



NEWSLETTER

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Festschriften und Altvater

Festschriften



Eric A. Rose relinquished his Chair this year to continue his, originally sabbatical, overseeing of the development and distribution of an effective, long shelf-life antiviral for Variola.¹ The May 8, 2009, Ninth Annual, John Jones Surgical Day will be devoted to a presentation of papers that will comprise a Festschrift honoring Dr. Rose's remarkably productive, home-grown, 14-year stewardship of our Department. Mark the

date on your calendars - this is no ordinary event. Thirty-eight years have elapsed since co-editors Steve Wangenstein and J. B. Price published the Department's only other Festschrift in the *American Journal of Surgery's* May 1970 issue, which commemorated George H. Humphreys II's 1946-69 tenure. Then you have to go back to the August 1946, volume 24, *Annals of Surgery* which consists solely of 32 papers by Allen O. Whipple's colleagues and trainees. The articles stand in tribute by themselves without mention of "festschrift" or of prior presentation at a festive assembly.

Festschrift is also no ordinary English word in that it has six consecutive consonants and was adopted, along with its pluralizing "en" suffix, directly from the German language without anglicizing. It is a linkage of two nouns that translate separately into ceremony and writing and, when, linked, translate best as commemorative or celebratory writing. Festschrift's English durability is notable for having weathered enmity towards almost anything Teutonic during two World Wars and for festschriften which continue to be published honoring Talmudic scholars.²

Festschriften go back at least to the Age of Enlightenment with the 1776 publication of a festschrift commemorating the 500th year of the Natural History & Medical Society of Heidelberg. Early festschriften were typically honorifics for humanitarian movements, societies, and learned institutions and have gradually transitioned to be predominantly celebrations of exceptional careers and scholarly influence.^{3,4} They are more likely to honor scholars in the social sciences and humanities than those engaged in the natural sciences, which is somewhat puzzling, given the more concrete and less debatable nature of natural science achievements.⁵ Such festschriften characteristically include the honoree's biography, as well as a separate article capturing a unique feature of the recipient's leadership style. Humphreys' era trainees will have no trouble recognizing Fred Herter's⁶ apt characterization of their junior resident rotations' "annual design flexibility."

Program Chairman and Editor, Henry Spotnitz, has already selected a great panel of authors, but he, in common with all other festschriften editors, still faces two difficult tasks. They must be the peer reviewers of their close friends, colleagues, and sometimes competitors, whom they would never peer review under other circumstances, and, ultimately, be solely responsible for the combined submission's quality. Festschrift editors must also be forceful in seeking publication. Journal editors might be honored to be asked, but they have to balance that honor with finite page limits and intense pressure for timely publication of already accepted articles. They also need to take into account the festschrift's inherently narrower readership appeal and its negligible citation indexing. Howard K. Beal (1899-1959), Teddy Roosevelt's biographer and a tireless crusader for academic freedom, once remarked that the festschrift is "a vehicle for the publication of otherwise unpublishable essays." Book sized festschriften typically encounter university presses already biased by having suffered through loosely-edited, unpredictable quality, coupled with predictable limited marketability.

These pressures have resulted in both smaller and book-sized festschriften being increasingly web published and the coining of etymologically abhorrent "Webfestschrift." The first public use of this term was in an October 2003 web publication of "Studies Presented to Boris Ilich Marshak on the Occasion of His 70th Birthday."⁷ Archaeologist, Professor Marshak (1933-2006) probably would have preferred a leather bound tome with gilt-edged pages. But, the new medium did allow for updates, the last noting his on-site death and burial among the 5th to 8th century Panjakent ruins, in northwest Tajikistan, which he had been excavating for 50 years. Pronouncing Webschrift's "W" as a "V," as it would be in German, makes the neologism even more offensive; far better to split it into two well accepted words with a hyphenated buffer because web-based festschriften are here to stay.

Memo to self: Rose Fest, 5/8/09, JJRF pin, typically rains!

Altvater

Friedrich and Magdalena Altvater left Berlin, Germany around 1769, eventually reaching what is now Somerset County, Pennsylvania, in a company of 20 families who founded Berlin, PA, chartered in 1784. They were part of a much larger, late 18th century emigration of Germans and German speaking Swiss seeking greater civil and religious liberty than they had within the Holy Roman Empire. They were mostly Lutherans, Anabaptists, and Presbyterians. Their neighbors and fellow citizens spoke of them as "Pennsylvania Dutch," probably referable to their speaking Deutsch. This proved to be an exceptionally "sticky" label and remains self descriptive of their descendants in southwestern PA and the Ohio River valley.⁸ Altvater was not at all sticky, becoming anglicized within one generation.

Friedrich and Magdalena's great grandson Jeremiah M. Oldfather and William L Whipple were Presbyterian seminary classmates. They and their respective brides, Felicia Rice and Mary Allen had a double wedding ceremony on July 17, 1872 and embarked together on August 2nd for ship and caravan journey to their assigned missionary duties. Their destination was Oroomiah in what was then Persia's (now Iran's) northern most Azerbaijan province, situated immediately south of the now independent country sharing the name.



Princeton Sr., "Oldfather," at age 23

The majority of their life's work was to take place in this area. The Whipples would one day name their oldest surviving son, Allen Oldfather Whipple for these good friends who shared "a three month-long honeymoon traveling 'half way around the world.' It would be as 'Oldfather' that Allen Whipple would be known to his friends throughout his college days at Princeton University." Mary Whipple was destined "to bear 9 children in Persia, four of whom were to die there...William Whipple would also die in Persia."⁹



John M. Howard

So sayeth Ravdin trained, John Malone Howard, Emeritus Professor of Surgery at the University of Toledo Medical Center, and consummate pancreatologist, in his beautiful, cardinal-red-bound, two-volume biography entitled "The Life and Times of Allen Oldfather Whipple - The Missionary and the Surgeon." This is a fascinating, scholarly study of the man and the profound effect of his early life as a missionary among the Assyrian Christians, followed by his devotion to Princeton and his faith, and his successes as a surgeon-educator and inspiring doyen. John Howard relates that he and co-editor, George L Jordan, Jr. of Houston, asked Dr. Whipple to write an introductory historical sketch for their 1960, first edition of "Surgical Diseases of the Pancreas," which has also proved to be rather sticky, last appearing in its 3rd edition in 1998.¹⁰

Professor Howard dedicates his book "To Mrs. Mary Allen Whipple and Joseph P. Cochran, MD [as being] role models for her son and his protégé." Dr. Cochran was Persian born, educated in medicine in America, and returned to found a hospital and then a medical school in Azerbaijan province. He and Dr. Whipple's father were close friends and collaborated to get important things accomplished. The sourcing of Oldfather could be "sub-dedicated" to the thousands of medical students and surgical residents who have been chided in the class or operating room for not knowing what the "O" stood for in AOW's name. Think of the thoroughness that this exposition represents: you want to write about the man, but you need to account for his unusual middle name. To do this properly you are obliged to frame the relationship between the parents and the namesake, and to do justice to that, you must educate your readership about Pennsylvania Dutch, Middle Eastern geography, and Nestorian Christians. Now, it is on to the main part of the story, but only after a thorough exploration of Whipple and Allen genealogies.

"Oldfather" entered Princeton in 1900, finishing high school in

Duluth MN, after the family had returned to the United States. His father, however, felt his calling to go back to Persia, where he contracted typhoid and died in May of 1901, causing Oldfather to defer his final exams and return to Duluth to support his Mother and siblings. AOW attended P&S from 1904-08, completing his medical student days before the Flexner report and doing his two-year internship at Roosevelt Hospital at a time when it would not allow students on its wards. A surprisingly romantic AOW married Episcopalian Mary Neales on September 12, 1912 in the Church of the Messiah, in Woods Hole, MA, where her late father had been Rector.

In 1921, "Sons of Eli," philanthropist, Edward Harkness and P&S Dean, Bill Darrach brokered a Columbia University-Presbyterian Hospital affiliation agreement that bound the two institutions together and ended a decade of fiscally-tepid intermingling.¹¹ Shortly thereafter, 39-year old AOW was appointed Chief of Surgery at the 70th Street and Madison Avenue Presbyterian Hospital, to reorganize the Surgical Department, preside over its move to Washington Heights, and chart its destiny as P&S Professor and Chairman. AOW retired from his Chair in 1946 and departed for Lebanon, as Visiting professor and Advisor to the American University in Beirut, to jump start its new hospital. He returned to New York in 1947 to begin a four-year stint as Memorial Hospital for Cancer and Allied Disease's Clinical Director. In the end, he returned to Princeton to enjoy a busier than it needed to be sinecure, advising undergraduates interested in medicine. AOW's interest in students was sticky too: its contemporary analog, the P&S medical students' Whipple Society, continues to serve as an easy-access forum for students and surgical faculty.

Memo to colleagues: These are two volumes that Al Markowitz would have loved to have read and quote often, and a book set that many of you might want to own or have your medical library purchase. Its ISBN is 978-0-9792058-0-4. It is available through the University of Toledo Medical Center's Department of Surgery. The cost for the two-volume set is \$210, including postage and handling. Checks should be made out to the University of Toledo Foundation, as sales are donated to support research in pancreatic diseases. Mail to Gerald Zelenock, MD, Department of Surgery, University of Toledo Medical Center, Health Science Campus Mail Stop 1095, Toledo, Ohio 43614.

Jim Chandler

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Presbyterian's 2nd General Hospital and Penicillin's Emergence in World War II An Anglo American Drama

With Four Principals and a Strong Supporting Cast

James G. Chandler, John N. Schullinger and Stephen E. Novak

The Principals, in order of appearance:



Alexander Fleming was born August 6, 1881 on a farm in Ayrshire, in southwestern Scotland, as the fourth son and the seventh of eight children. He was destined to become Professor of Bacteriology at the University of London University and St Mary's Hospital, knighted in 1944, and widely honored as a world-renowned medical hero. Professor Fleming died in 1955.



Ernst B. Chain, the son of an industrial chemist, was born in Berlin, Germany on June 19, 1906. He was to hold academic positions in Cambridge, Oxford, and the Istituto Superiore di Sanità in Rome, be knighted in 1969, and finish his career as Professor of Biochemistry at the Imperial College of the University of London. Professor Chain died in 1979.



Howard W. Florey, the third child and only son of a wealthy leather goods manufacturer, was born September 24, 1898 in Adelaide, Australia. His destiny was to become Professor and Chairman of Pathology at Oxford University, be knighted in 1944, and be given a life peerage and the British Order of Merit in 1965. Lord Florey died in 1968.



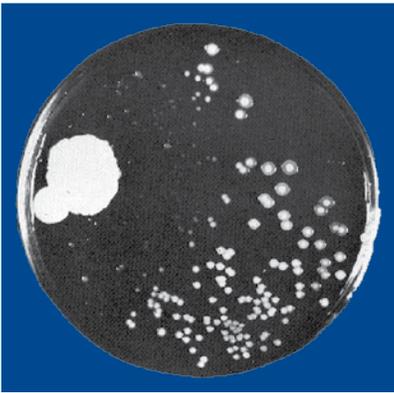
Rudolph N. Schullinger, the grandson of a musician from Vienna, was born March 11, 1896, in New York. He served as a World War I, Army hospital corpsman between Princeton and P&S. "Rudi" volunteered again when the US entered WW II, eventually assuming Command of Presbyterian's 2nd General Hospital, in Oxford, England, and later in Nancy, France. Professor Schullinger died in 1969.

Act 1

St. Mary's Hospital and Oxford and Columbia Universities

Alexander Fleming noted the clear area on his famous beef agar plate of staphylococcus around a contaminating mold that had grown at room temperature during his August summer vacation in early September 1928. Over the next decade, Fleming, working at St Mary's Hospital, near Paddington Station in London, was primarily focused on lysozyme as an antibacterial agent, which he had demonstrated to be ubiquitous in mucous. The rest of medical science was fascinated with the antiseptic potential of dyes, a preoccupation

that would eventually lead to the discovery and synthesis of sulfonamides.¹ This under appreciation of penicillin was all too obvious, when Fleming presented his observations in 1929 to an audience of his peers, who raised no questions and offered no comments. His published paper emphasized the value of adding penicillin to culture media to suppress other bacteria and allow selective growth of *Bacillus influenzae*, which Fleming² knew was completely unaffected by penicillin and, at the time, widely believed to be the cause



Fleming's *P. notatum*, on the left, erroneously first identified as *P. rubrum*, surrounded by inhibition zone.

of influenza. Later sections of the paper noted that his unique strain of *Penicillium notatum* took about four hours of contact to kill staphylococci, streptococcus pyogenes, and pneumococcus; was ineffective against others; was nontoxic, with a half-life of only two hours, when injected systemically in mice; and poorly penetrated tissues when applied topically. Inexplicably,

Fleming speculated about

penicillin's potential use as an injectable antiseptic, but stopped short of the critical experiment - testing penicillin in mice that had been injected with a lethal dose of susceptible bacteria.

The scene shifts up river, on the Thames, to Oxford University, where Howard Florey was appointed Chairman of the Dunn School of Pathology at Oxford in 1935, at the remarkably young age of 37. The Department was unique in that it was housed and initially funded by a bequest from the estate of Sir William Dunn, which freed its pathology teachers and researchers from the burden of routine hospital work. Florey and Ernst Chain, a refugee chemist from Hitler's Germany and other colleagues at Oxford shared Fleming's interest in lysozyme. Chain soon identified lysozyme to be an enzyme that specifically targeted a bacterial wall polysaccharide, N-acetyl glucosamine. They saw lysozyme as a natural defense mechanism that was of questionable clinical utility, since it was mainly effective against non-pathogenic bacteria, and moved on to characterize and attempt to isolate the active substance in Fleming's mold.

Obtaining the mold was just a matter of going down the corridor: Fleming's insistent promotion of penicillin for selective culturing had prompted a Dunn School technician, Miss Campbell-Renton, to have requested and maintain a culture of Fleming's original mold just doors away from Chain's laboratory. Beginning in 1938, Chain and Florey, along with another chemist, Edward Abraham, independently repeated most of Fleming's penicillin experiments. They understood that, like the sulfonamides, penicillin was not bactericidal, but interrupted the process of propagating by division; hence the necessity for prolonged contact. They found that penicillin was destroyed in the stomach, showed that repeated intravenous injections protected mice from uniformly lethal Streptococcal septicemia, and succeeded in extracting an impure, brown, penicillin powder, publishing their results in the *Lancet* in 1940.³ Later in the year Chain and Abraham reported that an enzyme ("penicillinase") produced by *Escherichia coli* inactivated penicillin.

The stage now needs to be partitioned by a narrow, wavy blue curtain with whitecap accents, simulating the high seas of the Atlantic Ocean, so that the action can shift back and forth across it, going left first, to Washington Heights in New York City. The *Lancet* article had attracted the attention of M. Henry Dawson, a Columbia College of Physicians and Surgeons associate professor of medicine, who was recently diagnosed as having myasthenia gravis. Dawson hoped that penicillin might be successful in treating patients with bacterial endocarditis.⁴ His interest in rheumatology and infectious diseases brought many such unfortunate individuals to him, and he found their endocarditis to be almost uniformly fatal, even with sul-

fonamides. Dawson obtained a culture of Fleming's mold and, along with Gladys Hobby,⁵ a microbiologist, and biochemist Karl Meyer, set up a production facility at Columbia modeled on the Oxford process. They made enough for a very low-dose trial that did no harm but did not arrest the endocardial infections. Laboratory scale apparatus was simply inadequate for clinically useful production. Dawson succumbed to his myasthenia gravis in 1945, unrecognized as having been the first person to have given penicillin systemically to a human patient.

To get a feeling for the situation in the US and Britain prior to our formal involvement in the European War in July 1940, the threat of a Nazi invasion of Britain impelled Yale University to organize the evacuation of Oxford faculty's children to the US.⁶ Famed Yale physiologist and Cushing biographer, John Fulton and Howard Florey had been friends since their days together as Rhodes Scholars at Oxford. The Fultons readily accepted Paquita and Charles Florey, ages 10 and 5, into their New Haven home for the duration of the War. The children made this momentous crossing with little advance knowledge for fear of leaking information that might have attracted German U-boat activity.

By June 1941, Florey and his associates had improved the purity of their extract 20-fold over what they had used in their animal experiments, as assessed in Oxford units per ml. Developing a reliable measure of potency was an important step, both for knowing the dosage being administered and for guiding further purification efforts. Norman G. Heatley, Florey's bacteriologist colleague, established one Oxford unit as the amount that will prevent *Staphylococcus aureus* growth over a 26-mm diameter area on a standard culture medium plate. This was eventually found to be equal to 0.6 µg of pure, crystalline, sodium penicillin. They produced barely enough penicillin to do a clinical trial on five patients, necessitating re-injection of recycled penicillin from the patient's own urine in one of them. Penicillin controlled the infections in all instances, but two patients went on to die anyway, one because they ran out of drug.

Having failed to get adequate funding in Britain, Florey barnstormed the US with Heatley in the summer and fall of 1941 with American colleagues, John Fulton and A. Newton Richards, head of Pharmacology at the University of Pennsylvania and Chairman of the US Committee on Medical Research, opening doors for him. They visited the Bureau of Agricultural Chemistry in Peoria, Illinois (a real stretch for the west side of the stage) where a team was working on brewing techniques for the production of useful chemicals. Florey persuaded the head of the Fermentation Division to develop a large-scale cultivation of the mold brought over from Oxford, and left Norman Heatley behind as a collaborator. Fleming's *Penicillium notatum* strain proved to be a unique, yet, inefficient producer - *P. notatum* from other sources did not produce penicillin. A wide search of all sorts of molds turned up a strain of *P. crysogenum* growing on rotting cantaloupe that produced far more penicillin, and was eventually purified as penicillin G. After considerable prodding by Florey, Merck, Charles F. Pfizer, E. R. Squibb, and Lederle all agreed to explore the process of deep fermentation production analogous to the cold fermentation brewing of beer. Heatley was transferred to Merck, in Rahway NJ, to help its commercial development. Pfizer actually had a leg up on the process as they were already producing citric acid from molasses by large batch fermentation, but the company dithered for months, fearing that mold growing might contaminate their profitable ongoing fermentation processes. At the insistence of Newton Richards and the War Production Board, Pfizer began in earnest and instituted a major breakthrough in early 1943 by cou-

pling continuous sterile-air aeration with constant slow stirring so that the mold could grow throughout the huge vats, rather than just on the surface of the brew.

Florey returned to Oxford in September 1941 and received only 5 grams from Merck for all his travels around the US. As a result he was forced to continue his own, all-consuming, scaled-up production at Oxford, which was impeded by Heatley's absence. In January

of 1942, a British dyestuff producer, Imperial Chemistry Industries (ICI), promised relief, by agreeing to enter into penicillin production. Because of the proprietary interests of Merck and ICI, Florey and Heatley became unable to exchange information freely, and, as a consequence, British production used Fleming's surface-growing, less efficient mold, which produced penicillin F that was also less potent than penicillin G.

Act 2

2nd General Hospital, Oxford, England

In March 1940, the US Army Surgeon General invited Presbyterian Hospital's Medical Board to develop a unit similar to the one that the Hospital had staffed in France in the World War.⁷ The Board readily acquiesced, and the scene opens in Maryland, on the left side of the segregated stage, where the main contingent is seen reporting for duty at Fort Meade on February 15, 1942. The Commanding Officer of the 2nd General Hospital is Colonel Paul M. Crawford, MC, USA, formerly the Chief of Medicine at Fitzsimmons Army Hospital, near Denver, Colorado, and having no previous connection with the Presbyterian Hospital. Lt. Col. Yale Kneeland Jr. is Chief of Medicine, Lt. Col. William Barclay Parsons is Chief of Surgery, and Major Rudolph Schullinger is his Assistant Chief of Service. Henry Dawson would have been Chief of Laboratories had his health not been failing. The 2nd General Hospital embarked for its 12-day, zigzag "cruise" through submarine infested waters to Britain in early July. Its destination was the Churchill Hospital, in Headington, just outside of Oxford, which had been built in 1941 to be run by a group of American physicians whose duties were to be assumed by the 2nd General's staff.

The stage's Atlantic separator curtain is drawn up for good, as the assimilation of the 2nd General was phenomenally rapid: Captains Patterson and Stinchfield performed its first operation on a British soldier with osteomyelitis of the femur on July 28th, in a setting of widely accepted principles of debridement and topical sulfonamide use.

The scene shifts to a large hall at Christ College, on October 2nd, where the Oxford faculty is hosting a reception for the 2nd General Hospital staff. In Dr. Schullinger's words: "It was my good fortune and privilege to meet Professor Howard Florey and his wife Dr. Mildred [sic]* Florey, [who was very much involved in the clinical aspects of his work]. In the course of our conversation, they spoke of their exciting studies with penicillin and invited me to visit their laboratory.... Once inside, the visitor could sense an atmosphere of considerable activity.... The process of preparing penicillin was so laborious in the early phases of this work that only carefully selected cases could be chosen for this therapy. In fact, the amount of penicillin was so limited that the urine of patients undergoing treatment was [often] saved and returned to the laboratory for extraction and re-purification for subsequent use."

The scarcity of penicillin was aggravated by competing interests in the British War Department who recognized its value in getting troops infected with gonorrhea back on the line in two days, which affected the soldiering ability of huge numbers in the North Africa Campaign. This needed to be balanced with its morale raising, humanitarian value in salvaging the lives of severely wounded



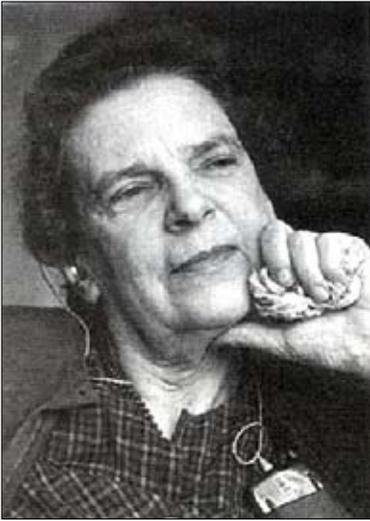
Capt Frank Stinchfield (later Columbia's Orthopedic Chairman & American College of Surgeons President) completing non-trivial positioning and prep for posterior fixation of cervical fracture at Churchill Hospital.

combatants who, in all likelihood, would not return to the field of battle. This conundrum worked its way up to Churchill, who wrote his ambiguous answer in the memorandum's margin: "This valuable drug must on no account be wasted. It must be used to the best military advantage." Moralists interpreted the Prime Minister's words as supporting penicillin's use for those harmed in battle, and hard-pressed unit commanders saw it as an endorsement for getting scallywags back on the firing line.

Proximity made the 2nd General an ideal place for furthering the Floreys' clinical observations, and Rudi Schullinger was the perfect choice to be its on-site Principal Investigator. His probity and calm, contemplative, caring nature assured Colonel Crawford and Rudi's colleagues, as well as the Floreys, that he would be impervious to the clamor surrounding an incompletely characterized, miraculous, wonder drug. His principled approach later became known to the entire command structure through his writing in a report to the Surgeon General that: "The writer cannot too strongly emphasize the importance of adhering to sound surgical principles in the treatment of patients with penicillin. To neglect such practice, with the expectation that penicillin can perform miracles, is pernicious and may even jeopardize a patient's life. It demands too much of penicillin, and nothing could place it more readily into disrepute."

Schullinger began by making several visits to the Royal Air Force (RAF) burn unit at Halton, witnessing first hand the dramatic effect that penicillin had on badly burned fighter pilots. He rounded with Ethel Florey, had lengthy discussions with her and sometimes with Professor Florey, and observed how she meticulously charted what was done. He reported these experiences and the remarkable results that were being achieved through the chain of command,

*Authors' note: Lamb, Schullinger, and Volume II of the US Army's Activities of Surgical Consultant refer to Professor Florey's wife as "Mildred." In all relevant biographies, and in her own book, her married name is Mary Ethel Florey, and biographers, as well as her friends and associates consistently refer to her, as Ethel Florey.



Ethel Florey after WW II with hearing aid for progressive otosclerotic deafness.

but his accompanying repeated requests for the drug could not be accommodated. The ramp-up in US penicillin production had yet to occur, ICI's output was still very limited, and the Florey Group's production was scarcely enough for their primary studies.

Routes of administration, including encapsulation to get past the stomach acid were explored by Ethel Florey⁸ in 189 cases published in the *Lancet* in March 1943, which was to prove timely for Schullinger's work. She and her husband favored every three-hour, 10,000-unit in-

lighted desk, beside a Spartan bed. As he begins to speak, a large white screen quietly drops down behind and to his left on which the relevant data will be projected. His narration is derived directly from Schullinger and his colleagues' observations, hence the frequent use of the first-person plural. We treated 40 surgical patients, exclusive of penicillin's use in freshly arriving casualties, from May 1943 through February 1944. This timing was propitious, and added to the importance of our observations, as the information could be disseminated in presentations to other within-theater medical units preparing for D-day. Two groups of patients were studied: 27 with a variety of infections, including osteomyelitis and some with bacteremia, and 13 patients undergoing operative procedures on compound fractures and soft tissue wounds that were deemed appropriate for penicillin prophylaxis.

The first chart presents an overview of our results with established infections. I will follow that with some illustrative examples, focusing on failures, as well as successes, as the former are typically great teachers. Our dosages and administration echoed Ethel Florey's precepts. We monitored blood bacteriostasis levels to avoid over usage and gage need for supplemental IV penicillin infusion. The

Chart 1: Established Infections

No.	Age range	Diagnosis	Culture	Route(s)*	Days treated	Total dose x1000 u. [†]	Follow up (mo)	% Good outcomes
8	20-36	Osteomyelitis	5 Staph aureus, 2 Streptococcus, 2 mixed or? [‡]	2 IM, 1 IM+IV, 2 IM+L, 2 LO	4-49	400-4,658	0-9	75
5	30-37	Surgically related bacteremia	4 Staph aureus, 1 Streptococcus	3 IM+IV, 1 IM, 1 IV	10-19	1,780-3,000	0-4	80
14	21-51	Other infections	4 Staph aureus, 2 Streptococcus, 7 mixed or? [‡]	8 IM, 1 IM+IV, 1 IM+L, 3 LO	28	300-3,640	0-5	58

*L = local, LO = local only; [†]Oxford units; [‡]potentially inclusive of penicillin resistant organisms.

tramuscular (IM) injection, which resulted in persistent bacteriostatic blood levels immediately before the next dose was due. In cases in which this was not found to be true, the Floreys advised supplementing the IM injections with a background intravenous (IV) infusion. They were also strongly attracted to topical administration and endorsed its effectiveness for culture-proven, susceptible mastoiditis and eye infections and for conserving their limited drug supply.

Finally, on May 8, 1943, now Lieutenant Colonel Schullinger received a consignment of 1 million units, which was followed by 10 million additional units later in the month, all sealed in individual 10,000-unit vials. The consignments came with strict instructions that the penicillin was to be used only on US military personnel. To his credit, however, Schullinger released some of the penicillin for British military and civilian use.⁹ The principles for treatment were the same as those used by Ethel Florey, namely, whenever possible culture confirmation of penicillin sensitivity; adherence to the principles of debridement and good wound care; no other reasonably effective therapy, meaning resistance to sulfonamides; and liberal dosing at the start to avoid emergence of penicillin resistant organisms.

The scene shifts from that of a general area in the hospital to show the narrator sitting on the right side of the stage, at a down-

original 10,000-unit vial packaging was dissolved in 1 ml of saline for IM injections, given every three hours around the clock. With a few exceptions, the patients accepted this unpleasant schedule, as they recognized its value and the scarcity of the drug.

The intravenous (IV) solution contained 50,000 to 100,000 units per liter to be infused over six to eight hours. Local applications involved concentrations of 250 to 1,000 units per ml of saline in cases where the anatomy of the disease was favorable for retaining liquid, such as in an infected joint cavity or sinus. When the wound did not provide good containment we used a cream containing 100 to 200 units per gram, which we had observed Flight Lieutenant Bodenham¹⁰ using with excellent results at the RAF burn center.

Our outcomes with the miscellaneous infections were less favorable than with osteomyelitis and surgically related bacteremia, which will be discussed later. The follow-up column always began at zero months and never reached beyond nine months, illustrating the physician-frustrating follow-up difficulties that are traditionally part of the fog of war.¹¹

Chart 2 shows the details of three of the eight cases of osteomyelitis. The first patient, and the only one with acute osteomyelitis, did not survive. He was treated at a nearby British hospital, where he

Chart 2: Illustrative Osteomyelitis Cases

Age	Site	Culture	Routes	Total days	Total dose x1000 u.	Follow up (mo)	Outcome
?	Iliac bone	Unknown	IM	4	400	—	Death
20	Hip joint	Staph aureus	IM	21	3,340	6	Pending ankylosis
34	Frontal bone	β -hemo Strep	IM/local	19	2,957	5	Full duty

presented with a very high, disorienting fever and acute suppuration of his left iliac bone. His condition appeared to be life threatening, so he was understandably treated without culture identification or confirmation of penicillin sensitivity. The great mistake was to defer opening the wound widely, debriding the infected bone, and tracing the infection to its origin, which could conceivably have been intestinal and penicillinase producing.

Overall, the therapeutic response, after an initial lag period, was typically dramatic. The fever lysed and a striking decrease in swelling and drainage occurred, which were accompanied by a noticeable change in facies, humor, and appetite. The chronic suppurative hip joint patient actually had such enormous appetite improvement that it necessitated changing his spica cast. The frontal-bone case is of particular interest because the sinus lining was completely destroyed and the bone deeply infected with susceptible β -hemolytic Streptococcus, threatening what surely would have been terminal meningitis. Sequestrectomy, covered by IM penicillin, and followed by twice daily local installations over the next couple of weeks resulted in complete resolution and return to full duty.

Look at Chart 3: The first two cases illustrate our experience with surgically related bacterial septicemia. They demonstrate vividly how minor infections could develop into life threatening sepsis and how penicillin could completely abort the process if the organism was sensitive and all grossly infected tissue could be surgically eliminated. The latter criterion was unachievable in the patient who died, as the infection was free to spread throughout the epidural

space. Penicillin treatment for Staphylococcal aureus bacteremia was routinely continued for at least five days after subsidence of the fever, even though blood cultures were typically sterile three- to six-days after initiating penicillin. We believed this was necessary to ensure elimination of Staphylococcal bacteremia. The 10-day course might not have been necessary for treating the β -hemolytic Streptococcus septicemia, had we been able to establish the source and be certain of its elimination.

We turn now to **Chart 4**, showing representative cases from a potpourri of other infections. Our use of penicillin was sometimes less appropriate than it should have been, as exemplified by the periodontitis case, where there was more to be grown than we identified, or retrospectively futile, as in the instance of the brain abscess that was associated with additional unrecognized, undrained abscesses.

On the other hand, sending a soldier back to full duty after treating bilateral hidradenitis was amazing as was the rapid resolution of the lung abscess once external drainage and penicillin came into play. Similarly, getting the chronic granulating face wound ready for successful grafting in less than a week, in the days when only Germans were meshing their grafts, thrilled all of us who cared for him. The disparity among these cases compromises meaningful conclusions. Successful outcomes appeared to be unrelated to dosage, route of administration, or treatment duration. The only conclusion that can be reached with confidence is that, on the whole, several of these very challenging patients had better outcomes than would have been anticipated without penicillin.

Chart 3: Selected Bacteremia Cases

Age	Source	Culture	Routes	Total days	Total dose x1000 u.	Follow up (mo)	Outcome
—	Epidural abscess*	Staph aureus	IV	12	200	—	Died after debridement
32	Furuncle	Staph aureus	IV \rightarrow IM	13	2,400	4	Full duty
37	Cryptic	β -hemolyt Strep	IM+IV	10	1,780	1	Full duty

*Preceded by a cervical furuncle and heralded by the onset of C₆-C₇ pain.

Chart 4: Representative Miscellaneous Infections

Age	Diagnosis	Culture	Route(s)	Total days	Total dose x1000 u.	Follow up (mo)	Outcome
—	Periodontitis	Strep, Staph, & spirochetes	IM	5	1,200	1	Failure
28	Brain abscesses*	Staph veridans	IV	14	3,640	0	Death
37	RLL abscesses*	Strep & diptheroids	IM	3	300	2	Well without drainage
29	Humerus fracture‡	Staph aureus	IM	10	1,185	<1	Improved
21	Hidradenitis	Staph aureus	IM	4	300	5	Full duty
26	Granulating face wound	Strep & Staph	Local only§	6	9.6	1	Healed with grafting

*Secondary to lung abscess and empyema – autopsy showed additional undrained abscesses; †spontaneously ruptured into bronchus before external drainage was provided; ‡Infection secondary to open reduction; §Penicillin cream.

The fifth and final chart summarizes our experience with the prophylactic use of penicillin for surgical procedures. The general rule for antibiotic prophylaxis was [and is] to use it when infection was particularly likely, as in delayed surgical treatment, or when consequences of infection had the potential to be particularly devastating, as with internal fixation of compound fractures. Assessing the value of antibiotic prophylaxis is always difficult. Rarely are comparable control cases available in which prophylaxis was omitted, and technical nuances and properly or ill or conceived treatment concepts are often more important determinants of success or a poor outcome.

For example, Staphylococcus aureus infection followed one operative fixation of compound tibia and fibula fractures, despite irrigating the wound with 10,000 units of penicillin. It could have occurred for many reasons, even assuming that the infecting organism was penicillin sensitive. The treatment concept was flawed: Brief exposure to a bacteriostatic agent belies its mechanism of action, and, as Fleming knew, penicillin penetrates tissues poorly and unreachable organisms thrive in the crevice-laden labyrinth of shrapnel wounds.¹²

Then, there is the issue of residual devitalized tissue, which, in conjunction with implanted hardware, was likely the real culprit. With respect to the soft tissue wounds, one can only wonder if the good outcomes despite long injury-to-operation intervals would have had the same salutary course if penicillin had not been given.

Lt. Col. Schullinger¹³ made several regional presentations describing his results and things that he wished had been done differently in advance of D-day, but his influence was wider than that. Colonel Elliot C. Cutler, Chief Surgical Consultant to the European Theater of Operations of the US Army (ETOUSA), notes in his diary, in April 1944, that he worked directly with Lt. Col. Schullinger in preparing his Directive for the Use of Penicillin for immediate distribution throughout ETOUSA.¹⁴ The 2nd General Hospital left the Churchill Hospital facility on April 29, 1944 to prepare for eventual embarkation to Normandy 21 months after their arrival. During this period, they had admitted 14,950 patients and performed 2,904 operations.¹⁵

Chart 5: Prophylactic Use of Penicillin

No.	Age range	Diagnosis	Injury to Rx*	Routes†	Days treated	Total dose x1000 u	Follow up (mo)	% Good outcomes
8	23-36	Compound fractures	5 h	2 IM, 4 IM+L, 2 LO	1-19	10-390	0-9	75 Union & healed
5	19-38	Soft tissue wounds	10 days	2 IM+L, 3 LO	1-3	1-240	<1-2	80

*Median times; †L = local, LO = local only

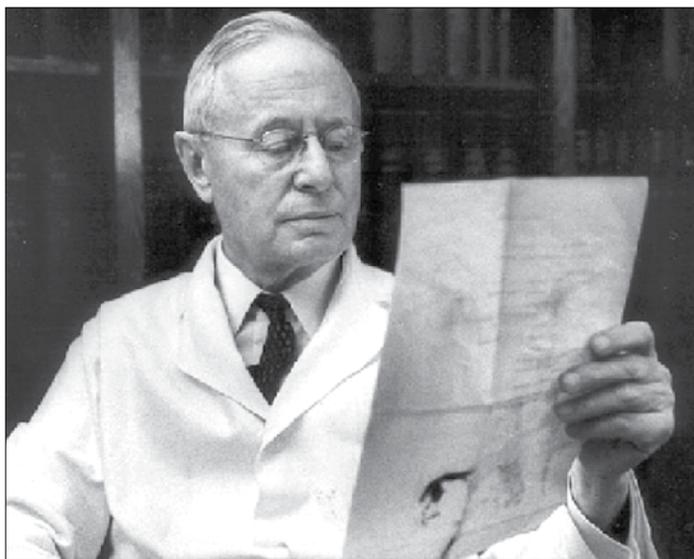
Epilogue

Among the Principals, Professors Fleming, Florey, and Chain shared the 1945 Nobel Prize in Medicine for the discovery and development of penicillin. Lieutenant Colonel Schullinger received the US Army's Legion of Merit, in which his work with penicillin was prominently cited.

Honors from many countries were bestowed upon Sir Alexander Fleming, causing him to travel extensively, including five separate Papal audiences. His diminutive stature at five-feet, six-inches and his taciturn Scotch demeanor left plenty of room for romantic mythology, which Fleming was generally reluctant to deny. The myths tended to eclipse the work at the Dunn School and the careful observations of Schullinger and others in the Allied Expeditionary Forces, as well as the US pharmaceutical industry's enormously successful production ramp-up.

Sir Howard was elected to a five-year term as President of the Royal Society in 1960, where he led with vigor. Peerage did not diminish Lord Florey's work ethic; in fact he worked productively in his laboratory until the evening of his death.

Dr. Schullinger returned to New York to become Professor of Clinical Surgery at Columbia University and Chief of one of Presbyterian's three surgical services. His 20-year tenure as Chief of the West Surgical Service exposed at least 80 finishing residents, including two of the authors, and a host of others, rotating from related specialties and affiliated hospitals, to his high ideals and fine surgical technique.



Chief of Presbyterian's West Surgical Service in the P&S library.

Prosperity blessed some of the strong supporting cast. Two years after its airy 1943 innovation, the Charles F. Pfizer Company was turning out more than half of the world's penicillin production, lowering the price of a million units from \$200 to \$6, and nearly tripling the value of a unit of the Company's stock by the end of 1945.

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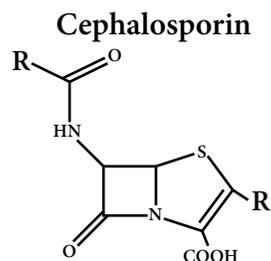
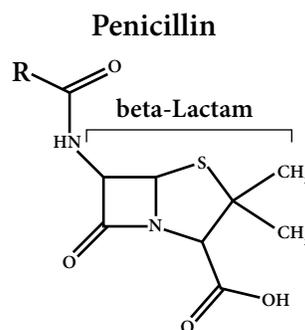
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Norman Heatley returned to the Dunn School at the end of the war and worked with Edward Abraham to characterize penicillin's beta lactam structure and to explore potential modifications that might lessen its vulnerability to gastric acid and penicillinase. An interesting twist merged this interest with that of Giuseppe Brotzu, Professor of Bacteriology at Cagliari, Sardinia. In 1945, Brotzu had identified a fungus in his city's sewerage outfall that exhibited broad antibacterial activity, which he called, *Cephalosporium*, based on its shape. After several years of failing to isolate its active component, he sought help and was advised to send his fungus to Florey's laboratory, which he did in 1949.



Norman Heatley and Edward Abraham recounting their work with semi-synthetic beta-lactams.

Five years later, Abraham and Guy Newton, building on Heatley and Abraham's earlier work, succeeded in isolating and purifying



a second beta lactam, Cephalosporin C. This molecule had an extra carbon in the ring that provided a second substitutable radical (R) site, doubling penicillin's potential for spectrum-broadening, semi-synthetic variants. It was to become the prototype of today's most widely prescribed antibiotic family. Abraham, learning from the laboratory's previous indifference to the economic aspects of its proprietary achievements, patented Cephalosporin C's structure and purification steps, resulting in huge royalties, which permitted him to become a generous patron of the Dunn School.

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Where Are They Now?

Kathleen W. McNicholas, Heart Surgeon, Lawyer, and Patient Advocate

Eric H. Liu



Kathleen McNicholas is a Philadelphia native, Chestnut Hill College alumna, and a 1973, magna cum laude graduate of Jefferson Medical College. She completed her general surgical training in 1978, and then became the first woman, and, one of, so far, only three, to finish Columbia University Medical Center's cardiothoracic training program. She had the opportunity to do an elective

at the Great Ormond Street Hospital (GOSH) for Sick Children during her general surgical residency, which opened the door for her to return to GOSH for a pediatric, cardiac surgery fellowship. Shortly after her return to the US, she was recruited by Gerald Lemole, Chief of Surgery at the Deborah Heart & Lung Center, in Browns Mills, New Jersey, to be the Director of Pediatric Thoracic and Cardiovascular Surgery. Baylor-trained Lemole is known by many as a man who can get big things done without ruffling feathers. In 1986, he decided to develop Delaware's first open heart surgery program. Not surprisingly, he took Kathleen along with him to the Christiana Care Health System in Newark, DE as his Associate Chief of Cardiac Surgery. They are both on staff there today.

Dr. McNicholas recently transitioned from provider to a consumer to have coronary artery bypass grafting, effectively adding an important perspective to her qualifications as a patient and quality advocate. She has also equipped herself with a cum laude JD from Widener Law School, occupies a seat on its Board of Trustees, and is currently a candidate for an LL.M in Health Law. She is following in some "interesting" footsteps. Charles Philamore Bailey (1910-93), Philadelphia's pioneering cardiac surgeon, and Deborah Heart & Lung Center's Director of Cardiovascular Surgery from 1956-61, turned to the Law in his later years, ostensibly to address malpractice issues. It is tantalizing to ponder the impact that Dr. McNicholas' notable experience and education will have in her new role as Christiana Care's Medical Director for Performance Improvement and Surgical Utilization Management. Add in Dr. Lemole's interest

in Integrative Health and you have what should be a very productive mix, well worth revisiting.

What was it like being a woman in an otherwise all male residency?

I was not the first interloper by far: Nina Star Braunwald was already mixing it up with the likes of Dwight Harken, Charles Bailey, Albert Starr, Charles Hufnagel, and Walt Lillehei, and Olga Jonasson had established a transplantation division at the University of Illinois, in Chicago. At CUMC, Barbara Barlow started her two-year pediatric surgery fellowship coincident with my internship year, and Rosamond Kane had been a pediatric orthopedic surgical attending for 15 years.

I did not regard my gender as being a whole lot different. We were all hard working, ambitious people, who wanted to take good care of patients. Generally, I was accepted as just one of the guys. Keith Reemtsma, Tom King, and Dr. Malm were wonderful. Of course there was a little ribbing, but all in good fun without real malice. My dear friend Morrison C. Bethea, who was a few years senior to me, enjoyed stirring the pot. Mo's New Orleans southern gentlemen upbringing simply would not allow him to see the propriety of a woman surgeon. He regularly insisted that that there were more than enough pediatric residencies to take care of "us." One day, I had just had enough and said so to Dr. Jaretzki, who said, "Mo, I think you should apologize." Mo then turns to me and says "Kathy, I'm awfully sorry," and then whispers, "that you're a girl."

Was gender issue equally low key on your GOSH elective?

I was there for six months, and it was really fun. There was a woman ahead of me in cardiac surgery, who had passed through Presbyterian as a medical resident and decided to train at GOSH. I also learned, before I left, that there had been a woman in the program who had committed suicide. The consultants and registrars seemed overly concerned about my happiness. So much so, that I wondered what was going on? I just wanted to work and learn. After a while, I simply became accustomed to their hovering. When you are really engaged in what you are doing, there is a lot you don't notice, like the Seasons. Eventually, my English colleagues overcame their reticence and spoke about the tragedy accounting for their solicitousness. I took this as evidence that I had won my stars and had been accepted as a member of the pack.

You must have seen a lot of changes in attitude over the years

Fortunately, my career has been tightly intertwined with Jerry Lemole's, an outstanding guy, who has been my mentor and friend for more than 25 years. So, I have to say I've been sheltered even though I never actively sought sheltering. It just happened as a natural consequence of working with incredibly wonderful people. Whatever novelty I represented was obscured because I kept up with the pack, and we pack members were bonded by our common goal of providing best patient care.

Women have now achieved a presence in medicine that is a force for change. Personally, I would not even presume to change medicine to suit my needs. But, there is a current market force saying "accommodate us," and it has the leverage of 78 million baby boomers trekking towards medical and surgical consumerism. It is not just women looking for reproductive and family time; it is the guys too. There is palpable pushback from working every third night and having 24/7 responsibility for one's own patients. If I have a patient with a problem at night, I want to be there. In fact, I'm offended if someone does not call me because that is the commitment that most of us made a long time ago. Beepers came into being while I was a resident, and we immediately thought it was imperative to have omnipresent communication. People do not want that now: they are looking for, and advocating, team care, which includes physician extenders. They want hospitalists and acute-care surgical specialists to take care of off-hour problems. I have seen a frightening change in values among those caring for patients with cardiac disease. There is no such thing as a cardiac surgery emergency. You're in the cath lab with a patient with an unyielding near total occlusion and the response you get is: "I'll do him tomorrow. It probably didn't just happen this morning – give him a little heparin and anti-platelet therapy."

Are we on the brink of becoming just technicians?

We are at the precipice. It is possible to just parachute in, do the operation and leave. In London, you rarely saw the attending consultants. They worked their 40 hours, preferably in four days, and then devoted the fifth day to their private practices. Off-hour problems were the province of senior registrars. There were a few high-energy, committed attendings, who seemed to be everywhere at once, but the dominant philosophy was you're not going to get paid more in the National Health System for more work, so I'm just going to put in my hours. When Mr. Waterston did the Prince's appendectomy, he did not even go out to talk to the Queen, because Mr. Waterston just never spoke to families. Your occupation seemed to be less important, since everyone has to work; it was what you did in your free time that was the measure of a person. You have a job; you're a surgeon, great. You're a baker, great. But, do you go to the opera, do you read, and what do you do for recreation? People are no longer willing to work as hard because they do not see glory in doing so. I can't say it is all bad: I have nine wonderful nieces and nephews who do not want to work as hard as I did.

Surgeons can make the team approach work, and the resident work hour limitations are showing us how. Anesthesiologists and emergency room doctors do it all the time. It just requires a different mind-set that happens to offend us dinosaurs. The patients will be our patients, not my patients. Professionalism has to persist but it will take a different form. Responsible hand offs will be a big part of it, as will be transparent, blameless error reporting and hunting down and purging system errors. Somehow, surgical team care has to be squared with the fact that surgical patients have yet to accept

"to err is human." To err as a surgeon is unacceptable; ergo, a surgeon has to transcend being human to meet a self- and patient-set standard. That is a tall order and is my current focus.

Looking back, could you have made more time available for other things?

I have received huge rewards and love for what I have done, but there was another life that I just did not have. Here is a quote from one of my nieces, who is now a political reporter at ABC news. When she was little, she was in a swim meet when I got called out. I told her that I was really sorry, but I had to be at the hospital because I was taking care of a sick baby. She said, "Aunt Kathleen, just once, why don't you disappoint that hospital?" That cut to the core because I realized her prioritizing was well reasoned.

I recognized long ago that I would not qualify as a competent parent because I was an incompetent dog owner. Consequently, hypothetical kids were spared. However, I am a phenomenal aunt, and about to become a great aunt. I think of those nine nieces and nephews as mine and they consider me on a par with their mothers. I was fortunate that my siblings had great children for me to spoil. It is a good plan to let the best parents be parents. I do not think I could have done both good parenting and good doctoring. The inevitable compromises would not have been fair to my children and unthinkable for my patients.

What do you tell female medical students and residents regarding surgery?

I talk to women medical students about the joys of being a surgeon, and particularly caring for children, but my remarks tend to fall on deaf ears. The Pediatric Ophthalmologist tells them that they can have the joys of surgery and helping children without lifestyle compromise. One student thought she wanted to do cardiac surgery, but she was clueless. I was inspired by the giants of thoracic surgery, but I had to be careful to separate my admiration for the giants from the issue of whether I really loved what they did. I have rarely encountered a female student who has looked with enough care to separate one from the other.

I advise women residents that it takes drive and hard work to stay with the pack. Training years coincide with your best reproductive years, so you may have to count on merging a research year with having a family, as time off from a clinical assignment for child bearing is often at odds with the needs of the program. You can't really expect everyone else to take up the slack, but that may be changing as women approach being 50% of the work force – that's honest-to-God leverage.

Ed Note: Congratulations to Eric Liu for this very timely interview. Surgical Oncologist, Janice Pasioka of the University of Calgary, speaking at a symposium entitled "Women in Surgery: International Challenges," at the recent 94th Annual Clinical Congress of the American College of Surgeons began by noting that women surgeons have historically been harassed and even prohibited from practicing surgery by laws and Royal decrees. Despite these obstacles, a small, and often necessarily clandestine, yet durable, contingent could be traced back to Queen Shubad of the Mesopotamian City of Ur, around 3500 BC, whose unearthed tomb was stocked with surgical instruments.¹ Despite the inclusion of male pronouns, necessitated by 16th century surgeons' inability to imagine having a female colleague, women are better equipped than men to fulfill surgeon John Halle's² (1529-68) pronouncement that a gifted surgeon

must have “A heart as the heart of a lion, his eyes like the eye of a hawk, and his hands like the hands of a woman.” Fast forwarding to the end of the 20th century, Dr Pasioka worried aloud about a 1991 to 2005 decline in the slope of the growth curve for women entering surgery, even as women achieved parity or outnumbered male medical students, noting that 60% of female graduates opted for non surgical fields. Although, unbiased by actual data, I think that the 60% figure would be equally applicable to male medical graduates during the same period. Surgery has gone through a popularity trough and is in the process of emerging on the other side.

Fortunately, we have timely proportional gender data covering a 2008-centered decade. Women accounted for 201 of the 1,189 American College of Surgeons, 2008 initiate class, or 17%, reflecting the relative proportion of women among all surgical and surgical specialty

trainees finishing 4 to 5 years ago. Closer to home and right now, 3 of this year’s 7 CUMC general surgical PGY 5’s are women; whereas, women comprise 5 of the 7 PGY 1’s, as well as 18 of the 35 trainees in the program. I see an upturn in that formerly worrisome slope.

Women are a boon to our field; bringing often exceptional technical skills, an expanded values scale, and innate compassion that simultaneously shorten patients’ paths back to good health and broaden their male colleagues’ professional horizons. I shared a secretary with Nina Starr Braunwald at the University of California, at San Diego and had ample opportunity to observe her careful, diligent surgery and clarity of thought. When we arrived, the Surgical Chairman did his best to emphasize my positives in the hospital’s newsletter, even to the extent of treading lightly on the truth, but Nina’s track record in surgery, and in life itself, needed no embellishment.

University Hospital of San Diego County News letter, July 1968

Dr. Orloff Announces Department Appointees



Dr. Braunwald

Associate professor Nina Braunwald, 40, received her under-graduate and medical education at New York University, graduating in 1952. She interned and did 2 years of surgical residency at Bellevue Hospital, then moved with her husband to Washington DC to complete residencies in general and thoracic surgery at Georgetown University. She joined the staff of the NHI Clinic of Surgery in 1958, serving from 1965 as its Deputy Chief. She is our Chairman of Medicine’s wife, the mother of their 3 daughters and an accomplished watercolorist. Dr. Braunwald is the author of 60 publications, performed the first surviving clinical total mitral valve replacement, was named as the outstanding woman in medicine, in 1965, and is the first woman to be elected to the American Association for Thoracic surgery.



Dr. Chandler

Assistant professor James Chandler, 34, was elected to Phi Beta Kappa and received a B.S. with great distinction from Stanford University in 1955. In 1958, he graduated from the Stanford University School of Medicine at the top of his class. He interned at the Columbia Presbyterian Hospital in New York and then completed 7 years of residency in general and pediatric surgery, being simultaneously appointed in his final year as the overall Chief Resident and an Instructor in Surgery. He served in the United States Navy in Vietnam and at the Oakland Naval Medical Center. Although he is well trained in all aspects of general surgery, he has particular expertise in the fields of vascular and pediatric surgery and has a number of scientific publications to his record.

Dr. Braunwald died of breast cancer at the age of 64. Her professional achievements are documented by her admirers, including her husband,³ as well as by her own 150 peer-reviewed publications.^{4,5} Her legacy endures as an inspiring icon for women surgeons everywhere.⁶

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The photograph on page 2 of Allen Oldfather Whipple at age 23 was used with the kind permission of the Princeton University Library’s Rare Books and Special Collections section.

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JJSS at the American College of Surgeons Baghdad-by-the-Bay Clinical Congress

*With apologies to Herb Caen**

The wonderfully speaker-less John Jones Surgical Society Fall Meeting commenced sharply at 6:00 PM, on Tuesday October 14th, in the Olympic Room of the old section of the Saint Francis Hotel.... the room's beautiful cherry wood paneling may well be a 100-year old replacement, as part of the hotel's 1907 refurbishment, following the interior-gutting fire that followed San Francisco's April 18, 1906, 5:13 AM earth quake. The room soon filled with a near record breaking 79 attendees. Jack and Ginny Connolly felt especially at home, having left the Olympic Room as the site of the John E. Connolly Surgical Society's banquet less than 24 hours previously.

Especially Welcomed

For the rest of the City, this was the fine mid-October, mid 70's sunny weather. The fog barely brushed the Golden Gate, and only hung around San Francisco's notoriously fog-prone, most-affluent neighborhoods until 10:00 AM. In the Olympic Room, Andy and Rhoda Whittemore, Mary Collins, and the Neely family were clearly among the especially welcomed. American Surgical Association President, Anthony "Andy" D. Whittemore is the first P&S graduate (1970), and the first Presbyterian Hospital trainee, to occupy that distinguished office since AOW's 1939-40 term....Andy's day jobs are being Brigham and Women's Chief Medical Officer and taking care of patients with vascular diseases....The spirit of 1977-92 Stanford Surgical Chairman, John A. Collins (1933-1992) was especially welcomed and well represented by his wife, Maureen "Mary" Collins." John's spirit also drifted through this year's ACS trauma sessions as speaker after speaker spoke of returning to whole blood as the optimal replacement for shed blood. This eminently logical conclusion echoed those derived by John Collins and Dick Simmons,^{1,2} based on personally acquired in-country, clinical data, 40 years ago....findings that were destined to be drowned out for years by unsubstantiated and unrequited love for cheap and storable crystalloid solutions.

Ethicist and former Chief of Pediatric Surgery at Olive View-UCLA Medical Center in Los Angeles, City of Hope in Duarte, CA, the University of Virginia, and St. Vincent's Hospital in NYC (Whew!) Tony Shaw,³ visiting with Mary Collins and reminiscing about John as an intern and resident....then sitting down with fellow pediatric surgeons Charlie Stolar and Roger Cowles....Tom Tracy,⁴ Pediatric Surgery Chief at Hasbro Children's Hospital in Providence and Vice Chair of Surgery at Brown University, who has been known

to refer to Santulli trainees as "Santullisaurs" (a thinly disguised term of endearment) just missed one on the hoof, as Tony had left to pay his respects to the University of Virginia shortly before Tom's arrival.... Jim Neely, P&S 1953, and Patti Neely chatting with their son Rob, P&S 2008, erstwhile JJSS newsletter contributor (along with classmate Joe Shonkwiler),....and one of only two NewYork-Presbyterian Hospital/Columbia University male PGY-1's (Joe's the other and is Bob and Betsy Mulcare's recently acquired son-in-law).

Notably Missing

On the West edge of town it is undeniably seals: there are none on the famous Seal Rocks viewable from the iconic, several times burned and rebuilt Cliff House....Only sea lions barking and basking on the guano covered rocks (its external ear flaps, you know – the lions have 'em where seals just have holes)....In the room overlooking Union Square and the Commodore George Dewey (1837-1917) Memorial....commemorating his April 30, 1898 invasion of Manila Bay on the cruiser Olympia....Olympic, aha!....and back to Notably Missing Jack and Joan Jacobson, who were guests at the ACS Governors' dinner....Delores Levin (wife of Shel and recuperating from the art and science we practice).... Jim McKinsey, Columbia/Cornell Vascular Service Chief, who chaired the ACS "Surgical Heroes" session attended by most of the College's 300 medical student guests.... a Missed Pied Piper Opportunity....the student guests must have included a Whipple Society member or two.... let's resolve to have some students at our party in Chicago. And, thinking a little further into future, regular attendee, Miss Kathryn Horvath stayed home to take care of her father, Fred, while her Mother, Washington University's Surgical Training Program Director and a 2008 ACGME (Accreditation Council for Graduate Medical Education) Parker J. Palmer Courage to Teach Awardee⁵....Surgical Oncologist....and ACS Surgical Forum Committee member (Whew squared!), Karen, downed JJSS's traditionally delicious shrimp in amounts befitting her role as sole proxy for the Horvath family. Which brings us to ice...those coral and white beauties with the bright red tail flippers as their only remaining appendages were carefully laid out in neat, single-layer rows on glass...prompting many to scoop them up before they were warmed by the heat of the crowd. Kudos to Ms. Hargaden for having a SPAR (Shrimp Per Attendee Ratio) of 2.5, despite more numerous than expected attendance.

*Pulitzer Prize winning, run-on sentences, columnist Herb Caen (1916-97) worked for the San Francisco Chronicle from the late 1930s until his death from lung cancer, with a salary dispute related, 1950-58 interruption, when he wrote for the Chronicle's former and since merged rival. Caen is credited with coining the term "beatnik" and commonly referred to the city as Baghdad-by-the-Bay for its multicultural exotic mystique, think Scheherazade and Arabian Nights, not the contentious Mesopotamian city of today.

Campaigns and Lapels

Seen in the dark hallway, purportedly by more than one observer, Saturday Night Live's Tina Fey studying Trisha Hargaden's mannerisms and movements as she tries to paste something on every one's nice blouse or jacket, while keeping tabs on who's arrived, playing society photographerand handing out, or pinning on, JJRF lapel buttons. The current election cycle is near its end, and Tina is being spotted everywhere these days, as she cannot afford to be hemmed in by preconceived or parochial opinions about where new material might be found.



Lapel Pins...Buttons...Emblems

As shown in the figure, lapel pins...buttons...emblems... are thrust and pinned upon us to signify we decry something... cigarette smoking...have given to charitable foundations, or Political Action Committees... survived 50 years after graduating from somewhere....don't like either current candidate...went to sea in the USS something... or slept in tents as a Navy doctor with the Marines and haven't a clue about who or what to salute

when boarding the USS something or other. Only one, hence, twice-represented, lapel pin...button...simply signals, "I like the concept." In this instance it's the character and purpose of the John Jones Research Fellowship's requirements that applicants have a two-year project in mind and committed sponsorship for its second year to be eligible for the Society's dollars. That's competitive and demandingly selective because we are seeking to nurture excellence. The work can be done on P&S' 17th floor or anywhere in the world. That's unusually liberal because we want to support excellence and have no precon-

ceived or parochial view of where a good fit for an excellent candidate might be found.

Happy to See Again

For the City, it was the Blue Angels against the blue sky, buzzing, zooming and later screaming (the relative slowness of sound) in tight- and coming/towards/each/other-formations.....skimming over the Trans-America building and reaching Walnut Creek in 1/500th of the 4:00 PM weekday going-home commute time from San Francisco's financial district. In the embrace of the Olympic Room's wood, NCI "lifer" Steve Libutti might just be about to return to the New York city area.....UCLA Vascular Surgery Chief, Peter Lawrence fingering his new lapel button....Patricia Sylla extolling the virtue of the Grateful Dead, San Francisco's 1960's rock band's NOTES (or so I thought).....she was talking about Massachusetts pigs and Natural Orifice Trans Endoscopic Surgery.... Peter and Judy Dillon from Chocolate Town, PA, yet another Pediatric Service Chief and Surgery Vice Chairman, this time at Pennsylvania State University.....reminiscent of running into David Kay's (Chief of Surgery at Shand's Children's Hospital in Gainesville, FL) mother-in-law at an unrelated venue last year, who proudly proclaimed that her daughter was married to the "World's expert in congenital diaphragmatic hernias, and that they were recently in NYC at a retirement for his boss.".....she didn't recognize R. Peter Altman's name....but no matter.....and no wonder everyone was happy and having a wonderful time at this year's party....it's great to be a JJSS member....along with so many Chiefs, as well some notable Indians, and, although neither was at the party, the boss of a World's Expert....or looked at another way, a group of accomplished surgeons, bonded by respect for each other and the special esteem that they hold for their former mentors, who are now usually also their good friends.⁶ See you in Chicago, on Tuesday, October 13, 2009.

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Danny and Tonja Feingold with Steve Libutti



Henry Spotnitz and Louis Ivey



Andre Campbell



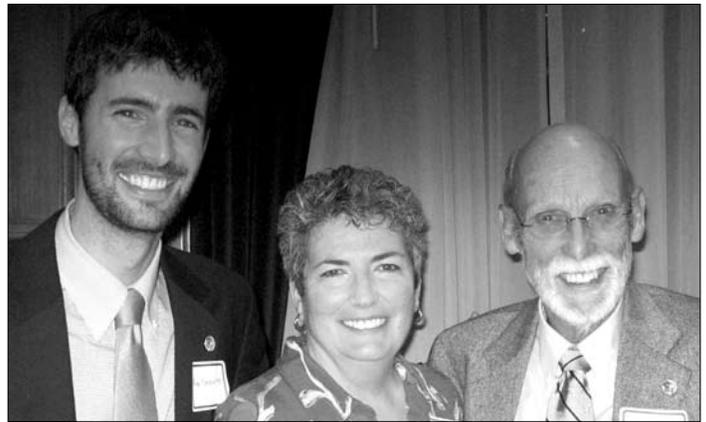
Michele Nogueras and Judy Dillon



Majorie and Thomas Magill with Mary Collins



Patricia Sylla, Mahmoud El-Tamer, Julie McGill Fogarty and Sheldon Feldman



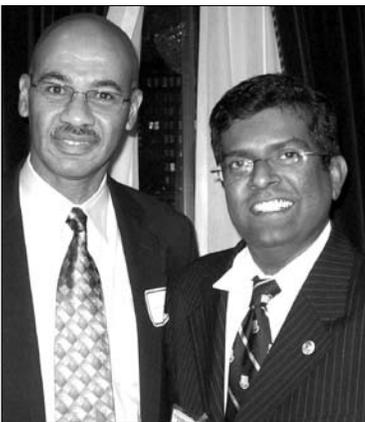
Rob, Patti and Jim Neely



Tony Shaw, Bob Cowles, Charlie Stolar, Marilyn Butler, Jonathan Greenfeld



Ann Larkin, Karen Fried and Karen Horvath



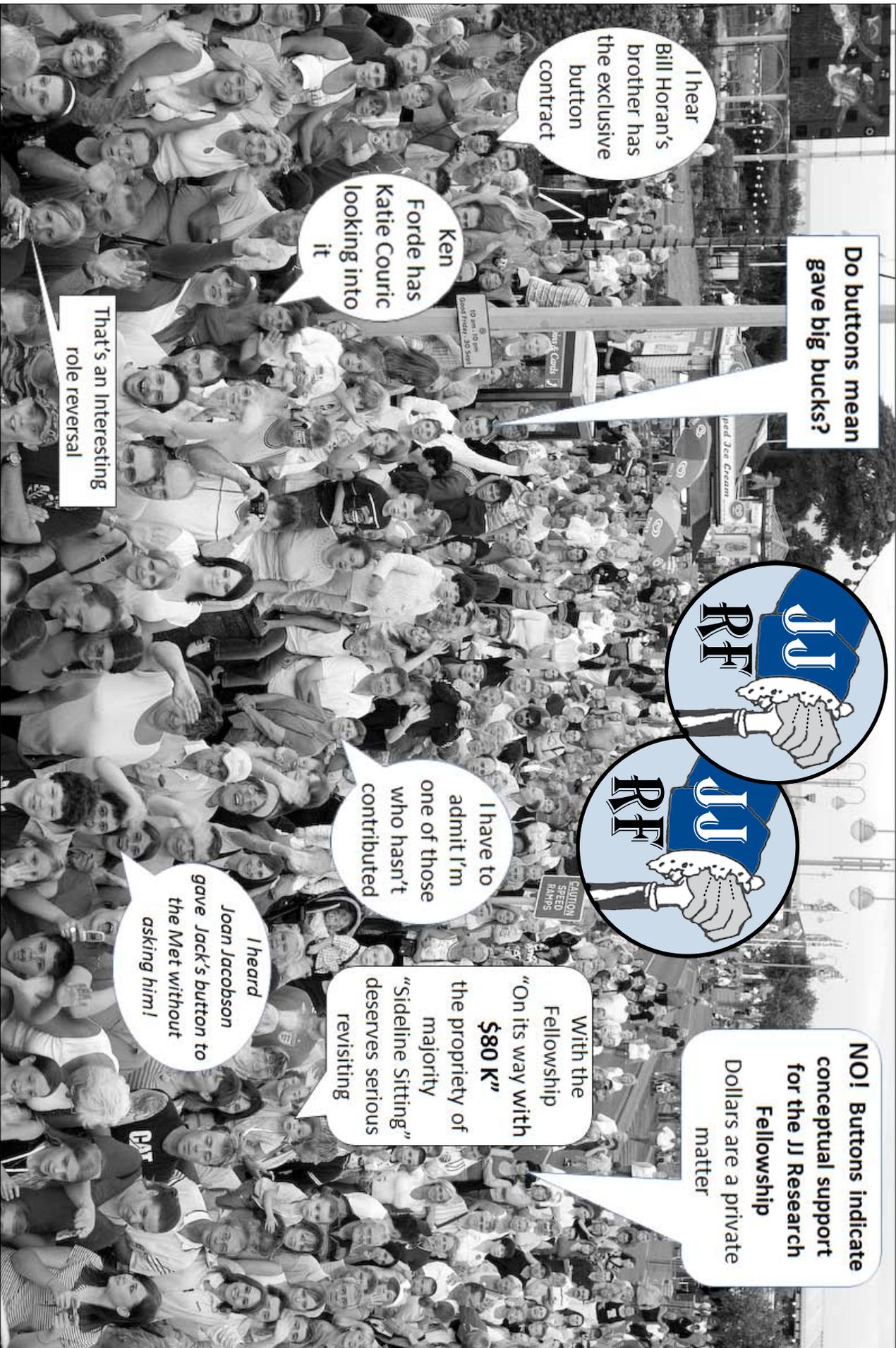
Spencer Amory and Siva Vithiananthan



Juan Nogueras



Claudette and Dennis Dove



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