for examination after having fulfilled certain requirements, one of which was special training. On October 20, 1937, the Board held its first written examination in Part I. The first examination in Part II was held in Philadelphia in May 1938. The first examination in Part II in San Francisco was not until January 18, 1940: that one I remember well.

At the time that the American Board of Surgery was in the process of organization, most of the surgery in the United States was being performed by general practitioners. Even today, solid manpower data demonstrate that three-eighths of the persons not still in training and performing surgery in this country do not carry the credentials of any American Board or recognized national college. When a group of surgeons affirms that surgery would be carried out only by qualified persons, they are accused of monopoly and exclusiveness. It was only natural that when this occurred a strong feeling of resentment soon became apparent, making it extremely difficult to develop authentic training programs except in the university centers. Unfortunately, this feeling lingers and still prevails in many quarters today.

All of the founding members of this society, by one means or another, had been trained as general surgeons and, while they recognized surgical specialties such as ENT, urology, orthopedics, ophthalmology, neurosurgery and gynecology, there existed a strong feeling that certain aspects of each of these specialties still resided in the realm of the general surgeon. While this attitude was never expressed in writing in the constitution and bylaws of the San Francisco Surgical Society, it was not until sometime after World War II, when so many subdivisions of general surgery developed, that specialization in these fields became acceptable for membership. At a meeting on May 18, 1949, 10 years after the founding of the society, the proposed membership of an outstanding thoracic surgeon was denied because his practice was strictly limited to that specialty. He was not elected to membership until 1956. On the other hand, both Drs. Leo Eloesser and Harold Brunn, outstanding pioneers of thoracic surgery who still practiced general surgery, were elected to membership in 1940.

As a result of the expanding advances being made in the subspecialties and their associated disciplines, the scope of knowledge that an aspiring specialist must acquire has increased dramatically. Not only must the young surgeon enter his field fully equipped with expertise in clinical surgery, but he must also have a sound knowledge of the technological and paramedical fields upon which he will rely in order to conduct his work safely and intelligently. As these specialties have emerged many general surgeons have had direct daily experience with many of the technologies and not only understood them completely but were the pioneers in developing them.

It is certainly predictable that this trend will continue to increase as more and more new ideas, diagnostic as well as therapeutic, enter into the subspecialties. This trend alone makes it more and more essential that the lines of communication between all surgeons be expanded and solidified. At the time that the San Francisco Surgical Society came into existence, these lines of communication were rare, and even though national and regional surgical societies existed, their meetings were held only once a year and were open to a limited number of highly selected surgeons. Outside of the occasional and poorly attended surgical meetings at the old County Medical Society at Laguna and Washington Streets, there was an unfortunate dearth of means of exchange between surgeons of the Bay Area. Each hospital was pretty much a unit unto itself where strong feelings of superiority and jealously prevailed.

Although the great influx of properly trained surgeons that accompanied the population explosion after World War II had not yet infiltrated every niche and corner of California, there was an ever increasing awareness in the surgical community that surgical training would soon be dictated by a National Board. This feeling prompted those hospitals interested in maintaining a house staff to alter their existing programs to meet the needs for Board certification.

In 1939 there were only a few approved residency programs in the United States, and only three in San Francisco came up to Board standards. Soon after the end of World War II the residency programs in the United States were expanded to accommodate returning veterans and subsequently were never cut back. In the absence of a sufficient number of American medical graduates to fill all the available slots, there has been a great influx of foreign medical graduates occupying the vacancies. Many of these have found themselves on a treadmill, stranded in marginal training programs sadly lacking in pro-

gressive educational facilities. One suspects that if the number of residency positions were significantly reduced the graduates would be better trained and would come largely from American medical schools. The surgeons who are members of this society, by close communication with one another, should be able to monitor the level of surgery practiced within our 50 mile boundaries, and certainly San Francisco need no longer exist as the referral center that it was in 1939.

Since the birth of this society, many of us have had the privilege of living through one of the most exciting and productive periods of medical history. The achievements during this period, brought about by advances in our knowledge of cardioangiology, hypothermia, partial and complete extracorporeal circulation, and cardiovascular techniques, have been so rapid and diverse that, for a time at least, they almost completely overshadowed equally important but less spectacular accomplishments in other surgical endeavors. While many of these advances were achieved before 1939, since then there has been an unprecedented explosion of medical knowledge. Antibiotics alone have opened an entirely new vista, to say nothing of antithyroid, radioactive and immunosuppressive drugs. Most of the dreaded diseases and complications so common in the early days of my training have either disappeared or are readily controlled: polio, diphtheria, smallpox, syphilis, tuberculosis, osteomyelitis, erysipelas, mastoiditis and Ludwig's angina, just to name a few.

Sir Harold Stiles, the famous Scotch surgeon and geologist, advised me in 1928 that I had best stick to trauma and orthopedics, for "when you reach my age," he said, "most surgical diseases will have been eliminated." To a degree, he was right, but he had not dreamed of cardiovascular surgery, peripheral vascular surgery, transplant surgery, chest surgery, microsurgery or even orthopedic surgery as we know it today. Lobectomy, pneumonectomy, esophagectomy, kidney transplants, breast implants, hip, knee and shoulder implants, all commonplace today, were not part of his armamentarium. Neither he nor his contemporaries had such aids as antibiotics, chemotherapy, blood banks, hemodialysis, intravenous alimentation, not to mention diagnostic aids such as the flexible fiberoptic endoscopes, radioactive isotopes, intravenous pyelograms, cholecystograms, tomograms, arteriograms, and now ultrasound and CAT scans.

In the intervening years from 1939 until 1980 our society has remained intact. With the exception of the war years 1943 to 1945, the original format of the meetings has continued. The scientific meetings have been held regularly without interruption. In November 1946, the biannual clinical meetings were resumed at the University of California and have continued throughout the area. Although, from time to time, certain minor changes in the constitution and bylaws have taken place, the society has remained fundamentally the same since its inception. As time has passed our attitudes have changed, but not our objectives. We have overcome many of our early prejudices, particularly against the Boards and the subspecialties, so that we can be proud to have had as presidents of our society one thoracic, two peripheral vascular and one hand surgeon.

My paternal grandfather, a surgeon of the old school, died at age 76 in his horse-drawn surrey while returning from an all-night vigil with a patient in the country. Shortly before his death, he said, "I had hoped to live long enough to encounter everything in medicine, but I am not going to make it." His son and now his grandson have lived to appreciate his concern.

A brief glance back over the past four decades attests that surgical knowledge is exploding and that most operations to be performed in the next century may not even have been conceived yet. Let us hope that the expanding stream of surgical knowledge and discovery, so visible behind us, will extend endlessly into the future.