Tape # 13

Dr. M. E. DeBakey

Houston, Texas

8/14-15/72
Ends in middle of Harvard Anecdote
Side A.

SCHANCHE: One, two, three, four, five. Five, four, three, two, one.

DR. DeBAKEY: Well,..

SCHANCHE: Where was this?

DR. DeBAKEY: Well, you see, you have to go back to that period. At that period in time, blood transfusion was no further than its infancy. And it was used as.. It was kind of a major effort to give a blood transfusion. And the experience with..clinical experience with the use of blood transfusion was relatively small. There were.. There had been some pioneers who had developed various ways--techniques of doing it, but as I say, it was kind of a major effort. Almost a major operation.

SCHANCHE: How was it done?

DR. DeBAKEY: Well, there were several different ways it was done. One was to take syringes of blood from a donor who was lying next to the patient. And you would take the blood--50 cc. and inject it into the patient. Another way was to take it in a large container, glass container, that was coated with a kind of a paraffin. The idea being to keep the blood from clotting during that period in time. That was the so called pressure tube, if I remember. Then.. And I wrote a chapter. ..Well, I wrote a book with another man on blood transfusion. And I wrote.. One of the chapters that I wrote in the book was on the history and it tells all of this.

Then there came into being a method by...where you do a direct transfusion from the donor to the recipient by using tubes that connected to two needles and you pull it out in the syringe and then turn the stop-cock and then you shove it back into the recipient. So that there was no good, efficient, easy way to do it. But it almost

DR. DeBAKEY: had to be done by...directly from a donor who was there. There was no way to preserve the blood. That came into being much later. So..

SCHANCHE: Bleed and often develop embolisms and that kind of problem?

DR. DeBAKEY: Well, the blood would clot while you were doing this so that you often made a mess or you never got it all done.

Well, as I say, I was working in the laboratory at the time trying to develop a pump to make a model for circulation--the study of circulation outside the body. I was interested in pulse waves and that sort of thing. In fact, the blood flow of people. When I perfected the pump for that purpose, then it became apparent that I had a pump which could be used for blood transfusions.

SCHANCHE: This was the roller pump?

DR. DeBAKEY: Yeah. And so we began using it for blood transfusions.

SCHANCHE: Before that though didn't you design an improvement on that...

DR. DeBAKEY: Yes, what I did was I designed a.. Well, actually it was based upon, you know, in motors in the automobile, there is what's called a sleeve valve. It's used..was used in old motors, you see, to shift the intake and output of gas going into the cylinder. And it was called the sleeve valve. Well, I just used.. All I did was borrow that principle, you see. And I made a sleeve valve that automatically when you hold back on the syringe, the sleeve pulled back automatically and pulled the blood from the donor. When you were ready to shove it into the recipient, the sleeve shifted and that changed the direction of the flow to the recipient. So all you had to do was hold it like that and go up and down.

SCHANCHE: Is that thanks to your taking cars apart when you were a child?

DR. DeBAKEY: Yeah, exactly. I knew that principle. When I was a kid, I used to take cars apart and learned all about

DR. DeBAKEY: the motors. So, I knew that principle and just applied it.

SCHANCHE: You used it clinically?

DR. DeBAKEY: Oh, yes. Oh, yes. Quite successfully. As a matter of fact, they made quite a number of these and sold them all around the country. And then when I made the roller pump, with this past experience on transfusion, I realized I had a much better way of doing it. So all I had to do then was to sterilize the tubing and the needles. And I'd just take my pump around. I used to give blood transfusions all over the hospital because I was so expert at it and everybody that wanted a blood transfusion on a patient, they'd call me and I'd have ten, fifteen, twenty of them scheduled in a day. And I'd go around and give them.

SCHANCHE: Were you then a resident?

DR. DeBAKEY: Yeah.

SCHANCHE: Or an intern?

DR. DeBAKEY: No, I think I was an intern--no resident. I guess I was a resident.

SCHANCHE: When you first used it clinically, then you first tested this with animals or?

DR. DeBAKEY: Oh, yes. Oh, sure. We tested it on animals, in fact were doing some experiments on them.

SCHANCHE: With what? Cats, dogs?

DR. DeBAKEY: Dogs.

SCHANCHE: Dogs. And did you have no .....?

DR. DeBAKEY: No, I could give 500 cc. of blood in five minutes or less. And that was less time than the blood would clot. The blood was outside of the body such a short time.

SCHANCHE: Right. What was the previous rate in the old fashioned method? 50 cc. in five minutes?

DR. DeBAKEY: Well, in the old fashion method... Yeah, well, yeah. It would sometimes take longer than that and then sometimes it would clot and everything..all your equipment was clotted. You have to start all over.

SCHANCHE: You couldn't go on.

DR. DeBAKEY: You couldn't go on. It was a mess.

SCHANCHE: Do you remember when you first used it clinically?

DR. DeBAKEY: Yeah, sure.

SCHANCHE: What was the situation?

DR. DeBAKEY: Oh, you mean the exact patient I used it on first clinically? No, I'm afraid I don't remember the exact patient. But, I remember this. Shortly after I started using it, there was a doctor's wife who is still living in New Orleans. He was a classmate of mine. No that's not quite correct. He was in the class ahead of me. But we were interns and residents together. So we were colleagues. And very fine old French family in New Orleans. And his wife had a gynecologic condition where she was sort of bleeding from the uterus. Well, it was actually... it was following delivery, I think. And they couldn't stop the bleeding. She kept on bleeding. She nearly bled to death. And they couldn't get blood into her fast enough. And they called me to come and help them. She was in another hospital which was several blocks away.

SCHANCHE: What was the name of the hospital?

DR. DeBAKEY: The Hotel Dieu.

SCHANCHE: Was it late at night, do you recall? Day time?

DR. DeBAKEY: I think it was in the late afternoon or evening. Anyway, I got there and she was white as a sheet and really almost bled to death. And we had donors lined up for her, so I lined them up and started my transfusion almost immediately. And in a matter of a few minutes, I had replaced her blood--just a few minutes--five or ten minutes. And she was breathing again and doing well, you know. Her blood pressure came up. She was in shock--apparent shock. And, you know, they all felt I had saved her life and they've always felt--you know, they still refer to the fact that I saved her life.

SCHANCHE: I'm sure that's true.

DR. DeBAKEY: There was no way you could have gotten blood into her that fast. And I just quickly got this blood right into her from the donor.

SCHANCHE: This you.. You worked your pump manually?

DR. DeBAKEY: Yeah. Yeah.

SCHANCHE: What happened after that? You used it all around New Orleans because you had it...

DR. DeBAKEY: Oh, yes. I even took it to...when I went to Leriche's Clinic, I took it with me. And I used to get blood for them.

SCHANCHE: For example?

DR. DeBAKEY: Yeah. Well, Leriche would ask me to come and give blood on his private patients. Yeah. I wrote an article while I was there, by the way.

SCHANCHE: Was it developed subsequently by others and used?

DR. DeBAKEY: Yeah. And actually the pump was used for a number of other purposes. And is still being used for a number of other purposes. It was used, for example, for feeding purposes. You see, you put a motor on it, you can control with rheostat , you can control the rate of the pump. And so, it was put on the market and sold and used, not only for transfusions but for other

DR. DeBAKEY: purposes. And, of course, the greatest use, of course, came with John Gibbon--the heart-lung machine.

SCHANCHE: Yeah. In developments like this, I know you never patent them. Is this generally true of the profession. Doctors simply don't patent this kind of thing?

DR. DeBAKEY: That's right. The instrument companies will often record them. They have an association which allows them to rec...to sort of record the thing, and therefore get priority and also and the companies ethically respect the companies that do this.

SCHANCHE: They don't trespass on their...?

DR. DeBAKEY: That's right, exactly.

SCHANCHE: ...priorities. Do they have any system of retaining the doctor or institution that's responsible for the invention?

DR. DeBAKEY: No.

SCHANCHE: Nothing ever comes back from this? Monetarily and so on?

DR. DeBAKEY: No. I think there are some things like.. I think they patented one of the vitamins, for example, at the University of Minnesota and it was put into a foundation and used. Things of that sort. They'll do something like that from time to time. But generally speaking most instruments are not patented by surgeons, for example, that develop them. Frequently they're sold or identified by their names, but that's all. I have some fifty odd instruments that I designed for--that Penning makes, for example--and they're sold as my instruments, but they're not patented.

SCHANCHE: Do you remember other stories about that--about the transfusion device besides the doctor's wife?

DR. DeBAKEY: Well, you see, at that particular time it made quite a nice, sort of advance in the clinical application of transfusions. But, it wasn't too long after that before the preserved blood saturated, I mean, stored blood--refrigerated blood--came into being. And once that

DR. DeBAKEY: came into being, why then it wasn't necessary..

SCHANCHE: Patient to patient transfer.

DR. DeBAKEY: That's right. Now, then, you see, the war came along and by that time the preservation method was perfected. And blood was even flown preserved. The war really--you know, sort of accelerated that particular development. And then, so there wasn't any longer any need to give that kind of a direct transfusion.

SCHANCHE: What was the next important step in medicine that you took after that?

DR. DeBAKEY: Well, I would say that from that point until the war I was really mostly... Well, I'd been to Leriche's then I'd come back and gotten started in vascular surgery and then the war came at us. So then I went to war for four years. Just preceding the war, I also began to sort of pioneer with Dr. Ochsner opening the chest. Opening up the chest and doing blunt surgery on the chest. So I became a thoracic surgeon, so to speak,

DR. DeBAKEY: and did work with him on cancer of the lung and resections of the lung, resections of the esophagus, certain types of surgery that we did for coronary disease, like.. They were sympathectomies really. But, the war then intervened and, of course, that had a profound influence upon my whole thinking. It opened up my whole idea--you know, my whole vista and horizons. It gave me a much broader and greater understanding of the political process, of the national role, and that sort of thing.

SCHANCHE: Did it give you more confidence in the feeling that you could move things?

DR. DeBAKEY: Yes. Yes. Because I did move things.

SCHANCHE: Whereas, earlier you made no effort to do this?

DR. DeBAKEY: No, I wasn't...well, I wasn't even aware. I had no awareness of these things. But the next clinical development took place here. Because I.. Shortly after the war, I did move here. And then I began

DR. DeBAKEY: to develop my department and then to develop a research laboratory and to work more directly in the cardiovascular field.

SCHANCHE: To go back to 1939, even though a good deal of it was speculative, you and Ochsner were voices in the wilderness linking smoking and lung cancer.

DR. DeBAKEY: That's right. Well, you see, actually we... What we did really was not entirely original, because there were others that had linked smoking and cancer of the lung. You've got to remember that in animals it's possible to demonstrate certain aspects of tobacco products producing...being cancerogenic to various types of animals, whether it's the lung or other areas of the body. And there had been some experimental work that had been done--that had linked it. Now, we were impressed, like others, with the fact that there was a steady and rapid phenomenal increase in cancer of the lung. And this concurred statistically. And

DR. DeBAKEY: looking around for various possible causes for this, smoking seemed to be an obvious one because of the increase in smoking that was taking place. This is particularly demonstrated by the statistics on the production of tobacco in this country. It had rapidly increased, and it had increased particularly since World War I. And with the, you might say, the manufacturing of cigarettes in the form that they have been manufactured--see, prior to that time, people smoked but there wasn't... They smoked cigars and they smoked pipes and chewing tobacco and, or they Bull Durham--you know, they made their tobacco to smoke it. But with the machines that came along to develop cigarettes, why there was a great increase in it. And when you plotted the rise in the production of tobacco, you found that it paralleled the rise in the incidence of cancer of the lung. So we pointed that out and spoke about it.

SCHANCHE: You did a number of reports in '39, '40, '41 on cases.

DR. DeBAKEY: That's right. Exactly. Exactly. We had an interesting experience at one of the medical meetings. Dr. Everest Graham, who is one of the great pioneers in thoracic surgery, challenged this sort of hypothesis at one of the meetings. And he did it in a very sort of devastating way because he pointed out that if we use those kind of statistics, that he was sure that if you took the increased production of nylon stockings, you would find out the same thing. See?

SCHANCHE: Or automobiles, or...

DR. DeBAKEY: Yeah. But the interesting part of that story is that Dr. Graham later became converted to that hypothesis and was a stronger advocate of that hypothesis than anyone. And then finally died from cancer of the lung.

SCHANCHE: Were you laughed at frequently at medical meetings? I know.. I've heard stories that people were actually being rude to Ochsner over this.

DR. DeBAKEY: Well, I wouldn't say we were laughed at, but we were in those days--we were in the minority. And we were in a sense subject to a certain amount of criticism for taking such a strong position on it.

SCHANCHE: Did you get pressured by the tobacco interests or any others?

DR. DeBAKEY: No. I think they disregarded it at that time.

SCHANCHE: Two nuts down at Tulane.

DR. DeBAKEY: Yeah. But later they did take cognizance of it, of course.

SCHANCHE: Were you subjected to any other notable criticisms, other than Dr. Graham, that you recall?

DR. DeBAKEY: Well, I would say that there were others, yes, who were critical of it, but politely so. I wouldn't say that they were..

SCHANCHE: Do you have any memorable flashes on ....?

DR. DeBAKEY: No, they.. You know, at the meetings they'd tend to be gentlemanly about it. Even Dr. Graham was gentlemanly, but he did make this remark, you see,

DR. DeBAKEY: and in a sense, it was kind of a devastating way of putting it. And, of course, he got a big laugh. It was understandable.

SCHANCHE: Did either you or Ochsner have a reply to that?

DR. DeBAKEY: Well, only in this sense, let me point this out. That if you use that kind of reasoning, of course, then you would have to point out that there are many other things that would not have any remote relationship. But the fact is that there is some experimental evidence to indicate there is a relationship between smoking and the production of cancer of the lung in animals. And there isn't for nylon stockings, you know.

SCHANCHE: Ochsner became something of a missionary in this conflict, but you never did, really, did you?

DR. DeBAKEY: Well, you see, my interests.. You see, he stayed in that field. He didn't get into cardiovascular surgery. My interest was in cardiovascular surgery and so I never did.. I wrote one article when I was president of one of the societies in which I as a presidential

DR. DeBAKEY: address--called attention to this for the last time really. It was the last time I was outspoken about it, as important a health matter to the people of the country as any epidemic and therefore should be regarded as such and therefore given that kind of priority. But that was the last thing I said about it. From that point on I was really a missionary for cardiovascular disease and I was trying to spread the word there. So I had to, in a sense, devote my time and energies to the area that I was primarily interested in.

SCHANCHE: Did you, when you were working with Ochsner, didn't you perform some of the first complete pneumectomies.

DR. DeBAKEY: Yes, oh yes. We were..

SCHANCHE: Were they successful?

DR. DeBAKEY: Oh, yes. We didn't perform the first successful. Dr. Graham did that. But we were right on his toes--right behind him--right on his heels. And we had the largest series for quite a while. We did more of them.

DR. DeBAKEY: And we had a.. And we did more of them successfully, so that we had quite a nice series, nice experience and we reported all of these. We did the same thing in carcinoma of the esophagus too. We had a nice, large series. So that we were among the pioneers in the field.

SCHANCHE: As surgeons were you apprehensive about this kind of pioneering surgery?

DR. DeBAKEY: Well, you know, when you say apprehensive, you've got to keep in mind that when you're starting any new field, you're apprehensive. Not because of any sense of apprehension that you can do it. You have the confidence of being able to do the job. You're apprehensive about the success. And what's going to happen, you don't know. So you always begin this kind of development with a certain degree of concern and anxiety, but you're not uptight about it. I don't think you're ever uptight about it.

SCHANCHE: Well, describe for me if you can the manifestations of the anxiety that you feel.

DR. DeBAKEY: Well, I think it's mostly...

SCHANCHE: Going back to the first pulmonectomy you did.

DR. DeBAKEY: Well, I think it's best described as sort of being concerned with whether or not it is...it's really justifiable. You don't know whether it is. And you don't know what the success rate is. And until your success rate is written up, why it may not be. Now you take, for example, when I did the first successful resection of an aneurysm of the aortic arch, which was the first one, it was successful. And I was sort of jubilant, you see, with the fact that it was successful. It was a tremendous challenge and I succeeded in getting it done.

SCHANCHE: You did this with a shunt?

DR. DeBAKEY: Yeah, that's right. With a shunt. Now we did... Then I did several more and they were all failures. Well, I, you know, that shook me up and I was really concerned that maybe this was a fluke that the first case was a success, you know. And then to have three or four of

DR. DeBAKEY: them go bad. And, there are little complications that can occur that..over which you really don't have any control, exactly. You don't.. You can't be sure. The patient's under an anesthetic. And you don't know what's happened or why. He wakes up and he's paralyzed or he's had stroke or so on, you see.

SCHANCHE: These are things you can't know until the anesthetic wears off.

DR. DeBAKEY: That's right. Exactly. And so, you have that kind of anxiety and.. I was so concerned about this that frankly I had to stop and wonder whether I ought to do any more.

SCHANCHE: The arch one?

DR. DeBAKEY: Yeah. And it was only because of the pressing necessity of doing something to a patient who is suffering and going to die that I felt justified in doing something more. Trying it again. That's what I mean by the kind of anxiety you have. If you're going to have a success rate

DR. DeBAKEY: of 5 percent or 10 percent, it's not very good. And that's the kind of anxiety you worry about.

SCHANCHE: Like a pitcher who wonders if his arm's going to hurt.

DR. DeBAKEY: Yeah. That's right.

SCHANCHE: Well, what sorts of things go through your mind, if you can recall, when you're a young surgeon and you're just beginning to assume major responsibility. You've been well-trained so you have some kind of ability to do things.

DR. DeBAKEY: Well, you see, if you've had any experience in surgery, when I say experience I mean if you've been through training and you've seen a lot, you've helped on a lot of cases, you know that all kinds of things can happen. And go wrong. All kinds of complications--many of which you have no control over. For example, I remember a patient that I operated on who did extremely well. And I went by to tell him good-bye. He was

DR. DeBAKEY: perfectly well, ready to go. His wound was healed. Walked out with his wife to the elevator and dropped dead right there at the elevator. Because, they were leaving.

SCHANCHE: What kind of an operation had he had?

DR. DeBAKEY: He had had a Leriche syndrome that I operated on him for. Well, that shakes you up. And when you get a post-mortem on him, you find he's had a pulmonary embolism. Massive pulmonary embolus. You see? All the manifestations were silent. There was no evidence that this was going to happen. Now you have no control over that. There's no way to prevent it. And it almost.. You get the sense that this is fate. That this was his time to die, no matter what you did for him. You have no control over it and even though this happens very infrequently, this happened to you. You know it can happen.

SCHANCHE: Is this an awareness that comes to you fairly early in your career?

DR. DeBAKEY: Sure.

SCHANCHE: When did it come to you?

DR. DeBAKEY: Oh, it came to me in my early experience in surgery, because I saw it happen. I saw it happen.

SCHANCHE: This is a knowledge you acquire as an intern and a resident.

DR. DeBAKEY: That's right. Exactly. Exactly. And, you see, the incidence of some of these complications is relatively uncommon. They vary, of course, from hand to hand, but still they occur. They occur to everybody. And that's the way it is. If you're lucky, you know, you might go for some time and not have one and you begin to feel sort of...you'll forget that it'll happen to you. And then "bang", there it is.

SCHANCHE: And what does it do to you when it happens?

DR. DeBAKEY: Well, it's very depressing when it happens. You feel very badly about it, because you have no control

DR. DeBAKEY: over it. It's frustrating, for one thing. And you feel why does this have to happen to this poor gentleman, you know. He was doing so well. I did a perfect job on him. It went well and then "bang", he dies from this. Or he has a massive myocardial infarct and dies.

SCHANCHE: Well, that is just fate, isn't it?

DR. DeBAKEY: Well, I think we have to call it that because we don't have enough scientific knowledge to be able to predict, to be able to say why it happened. You know, there's a reason for everything. But sometimes we don't know the reasons. When you don't have enough scientific knowledge, you have to put it in the sort of category of fate. Of course, it's fate anyway, but I mean it's unexplained fate. You know, I remember that old story that--I think it's told maybe in the Arabian Nights or someplace..something like that--where this man found out that death was looking for him.

SCHANCHE: That's in Appointment of Sumara.

DR. DeBAKEY: That's right. So there you are. I think we have to classify some of these things as fate, or the destiny of the individual because we don't know. Some day the scientific knowledge will be able to explain them and we'll know why a patient develops a massive pulmonary embolism. And we'll maybe know how to prevent it completely.

SCHANCHE: When you first began surgery, do you recall your feelings on the very first time you participated in surgery? And what the circumstances were?

DR. DeBAKEY: Well, you see, when I first participated in surgery on human beings I was a junior medical student. And I participated in the hospital during the summer--working. I had just finished my sophomore year. And I was working in the hospital. And I was taking one of these summer jobs. So I was virtually an intern in the hospital. And I actually began giving anesthetics. Using drip ether, which was on a patient who was going to have a tonsilectomy. And..

SCHANCHE: A child?

DR. DeBAKEY: Yeah. Yeah. And naturally I was very much concerned

DR. DeBAKEY: that I was giving..give him.. do it right, you see. And so, I was very slow about it and the surgeon was pushing me.

SCHANCHE: Who was it? Do you remember?

DR. DeBAKEY: Yes, I remember the surgeon but I can't think of his name now. Erwin was his name. Erwin. Fine man.

SCHANCHE: Older surgeon?

DR. DeBAKEY: Yeah. Very fine man. Not too old. He was much older than I was then.

SCHANCHE: Is he what used to be called an Eye, Ear, Nose and Throat surgeon?

DR. DeBAKEY: Yeah. But very good. Very precise. Very careful. He later offered me a job to come in partnership with him. And I got to know him very well. I liked him very much. He liked me. Then later, I assisted. Actually acted as an assistant. And it was interesting. I was assisting a man who was doing a hernia operation.

DR. DeBAKEY: And I kept thinking the whole time he was doing this--as he was doing it--because I had watched others do it, you know. As he was doing it, I wanted to do what he was doing, because I felt I could do it better. He was tying a knot and fumbling around. I knew I could tie that knot better because I had been practicing tying knots. And I wanted to tie that knot. And I'd watch how he held the scissors and I was.. All the time I was assisting him, I was thinking to myself how I could better do it. And so I developed a kind of confidence in myself about it. I'd go.. Afterwards I'd go and read about these things and think about it and kind of..

SCHANCHE: Plan a strategy of your own.

DR. DeBAKEY: Yeah. Exactly.

SCHANCHE: When did you first pick up a scalpel and use it? On a human patient?

DR. DeBAKEY: Oh, by the time I was.. Actually, even then I did, because I also worked in the emergency room.

DR. DeBAKEY: I'll never forget. I was still, I guess, a sophomore or a junior, I've forgotten now. But I was working in the same hospital in the summer.

SCHANCHE: Was that Charity Hospital?

DR. DeBAKEY: No, this was Mercy Hospital. And they brought a little child in with an abscess right here on his face. And it was pointing and you could see pus under it and all you had to do was knick it. And we used to use local anesthesia which was called ethel chloride spray, which would freeze the tissue. You'd press a button and out of it would come a spray under pressure because ethel chloride had been putting..was compressed in this little small container. But ethel chloride is also a general anesthetic if you inhale it--its fumes. And then was used as such. So I put a towel around this little baby--like that--with an opening just where the..

SCHANCHE: Where the chloride wouldn't...

DR. DeBAKEY: Well, no, you see, supposedly you have a sterile towel to put around it so that you wouldn't contaminate. And

DR. DeBAKEY: had a little hole in this towel. And the hole exposed the little abscess. The rest of his face was covered up with the towel. And I took the spray and sprayed it. And then I just knicked it and got all the pus out, put a little dressing on and took the towel off, and the child was...looked like he was dead. He was actually sound asleep, but I didn't realize it at the moment. I didn't realize what I had done. I had given him a general anesthetic because the towel was over him and the fumes had gotten under the towel and he was just breathing these fumes. And I had put him sound to sleep, but he looked dead. And I was about the most frightened person that I just.. I'm sure I turned white.

SCHANCHE: How terrifying.

DR. DeBAKEY: Just absolutely terrified. And I couldn't say anything, I was..

SCHANCHE: Was his mother or father..?

DR. DeBAKEY: His mother was there. And fortunately about that moment he started taking a deep breath. And I saw

DR. DeBAKEY: him breathe and I then quickly realized what had happened to him. And I turned around to her and I said he'll wake up in just a few minutes.

SCHANCHE: And trying to keep your cool.

DR. DeBAKEY: Trying to keep my cool, yeah. But my.. I can still remember this. My heart was racing. It must have been going 200 beats a minute.

SCHANCHE: What were you? A junior in med school?

DR. DeBAKEY: Yeah. I was still in medical school. And, of course, it was a great lesson to me. I realized what I had done. But it simply goes to show how these things can happen to you and without--just suddenly, this child could have died. You can imagine the fix I'd have been in then.

SCHANCHE: Were you even supposed to be doing that kind of work as a student?

DR. DeBAKEY: Well, I would say yes and no. We were supposed to be supervised--the doctors ran it, but there was so much of this kind of little stuff going on that very often

DR. DeBAKEY: the doctors would come by, see what it was, and say go ahead and just make that abscess. And go on to another patient or something like that.

SCHANCHE: What was the first major surgery you participated in?

DR. DeBAKEY: Well, even.. Oh, I did it even before I graduated. They.. I was still working in the hospital and by that time I may have been a junior or a senior. And I.. One of the doctors let me do an appendectomy. And..

SCHANCHE: That was your first?

DR. DeBAKEY: Yeah, and I was so thrilled because I did it well and everything went well.

SCHANCHE: You had assisted at a number of them.

DR. DeBAKEY: Oh, yes. Oh, yes. And I knew everything I was doing. I had read about it. I knew it well and I was so pleased when he said to me, "Would you like to do this?" And I said, "Sure." And I did. He was right there with me all the time.

SCHANCHE: Did you do a great deal of general surgery before you...?

DR. DeBAKEY: Oh, yes, I did all kinds of general surgery. I seized

DR. DeBAKEY: every opportunity. When I was a resident at the hospital--an intern--the boys used to check out on me. You see, in those days everybody was assigned a service--a certain number of patients from a certain area. And you had that assignment all the time. You didn't have it just eight hours a day. No, you were assigned. So when they went out--see, we lived in the hospital--in interns quarters--we lived right there in the hospital. So whenever they went out on dates or anything like that, they had to sign out on somebody. And I used to let them sign out on me because I was there and I liked to do the work. At night, there was a lot of work to do--all the emergencies and things like that. I was working all night, you know. And I just..

SCHANCHE: Thrived on that?

DR. DeBAKEY: Yeah, oh I loved to stay there and get as much work as I could do and do as many operations. So I had a tremendous experience. And I...

SCHANCHE: Do you feel that you sort of doubled your residency by doing that?

DR. DeBAKEY: Absolutely. Yes. The more experience you have the better you are, if you learn from it. And I tried to learn from it. That's one reason I feel so confident in the area of general surgery even today, you see. And en passant, I do it, you know whenever it's, whenever I have to do it, even in my own patients. You know, I'll do a hernia in my own patients, a gall bladder, a stomach resection, whatever needs to be done. I feel absolutely competent and confident of being able to do it well. Because I've simply done so many of them.

SCHANCHE: Well, let's take you back to Houston now and your next development which was, whic was what--using homografts and...?

DR. DeBAKEY: Yeah, you know, I think that it would be better if you would take these Annual Reports. I'll just show you why. Because I...

...On the pump, you see, when you cannulate to put

DR. DeBAKEY: them on the pump, one cannula or two cannulas go into the venae cava to get the blood to come out. The other cannula goes into one of the main arteries. It could be the ascending aorta or axillary artery or the femoral artery. Now it's extremely important that the cannula is put in precisely in the artery, because any damage to the intimal layer of the artery will result in what's called a dissection. That is the wall separates. The pressure of the blood acts as a means of separating the wall.

SCHANCHE: It'll create a dissecting aneurysm?

DR. DeBAKEY: It creates a dissecting aneurysm. And once this happens, it's a hopeless situation. There's no way to correct it. I have only saved one patient in all my experience with this kind of a problem and that was because I was there. I recognized it virtually before it occurred and quickly stopped the pump and immediately went up to the ascending aorta, occluded it, put a cannula

DR. DeBAKEY: into the normal lumen and got flow going into the normal lumen again. So as now to reverse the flow and to flatten out that dissecting area. And I did save that patient. But I wasn't in the room when this happened. They had cannulated it and had started off on the pump. And when I got to them, it was too late to do anything. And it's all due to the fact that they were not precise and careful in cannulating this and killed the man. And you see, you have to take the responsibility for all of this. You can't say, "Well, my assistants and my associates made an error." You can't tell the family that.

SCHANCHE: What can you tell the family?

DR. DeBAKEY: Well, you tell them that things...that there were complications that developed during the operation which you can't explain all of the basis for it. You can't explain how you feel about it. And you see, it's your responsibility and it's your responsibility to tell the family. They don't talk with the family. So they never feel this very keen responsibility. And they don't know how it

DR. DeBAKEY: feels until, of course, it will happen to them. But it's an error. And you see how.. And you see I keep saying constantly, I'm raising hell about small things because I know from experience that small things can develop into big things. It doesn't make any difference how small or how insignificant it may seem, in surgery every error is a significant one and may be a fatal one. And how do you teach that? You say it over and over. You're constantly calling attention to the lack of concentration and paying attention to what they're doing. I say to them, "Look, the reason the retractor has moved is because you're not concentrating on holding it in the place that I showed you to hold it. The retractor doesn't move on its own. It's the fact that your hands have gone to sleep. You're no longer in control of your hands, because you're mesmerized. You're not concentrating on what you're doing! Your mind is flitting in all directions."

SCHANCHE: That is a chronic problem, isn't it, with people who are essentially students. They're going to be watching

SCHANCHE: you, instead of what they're doing?

DR. DeBAKEY: It's a chronic problem with all of them. It's even a chronic problem with the anesthesiologists. You've got to constantly be calling his attention to what he's doing. He should be watching the pressure and the pulse and the E.K.G. and everything else. But I have to call their attention to it. I have to wake them up and say, "Look, the pressure is down. Look, he's having P.V.C's. He's got an arrhythmia." This is what you constantly are doing. And then, you know, you get the reputation for being a kind of mean old bastard, because you're constantly calling their attention to what--you know, to their own deficiencies. And yet, these deficiencies, you see, are so important.

SCHANCHE: They're vital.

DR. DeBAKEY: Absolutely vital, you see. They cause death.

SCHANCHE: Were they aware they had dissected the artery before you got into the operating room?

DR. DeBAKEY: Oh, yeah, sure. Oh, when Dr. Daniell.. By the time Dr. Daniell got there and started, yes, he

DR. DeBAKEY: finally recognized it. But it was too late when he recognized it.

But, you know, it's so depressing. It just knocks you out when it happens. It's so hard to take because I know if I had been there it wouldn't have happened. If I had done the thing, it wouldn't have happened. And yet, I can't be everywhere all the time. That's my problem.

SCHANCHE: Is it a very delicate and difficult thing to do?

DR. DeBAKEY: No, ordinarily.

SCHANCHE: Not if you exercise care.

DR. DeBAKEY: And if you exercise care and judgement, it won't happen, because if you find an artery that's, let's say, diseased, you just don't cannulate that. You know this can happen in a diseased artery. You don't do it there. Many times, and I showed them this, this is the thing I say to them: "Why can't you learn?" Repeatedly I've got to say the same damn thing over and over case after case. I just can't understand why they can't

DR. DeBAKEY: learn! That's why I say my definition of stupidity is the inability to learn from experience. To me that's being stupid. That's the definition of stupidity. Well...

SCHANCHE: Did you get a chance to go through any of this.....

(PAUSE)

DR. DeBAKEY: ...early origins, you see, of the Medical Center which I had to fight and overcome and constantly. And that is the fact that this medical school arrived in Houston with no really agreements for a clinical, let's say, services--for clinical services for their clinical departments. They brought down mostly second and third rate basic science people, you see, in the basic sciences--anatomy, pathology, bio-chemistry. And no clinical people. And what is more, there was no clear understanding or agreement as to how the clinical services were to be organized. And that's the reason when I first came here to look over the job I was offered, I turned it down, because they

DR. DeBAKEY: had none. And I said, "Well, I.. What do you want me to do. I can't create these for you. You've got to have a hospital. You've got to have a clinical service in a hospital. There have got to be a certain number of beds that are going to be under the control of the professor of surgery, the professor of medicine, and so on. And there isn't any." And they said, "Well, you can use the teaching beds at the Jefferson Davis Hospital and we're going to plan to do something at the Hermann Hospital." I said, "Well, when you have that worked out, then I'll be glad to reconsider it."

So..

SCHANCHE: Was it Dr. Moursund you were talking to then?

DR. DeBAKEY: Yeah, Dr. Moursund. And they had a committee that Dr. Moursund had appointed of surgeons mostly--clinical surgeons here in town. And they were all for me coming. They wanted me here. But, I explained to them I couldn't do it under the cir... So they asked

DR. DeBAKEY: me to come over a second time, which I did. They hadn't made any more progress, as far as I could tell.

SCHANCHE: Several months later or..?

DR. DeBAKEY: Well, several, yeah, several months later. And they hadn't made any more progress and I turned it down again. Well, Dr. Moursund, apparently, was determined to try to get me. So he came to New Orleans to see me a third time. I had written him a rather lengthly letter and I must try to find that letter. And then.. And he came to New Orleans and said, "Well, now I have the assurance of this committee of surgeons that they will see to it that you get a service. But we need you to come help organize it--the way you want it." So, I did talk to a few of them and they said, "Yes. Definitely we are backing Dr. Moursund on this. We're going to get it at Hermann first and also at Jefferson Davis."

Well, hell, when I arrived here, you see, they were all.. it was nice, you know. They were very affiable. They

DR. DeBAKEY: were very.. You know, they invited me to their homes and all that kind of stuff. But nothing happened.

SCHANCHE: They'd let you work in their hospital, but they wouldn't let you run it, is that it?

DR. DeBAKEY: Well, you see, at the Jefferson Davis Hospital that was organized.. The staff ran it. The Board didn't really run it. The staff ran it and had been. That was traditional. And at the Hermann Hospital, the staff ran it there as a private institution, really. They had about twenty beds that were the service beds, but they.. These private doctors ran that. And they had meetings and they discussed it and so on.. Some six months later they came to see me and said well, they had it all settled there. It was all ready to go. And that I would be made chief of the teaching service. And I said, "Well, who's chief of the surgical service?" "Oh, that's Dr. so and so." Dr. Waldron, I think. He was still the chief of the surgical service. And I said, "Well, who does.. who's in control of the patients as far as operating is concerned?"

DR. DeBAKEY: "Well, Dr. Waldron is." And I said, "Well, I don't understand how that's going to work. You going to put me in charge of teaching on these patients. And I'm going to be teaching students on these patients that somebody else operates on!" And I said, "Suppose that in doing my teaching I call attention to the fact that it's the wrong operation that's done for the wrong condition. How do you think that's gonna go?" "Oh, well," he said, "that's not going to happen at all." I said, "Don't tell me." I said, "From what I've seen around here, that will happen more often than not."

And they didn't like that at all. So they said well, they.. that's the way they had decided to do it. And I said, "Well, can you tell me if there's any experience with this anywhere else in the country? Because, if there is, I'd like to know how it..what that experience has shown." "Well, we don't have to do what they do everywhere else." And I said, "Well, as far as I'm

DR. DeBAKEY: concerned, that's not going to work for me." So they left and that's when, apparently, they went to see some of the members of the Board, you see. And I got this later when I went to see them--some of the Board members. They had said that I was trying to sweep--come in with a new broom and sweep them clean and I had proceeded with evolution, not revolution, and used a few cliches like that. But, as I indicated, two things happened, you see, that changed the whole course of events. And these were, and it's brought out in here, the..

(Telephone Pause)

...very good friends and supporters. And, as a matter of fact, I went to her to get her to get her husband to take the Chairmanship of our Board. And he.. And she was very helpful to me in getting him to do it, because I knew that if she pressured him into doing it, he'd do it. And in addition, I got the son to help me. So, I had the family all on my side

DR. DeBAKEY: and they're a wonderful family and I'm very fond of them. And she's one of my favorite gals. She's a..

SCHANCHE: Do they have a problem that needs medical attention?

DR. DeBAKEY: Yeah, it's her sister.

SCHANCHE: Her sister?

DR. DeBAKEY: Her sister, yeah. She's out at the ranch and then she's coming from the ranch.

Well, to come back:

There were two things that happened, you see, that changed the whole course of events and are very significant. One was the conversion of that Navy Hospital into a Veterans Hospital. Now, as I think I've already told you the story about how that occurred, so that's interesting in itself, you see. And the second thing was, of course, was the Jefferson Davis Hospital. Now the background of that is not in here, but you remember I told you the background of that and that was Mr. Taub. You see, actually, you remember the

DR. DeBAKEY: man whose name I couldn't think of. It was Basil McLean. Now what happened was that Basil was an old friend of mine. In fact, he was the administrator of the Touro Infirmary Hospital in New Orleans when I was there. So I got to know him very well. And during the war he was one of our chief consultants in hospital administration--really a great fellow. And I was very fond of him. We worked together during the war. I went up to his home and visited with him. He used to come down and visit with us. He and his wife. His wife's name was Dixie--charming lady. And when..after I got started with Mr. Ben Taub and I was absolutely green, fresh, never had met him before and he was kind enough to give me this appointment. I went down to his office. He looks like an old Southern gentleman, you know. He's just a fine looking man, very soft-spoken, very kindly looking. And extremely well-respected in this community. And it was interesting to

DR. DeBAKEY: go back to his office because he.. the wholesale. He has wholesale tobacco.

SCHANCHE: Described as kind of a warehouse for..

DR. DeBAKEY: Yeah, you go through what looks like a warehouse. Of course, actually it's not the warehouse, because the warehouse was in another place. But this is where they had the various products, you see, on display. And you go through that...through this whole open kind of building with..looks like a warehouse, except.. with all the tobacco products and candy and that sort of thing. And then finally you get in the back and there's his office, you see, in the back. And he has a roll-top desk, old fashioned looking office, very cluttered. And obviously he knows where everything is. And he had me sit down in a chair near by him. And I told him right from the start, you know. I said, "I've come down to talk with you about Jefferson Davis Hospital because you're chairman of the Board of Managers and I understand that you're very

DR. DeBAKEY: much interested in it." And I said, "I just wanted to give you a kind of point of view about this and then have you think about it."

(Telephone Pause)

I said to him, "This is really what I'm going to say." When I had called for the appointment, I told his secretary who I was and I said I just wanted to see Mr. Taub for about fifteen minutes. So I told him, "I promised you I would be here only fifteen minutes. I know you're busy and I won't take any more of your time, in that I think I can tell you all I've got to say in fifteen minutes." So I expressed in general the point of view that a charity hospital in the community, since it was Jefferson Davis, was a very valuable source of teaching. But I said, "From your standpoint you're really not interested in teaching, except as a person who's interested in improving the quality of the teaching of doctors in the community. Because you're

DR. DeBAKEY: primarily interested in what is in the best..what kind of quality care you can give the poor sick. Because that's your primary responsibility." And I said, "This is the way to do it, because you cannot teach poor quality. You're teaching the best quality you can. And your teachers know quality in a medical school and they're going to see that the standards of good medical care are being provided to the patients because they're teaching that. And that is why in any large community, the university teaching hospital is where you get high quality care." I went on to say. Interestingly enough, he had read a book by Allen Gregg that..who was chairman of the..director of the Rockefeller Foundation for many years. And in this book Allen Gregg had made some statement to the fact that, if he ever got sick in a strange place, he would like to have a sign on him saying "Take me to the university teaching hospital." You see. He had read that and remembered

DR. DeBAKEY: it. So it struck a good chord in him. Well, after I got through explaining all this and explaining that we.. The problems we would have in doing it, because of the way the staff was organized, he... I said, "Now my fifteen minutes is up. And that's all I wanted to say. I appreciate your time. I hope you'll give some thought to this. And if there's anything else I can do, would you please call me."

END SIDE A.

DR. DeBAKEY: "...questions I want to ask you." And I said, "I'm willing to stay as long as you want me. I just didn't want to take up your time."

He said, "Well, if you've got a little time, let me ask you some questions." So he started asking me some questions, particularly about what would the teaching faculty do, how they would relate to the present staff, and that sort of thing. Well, I stayed there for over an hour. And he said, "I may want to talk to you some

DR. DeBAKEY: more." I said, "Well, by all means." Well, it wasn't long before he called me again and wanted to know if I could come down and talk to him, which I did. And now he was more interested in how to do this. Now he was asking questions how to go about it. What it would involve, and that sort of thing. And I said, "Well, it's going to create a problem from the staff standpoint. They're not going to like it, I can tell you that. And so you're going to have a problem."

He said, "Well, we've been thinking of making a survey at the hospital for some time." He said, "What do you think about having a survey made? On the basis of this maybe some recommendations could be made." And I said, "I think that's an excellent idea." I said, "Why don't you propose to have a survey made by an outstanding hospital consultant that no one could in any way question. I mean his reputation is so established nobody could question it."

DR. DeBAKEY: He said, "Do you know anybody like that?"

I said, "I certainly do. I know the top man in the world."

He said, "Who is that?"

I said, "Basil."

He said, "Can you get him to come down?"

I said, "I certainly can."

SCHANCHE: That's Basil McLean.

DR. DeBAKEY: Yeah. I said, "I certainly can."

SCHANCHE: Is it M-C-L-E-A-N?

DR. DeBAKEY: Yeah. He said, "Oh, will you call him?" I said, "Sure." So I called Basil and he was at Rochester at that time and I told him what the problem was. And I said, "Basil, we can certainly use your help." Well, Basil McLean came down and Mr. Taub set it up quite cleverly. And all this, of course, wasn't known. He set it up very cleverly as a survey. Well, Basil did. He spent a couple of days and he made a survey of the hospital. Then he met with Mr. Taub privately and

DR. DeBAKEY: told him what he would recommend. And, of course, one of his major recommendations was that he'd affiliate with Baylor, which was a foregone conclusions.

SCHANCHE: He would have recommended this with or without your influence, wouldn't he?

DR. DeBAKEY: Oh, yes. Oh, yes. No question about that. No question about that. No, I didn't really influence him to do this because this was..

SCHANCHE: Was obvious.

DR. DeBAKEY: Not only obvious, but this was a recommendation that would have been made in any other situation, you see. Well, then the question came about how to proceed to do this and get the staff to go along. He had the report. Basil made quite a splash locally in the papers, too, you see. So, he.. Mr. Cullen was living there and Mr. Cullen wanted to talk to him, because Basil also said that the Medical Center.. well, he said the hospital was too small. That it

DR. DeBAKEY: needed. It was too old.. It needed to be.. They need a new one. And he made the recommendation that they build a new hospital in the Medical Center. So, that, you know, was highly publicized on the front pages of the papers and then he went to see Mr. Cullen. Mr. Cullen asked to have him come and see him.

SCHANCHE: Was Cullen then chairman of the Medical Center?

DR. DeBAKEY: No, no, no. Cullen was living...

SCHANCHE: He was not involved. He was just very rich and very interested.

DR. DeBAKEY: Yeah, that's right. So, he spent several hours with Mr. Cullen. I went down there with him one evening. Had dinner. The next day, Mr. Cullen made a big splash in the papers by saying that he strongly supported this and would give money to start it in the Medical Center.

Well, that put the staff, of course, at a disadvantage in opposing all of this.

SCHANCHE: They'd already been hit by the heavy artillery.

DR. DeBAKEY: You see? And so some of the leaders of the staff were very strongly opposed to this, but there were others who weren't and were ready to go along. So they had a meeting-- a staff meeting. And Mr. Taub had talked to several of them. Called them up and talked to them and they finally agreed with him that they would go along with this. Well, they came to the meeting and the votes were just about to go the other way. So the chairman sort of tabled it. He said, "Well, we don't have enough people. Other people ought to be here. I want to postpone it."

So he was clever about that. And so they postponed it and Mr. Taub really put a lot of pressure on them by simpley, in a sense, not threatening, but indicating to them that he may go to higher authority--that is the city council or commission or whatever it was that had the authority for this--and make them change all the by-laws. So, they.. At the next meeting which

DR. DeBAKEY: was, I think, a week or so later, something like that, they voted to agree with this. Well, then I wrote up, in the meantime, I had written up an agreement and given it to Mr. Taub.

SCHANCHE: The affiliation agreement.

DR. DeBAKEY: Yeah, affiliation agreement, based upon. Well, I didn't write anything denotable. We had several of them that we used as a pattern. And that constituted the real agreement.

SCHANCHE: You had Dr. Moursund's active collaboration all this..

DR. DeBAKEY: Oh, yes. All this time, of course. Of course. He was in complete.. But he kind of let me carry the ball, because of my relationship with Mr. Taub. So, that's how that came about. But, you see, that's the.. I'm referring here to the Medical Center in some places here you can see, where I say about: "In view of the misconceptions which have prevailed concerning the role of the College and the Medical Center and the difficulties encountered in providing it

DR. DeBAKEY: with the clinical facilities essential to its proper function, the importance of these events can not be over-emphasized."

You see, I used "misconceptions" because it was a misconception on the part of the Medical Center Board. They were the ones that had misconceived the organization of a medical center, which really as far as they were concerned consisted essentially of a gathering together in a general area of some buildings--hospitals.

SCHANCHE: And a post-graduate..

DR. DeBAKEY: And a post-graduate medical school. Now, and this was something we were constantly really fighting in those early days. Now, you'll notice that I point out the two important events: the Jefferson Davis Hospital and then the Veterans Administration. And it was with their..once we got those two, then of course it became possible for me to start functioning effectively in the development of a surgical service. Now, it's

DR. DeBAKEY: more than that, because, you see, surgery was simply highlighted and in a sense sharpened into focus the problems that effected all the other services. All the other services. Now you could never get quality people to come and take any of the other services either. And here I was about to leave. Until these events occurred.

SCHANCHE: How did they get Dr. Hoff here? He came a few months before you did?

DR. DeBAKEY: There's a difference. He was professor of physiology. That's a basic science. He doesn't need a clinical service. There's the big difference.

SCHANCHE: They had someone else in pediatrics, I guess.

DR. DeBAKEY: They brought a young man in pediatrics, Russell Blatner, and he had a service at the Hermann Hospital. They gave him a service, which he ran. Now in this service--in running this, he really didn't interfere with the private practitioners. There's a difference there. And they had already indicated they were going to

DR. DeBAKEY: build a children's hospital. So, he had something to look to.

SCHANCHE: Maybe it will help if I just direct you to some pages on that report that you're looking at on page 7. You've described how the surgical service at Jefferson Davis is organized in "white and colored division" in both male and female units.

DR. DeBAKEY: And I.. I remember this very well and I changed it, you know.

SCHANCHE: Well, I noticed that a few years later in the '50's it was still...there was still a reference to white and colored, I think in '58.

DR. DeBAKEY: That's right. Something.. Well, I don't know whether it's fif..how long afterwards, but I got. . . The first things I changed..

SCHANCHE: '58-'59..

DR. DeBAKEY: But the first thing that I changed was the recovery ward and the emergency wards. That became completely integrated. Mr. Taub was very progressive in this

DR. DeBAKEY: regard. And I used to complain about this organization, because I said, "You see, it's very inefficient." I mean you've got to have a male and female service divided into two parts duplicating all these functions. And I used to complain about this all the time. And then I used to refer to the fact that I got the approval of the Board to let me integrate the emergency.. We can't have two emergency services. We can't.. We just don't have that kind of personnel. We don't have the money to do it. We don't have segregated operating rooms. We don't have segregated recovery rooms. It works and there are no problems. We've had no problems. There's been no complaints. Nobody's complained about it. It works beautifully. And Mr. Taub was all with me. He allowed me..actually gave me the go ahead to integrate these other areas. And I used to complain about this. And we finally integrated these areas. And I think probably the first

DR. DeBAKEY: hospital in town that integrated. We did it on the qt. We didn't say anything about it. Yeah, we just did it, you see. And it worked fine. Nobody complained.

SCHANCHE: That must have been terribly burdensome, though, to have to break down like that into...

DR. DeBAKEY: Well, it's irrational, not only burdensome, absolutely irrational. If there's anything , if there's anything that makes people the same, it's illness. They're all the same--rich, poor, all colors and everything else. And you treat them the same way. They were treated the same way. So that it was ridiculous, absolutely ridiculous and it simply illustrates even better than anything I know the irrationality of segregation. It's absolutely the most irrational thing in the world. Now I'm not saying that you.. that in your personal life and in your family life and in your home you have to take everybody in. Well, hell, you don't.

DR. DeBAKEY: You take the people you like and want. But, it shouldn't be based on color. You see? That's the point I was making here.

SCHANCHE: On page 31 of the Report, this is at a time when you were doing very little research. You mentioned the research program of shooting dogs in the femoral artery and grafting preserved arteries.. Was that the first of the arterial research projects?

DR. DeBAKEY: Yeah, trauma was the earliest research program that we began, because you see, we had a lot of trauma. And..

SCHANCHE: Particularly in the city hospital.

DR. DeBAKEY: That's right. Notice on page 21 of the Report, it says that these two institutions, the Veterans Administration and the Jefferson Davis, thus became the only hospitals and for the first time in the city of Houston to receive full approval for complete graded residency program in surgery. You see.

Then on page 22, I point out: "At the request of the Methodist Hospital and in light of their expressed desire

DR. DeBAKEY: to affiliate with Baylor responsibility for their surgical residency training program was assumed by the department of surgery." You see. That was the first actual affiliation with Methodist Hospital we had. And that was sort of a verbal agreement with the Methodist Hospital before they came in the Center. This is when they were..

SCHANCHE: What year did Methodist build this building? There's no mention of it in this report.

DR. DeBAKEY: I think it was in '53. I think so. We can get that figure. In fact, I think it was '53. I think they started in '51.

Well, you can see we really began to move from that point on, because once we had the service organized we got some people. And then the research activities we put into effect. These included both laboratory and clinical research. The laboratory ones we did in a small room about the size of this room. That's the only laboratory we had. And the arterial injuries was..

SCHANCHE: That was your laboratory on the roof?

DR. DeBAKEY: Up there. On the roof. That's right. Now, we also began a study on dextran for the Army. Now I was getting some money from the Army for this. That's how I got started with the research. Baylor College of Medicine, I mean Baylor University gave me no money. I had.. I think my total budget was forty some odd thousand dollars. This included salaries for all the personnel.

SCHANCHE: Including you?

DR. DeBAKEY: Including me. That's right. So that we had to find our own way. But because of my relationship with the Army and the fact that they had funds for grants for research, I applied for these kind of things. The dextran we did as a clinical study, too, at the Jefferson Davis Hospital. And that's how I set up the first research laboratory in any hospital in town. The first.. And that was done at Jefferson Davis.

DR. DeBAKEY: Now the first research laboratory in any private hospital was done here. Again with funds that I obtained through the Army. And we did this dextran study for them because they were ready to release this but they wanted to know whether it was effective in the treatment of shock before they sent it to Korea. It was a substitute. So we did the study and proved that it was and it was on the basis of that report that the Army released it for it's use in the Army.

SCHANCHE: What is dextran actually? Is it a dextrose and and water mixture or?

DR. DeBAKEY: No, it's a heavy molecule and it's water-soluble, of course. It's a heavy molecule and therefore it doesn't seep through the blood vessel wall rapidly. You see, water goes through pretty rapidly. It doesn't stay and it doesn't build the volume up. Dextran builds the volume up--quite well tolerated. It is excreted--absorbed and excreted without any toxic reaction. But it's a heavy molecule and therefore it stays in longer.

DR. DeBAKEY: So it held the volume of the bloodstream.

SCHANCHE: I note in your ten year report to Stanley Olson, you said that the Armed Forces' policy of accepting dextran as a plasma substitute was based on observations made in the _____ you were responsible for.

DR. DeBAKEY: That's right. Correct. That's right.

SCHANCHE: There's no link between that and the dextrose priming of the pump?

DR. DeBAKEY: No, it's a different thing. It's a different thing.

SCHANCHE: I noticed that the key to your...to the beginning of your research program.

DR. DeBAKEY: That's right.

SCHANCHE: Who paid for the trauma studies--the arterial?

DR. DeBAKEY: The Army.

SCHANCHE: The Army paid for that too?

DR. DeBAKEY: Yeah. That's right.

SCHANCHE: Did anything truly significant come from it?

DR. DeBAKEY: Yeah. We demonstrated the need.. You see, what you've got to keep in mind is that up until that time

DR. DeBAKEY: really up until the Korean War, there was..Because right after World War II.. See, I wrote..I did a sort of a classic study now because it's the largest experience of war injuries of arteries that we reported that and analysed it and reported it. And we showed that the incidence of amputation and complications from the way they were treated was very, very high. This is because there was no effort made to repair and restore circulation in the injured extremity. What we were trying to do in this experiment was demonstrate that this could be done at the first stage at the time of the injury. Even if you have to use a graft, you see? So what our goal was to demonstrate that primary repair of an arterial injury was the best way to save the extremity. And this, of course, is now fully accepted, of course. But, that was a new concept.

SCHANCHE: Yeah. Were you active in the laboratory on this project?

DR. DeBAKEY: Oh, yes. Oh, yes. I did a lot of the work myself. And my associates. Well, there were only..you see how many people there were. When I arrived here there was one man full-time. He was hired before I got here. And he was nuts. And there was one secretary who wasn't much better. She wasn't nuts but she was stupid. That was the department of surgery. So I had to get rid of this nutty fellow and get rid of the secretary because she was stupid and start getting some new personnel and getting some more people in the department with me. And I point out the people that I got in here. And they were really very fine people and I must say going back to those days that they really did everything. They worked like dogs and they were very loyal, very close-knit group because we were very small working together all day. And it was a lot of fun. They were a fun group. They enjoyed their work. They were happy together. And there was a lot to do and we had a lot of fun.

SCHANCHE: Was this..this dog program a sort of an essential first step to the development of the homografts and then Dacron grafts?

DR. DeBAKEY: Yeah. Sure. Sure. We.. This was where we really started. In preserving grafts we learned..we developed techniques, some of which had already been known of course. And we either perfected them or improved them and worked with them. We developed the freeze-dried method, not originally with us, because this had already been developed. But we learned to do it well and we collected the grafts ourselves. We tried various types of heterografts and so on. We learned that heterografts weren't any good. And..

SCHANCHE: I noticed in a later report the heterograft program. That was in '52-'53. Incidentally, the other night when you mentioned that somebody came up with the idea of giving giraffes as likely donors for them. Was that seriously considered at that time?

DR. DeBAKEY: Oh, yes. We did get horse aortas, you know. And they've got a pretty long aorta. You see, it goes all

DR. DeBAKEY: the way up the neck. And we did.. Oh, yes, we didn't use any of these, but it came up because there were some African surgeons who had suggested that idea. But we never did try it, of course. We had no giraffes. But, the.. We tried the horse aorta, but that didn't work either. Heterografts just don't work on it. They rejected it.

SCHANCHE: They never did.

DR. DeBAKEY: No, they never did. But we had to go through that experience and we did.

SCHANCHE: Was this experience, you know, this experience in the background of your telling Liotta not to bother with heterografts ... right?

DR. DeBAKEY: Yeah, yeah. Sure. But that was.. In the pump, you see, the reason I didn't want to bother with it in the pump too was because it is very difficult to take a heterograft and the configuration of the pump and put it in the right position and place and make it function effectively. That I know, you see. I knew that. That's

DR. DeBAKEY: why I told him it would be ridiculous. Now in the '50-'51 report, you will notice that in the research activities we expand a little bit on some of the things that...

And you'll notice that again..

SCHANCHE: There's a little more in '50-'51, but it's '55 that you really zoomed up to fifty-three different projects versus thirty in '52-'53.

DR. DeBAKEY: No, but you see, I was saying that in the '50-'51 there's a research project on hetrologous arterial and we point out, you see, that we're doing studies in that area in there. I have the feeling that maybe Methodist Hospital came into the Center about '51 or '52. Let me see, it says Methodist Hospital here.

SCHANCHE: Yeah, Methodist Hospital was mentioned every time, but never does it say that..

DR. DeBAKEY: ..twenty..

SCHANCHE: ..Methodist moved during the period or they built a new building. It says a certain number of beds were

SCHANCHE: added every year, which will finally get up to nine hundred. Unless, I overlooked it. I didn't...

DR. DeBAKEY: Well, let me see, it ways here Methodist Hospital--affiliated hospital--twenty.

Now wait a minute, it does say in the '52-'53 report that "the affiliation of Methodist Hospital was formally completed on October 3rd..which was described in the last annual report. An account was also given into the organizational structure of the staff which was similar in principle to that described by the other affiliated hospitals. This even, along with the subsequent occupancy of the newly constructed 300 bed hospital in the Medical Center, brought the Methodist Hospital under the orbit of educational institutions." So it must have happened in '52-'53. I think '53 is when it occurred. You see.

SCHANCHE: Are you in the '52-'53 report?

DR. DeBAKEY: Yeah.

SCHANCHE: On page 36 you mentioned the outstanding contribution of the period is the surgical removal of

SCHANCHE: aneurysms of the aorta. This was the beginning of that..

DR. DeBAKEY: Uh-huh.

SCHANCHE: As I recall there is no detail given there.

DR. DeBAKEY: "Surgery on the Aneurysm of the Aorta. For the past two years it has been the policy of the surgeon to attempt excision of the aortic aneurysm in almost all cases."

Well, you see, we began that actually--The first one I did at Jefferson Davis Hospital in '49, the first aneurysm of the thoracic aorta.

SCHANCHE: Well, now this was a realization of an almost life-long dream. Something that you and your colleagues had talked about when you were with Leriche. A powerfully significant advance in surgery.

DR. DeBAKEY: Yeah, well, you see, historically aneurysms.. You see aneurysms in the historical span as a very interesting lesion. It has fascinated people throughout history. And it is a very interesting lesion, you see, because in its own way it's like.. in the vascular way.. it's

DR. DeBAKEY: like cancer because it represents a lesion that can be diagnosed clinically. And once you know it's there you know if that fellow lives long enough he's going to die from it. And there have been some dramatic kinds of deaths from it because they used to develop in such a way sometimes as to even erode right through the sternum. And a patient would bleed to death and he could see himself bleeding to death. You see? And there have been interesting case reports in the background where they put a cork into the hole to stop the bleeding.

SCHANCHE: Put a cork temporarily?

DR. DeBAKEY: Temporarily, yeah.

SCHANCHE: Not very long though. That's an interesting phenomenom to me. I've noticed in some of your papers that aneurysms pressing against the spinal canal against the spine had eroded..

DR. DeBAKEY: Eroded the spine. Absolutely.

SCHANCHE: What causes this?

DR. DeBAKEY: The constant pounding pressure. Like a drop of water hitting a stone down below. Ultimately it will erode it. You wouldn't think water would be able to do that. But it's that constant pounding pressure. And it is well-known throughout history and in the earliest recorded..the earliest recordings on..in medicine, you'll find something about aneurysms. So it has fascinated medical men throughout history. It has challenged medical men throughout history and surgeons have done all kinds of things to aneurysms in an attempt to overcome them.

SCHANCHE: Did they wrap them with cellophane?

DR. DeBAKEY: Oh, they've wrapped them with cellophane, with other things. They've put powder. They've put asbestus. They've put all kinds of things around them in the hope of trying to develop some kind of tissue reaction that would strengthen them. Keep them..keep it from expanding. They have put all kinds of things inside the aneurysm. Wire of all kinds, metal of a kinds, hair, everything

DR. DeBAKEY: in an effort to..gold..in an effort to clot them up, so as to stop this pounding and dilatation. They have put ligatures around the vessel to stop the blood flow through it. That eroded. All that did was kill them sooner. Matas. Dr. Matas and others developed a kind of pinsor device that would..that you gradually screwed and put the pressure on it so it's obliterated. One surgeon in Ireland used his.. used a series of assistants to pressure..put pressure on by hand. To compress it, you see.

SCHANCHE: Like for hours doing it one at a time..

DR. DeBAKEY: Oh, yes. Just one assistant would get tired and the next one would take his place over a period of hours and hours, and days.

SCHANCHE: This is what killed Albert Einstein.

DR. DeBAKEY: That's right. This is what killed him. Aneurysm. Upper abdominal aneurysm. That's right.

SCHANCHE: And weren't you called by his..

DR. DeBAKEY: Yes, I was called by his doctor and I told him that he should be operated on. And he said..the doctor

DR. DeBAKEY: said I think so too. And he said, "Can you do it?" "Of course," I said. "Will you come up here?" I said, "Sure. I'll bring my whole team if you want me to." He refused. Wouldn't consider an operation.

SCHANCHE: Did you ever get his reasonings?

DR. DeBAKEY: Only to the extent that he just refused operations. He didn't want to be operated on. If he was going to die, then it was time for him to die. He took it apparently very fatefully.

SCHANCHE: And stoically.

DR. DeBAKEY: And stoically. Yeah. I guess he.. You know there are some people when they reach a certain age are really tired of living. And life doesn't mean a great deal to them anymore. And I can understand that. If you don't have any reason to live and enjoy living..

SCHANCHE: He was still working on his unified field theory. Maybe he thought it was hopeless.

DR. DeBAKEY: Yeah. Frustrating because he couldn't..

SCHANCHE: He left a lot of physicist and mathematicians in the lurch.

DR. DeBAKEY: That's right. Well, ..

SCHANCHE: While you're on that, do you remember the circumstances of the call, what time of day or night it was and what perhaps the conversation was with this doctor?

DR. DeBAKEY: I don't remember whether it was in the afternoon or evening. It seems to me it was in the evening when he called. It seems to me it was in the evening. And he described his symptoms to me and he said, "I think it's a rupturing aneurysm of the abdominal aorta. It sounds like it." He had backache. He was shocklike, temporarily he'd recover and get more shocklike and recover. And I said, "It sounds absolutely characteristic." Characteristic. He had some tenderness in the abdomen and it was a little swollen. And I said, "He needs to be operated on immediately or he's going to die. There's no question about it. He's lucky that he's lived this long because you see, some of them just go like that. Others go

DR. DeBAKEY: in stages.

SCHANCHE: That's _____ing a catastrophic blow on him in the abdomen.

DR. DeBAKEY: Yeah. That's right. That's right.

Well, I think it was in the evening.

Well, the, you see, that's one reason that aneurysms are so exciting to surgeons because of the challenge it has had for four thousand years or longer. It has challenged medical men. And this challenge was never fully met until we were able to remove the segment and replace it.

SCHANCHE: This must have been a terribly exciting thing.

DR. DeBAKEY: Well, it was. It was. Very exciting. To be able to successfully do something that had been tried unsuccessfully for four thousand years. See?

SCHANCHE: When you say four thousand years, you're going back into reading the Egyptian hieroglyphics.

DR. DeBAKEY: Yeah. Sure. It was known then.

SCHANCHE: Was it?

DR. DeBAKEY: Oh, it was known to be ancient. Aneurysms? Yes. You..

SCHANCHE: Do you know whether they made the effort to repair them at that time?

DR. DeBAKEY: Uh, not repair them, no. Nobody could repair them. The idea was to stop the progression.

SCHANCHE: They couldn't do brain surgery either, but they opened skulls.

DR. DeBAKEY: Oh, yes. That's right. Oh, yes. No, it's amazing how much they knew and could do in clinical medicine. It really is. It's hard to believe, when you think back. I mean you read what they did. The Arabian physicians were extremely knowledgeable in the field of aneurysms and also in clinical medicine, especially the Arabian surgeons. They did a lot of writing about it. And really set the stage for much of the medicine that developed in Europe later. They had great teachers. They had a lot of experience.

SCHANCHE: Was anyone else close to the same achievement as you who did the first successful aneurysm?

DR. DeBAKEY: Well, as I said to you before this Dr. DuBost in Paris had done one before we did in the abdominal aorta. You see? And we didn't know it.

SCHANCHE: That was the one you didn't know about?

DR. DeBAKEY: Yeah. We didn't know it. But nobody had done anything in the thoracic aorta. And that's understandable in a way, because you see there's a big difference between the abdominal aorta and the thoracic aorta. You can occlude the abdominal aorta without too much trouble. But you can get into serious problem with the thoracic aorta. And that's because it's closer to the heart and it's because it's closer to the, you might say, the basis for circulation, you see. The initial thrust of the circulation. And the organs that, you might say, are dependent upon blood flow become increasingly more jeopardized in handling that part. So that's why once we had done the first thoracic aorta successfully, it was a

DR. DeBAKEY: major accomplishment.

SCHANCHE: This wasn't a thoracic aorta that's referred to here?

DR. DeBAKEY: Referred to where?

SCHANCHE: In the '52-'53 report.

DR. DeBAKEY: Yeah.

SCHANCHE: The surgical review for aneurysms of the aorta.

DR. DeBAKEY: Well, but you see, in that report we were talking about all of them. We began ...

SCHANCHE: I thought the progress you...there was great triumph in doing an abdominal aorta and then a thoracic aneurysm too.

DR. DeBAKEY: Well, it was. It was, you see. But that's what.. I mean the success in these first cases of aor.. The success in that was what, in a sense, gave us the courage to attack the ones in the chest. See there had been a policy to attempt excision of aortic aneurysm in all cases. For aneurysms of the thoracic aorta, particularly of the arch, it is possible to excise the lesion tangentially and perform lateral aortorrhaphy.

DR. DeBAKEY: In aneurysms of the thoracic aorta, the lesions have been resected and continuity restored by means of preserved aortic homografts. See. That's in the '50-to '52-'53 report.

SCHANCHE: The next step after that was doing a dissecting aorta on aneurysms?

DR. DeBAKEY: Yes. Yes. Yes. That's right.

SCHANCHE: Which was a monumental step..

DR. DeBAKEY: Yes, well, actually, I'm not sure whether that was the next major event or.. I think the carotid was the next major event. Because, I think, if I remember correctly, it was in 1955 that we did the first successful dissecting. It was in 1954 that we did the carotid.

SCHANCHE: This must have been a very, very exciting period for you.

DR. DeBAKEY: Oh, it was.

SCHANCHE: It was advance following advance, wasn't it?

Dr. DeBAKEY: That's right. Exactly. But you see, it's really

DR. DeBAKEY: sort of following through. You take your.. It was taking one advance and using that as a springboard to the next advance. From the aneurysms of the abdominal aorta, we then moved to the thoracic aorta. Once we had the thoracic aorta, we then..we were then where we were able to move to bridging the defects involving the critical vessels like the carotid vessels, the renal arteries. You see, the celiac, superior mesenteric.. We were sort of embolden really by our experience. Success in one area gives you the courage to move to the next area. And that experience allows you to feel that perhaps you can solve this next problem using basically the same principles.

SCHANCHE: Your basic two problems with it were how much time you had if you did cut off circulation to the, let's say, the kidneys, and how much blood flow you had...

DR. DeBAKEY: Yeah, well, you see, the concept of temporary--use of temporary circulation around a diseased segment came into being with the bypass principle. Now the fellow that deserves credit for that principle and that

DR. DeBAKEY: concept was this man Kunlin.

SCHANCHE: Your former colleague..

DR. DeBAKEY: Who was one of my colleagues in Leriche's Clinic. And he was using it. You see, he.. It shows you how once you put--plant something in the mind of a person, he can expand on it. Now, his concept was to bypass the block in the femoral artery. And his idea was to take that vein out and just go around that block. Very simple concept, yet nobody thought of it. Well, I soon as I knew it, he sent me--soon as he did the first case, he sent it to me, before it was reported.

SCHANCHE: Was this something he had incidentally had talked about wanting do to when you were young?

DR. DeBAKEY: No.

SCHANCHE: No. This is something he did after he started.

DR. DeBAKEY: Started. Yeah, that's right. But he sent me the case and he was so successful and he was so overjoyed with it--he sent me the case report and told me

DR. DeBAKEY: about it and what did I think about it. Well, I was highly excited about it. I thought it was wonderful. And, of course, it immediately started my mind to working. Well, if you can do that why can't you use a temporary graft..

SCHANCHE: A shunt.

DR. DeBAKEY: A shunt. You see? And this whole concept of temporary bypass. Now to show you how that is further expanded in your thinking. When I first had a patient with an aneurysm of the..what we call a thoracal abdominal. That, again, was the first successful one which I did. The bypass concept became critical to its application. But what is more, I even converted that concept into using a bypass as a permanent bypass by simply bypassing it first as a temporary, using the graft as a temporary shunt to get circulation down below and then attaching grafts to that..

SCHANCHE: To renal arteries.

DR. DeBAKEY: To the renal arteries and the celiac, superior mesenteric and then taking out the aneurysm. Once I had the aneurysm out, then I let that bypass function as a permanent graft. You see?

SCHANCHE: And that's the step by step development.

DR. DeBAKEY: That's the step by step development. Exactly. And that's how you march, you see, from one step to the next step, once you have made that one step.

SCHANCHE: Can you recall the circumstances of each of these epical conquerations?

DR. DeBAKEY: Well, I can recall when they occurred, yes, because they were pretty dramatic cases in that sense. Now the fellow with the thoracic aneurysm, for example, was a man who had been a soldier in Korea and was in a jeep accident. He nearly died. He recovered and after he recovered came home and they found that he had this mass in his chest from an X-ray. They weren't sure it was an aneurysm, but they suspected it might be. Well, we saw him because, I think he

DR. DeBAKEY: was referred to us thinking it might be an aneurysm, and we examined him and indeed it proved to be. We studied him and found out it was. Well, then actually, you see, it was a traumatic aneurysm which really is a kind of false aneurysm because it's a break in the tear and then a big clot forms in the tissue that surrounds that and it becomes a false aneurysm. Now, we operated on him--I'll have to get the details of it, because we reported it as a case. And if I remember correctly, the first time we operated on him, we only removed part of the aneurysm.

SCHANCHE: I read the paper on it and as I recall there was a lot of spinal erosion from it and didn't the aneurysm adhere to the spine in that case?

DR. DeBAKEY: Yeah. I think that's right. In fact, wasn't he a sheriff.

SCHANCHE: No, I think you're right. Well, he may have been, but it was a war connected injury.

DR. DeBAKEY: Well, I'll have to get the reports and refresh my memory about that aspect of it. But in any case, we used a homograft finally. And this was not a frozen homograft, if I remember correctly. It was a fresh one. And it seemed to me.. You know, we used to have all the information about where these grafts came from. Some of these were criminals. You know, they had been killed in a.. by the police or in fights, or something of that sort. We used to get all the bodies over here. And a good many of them were Negroes. And I remember when I operated on Dr. Mims Gage he used to brag about the fact--he had an aneurysm and he was one of my former teachers at Tulane. And he developed an aneurysm of the abdominal aorta and he came over here for me to operate on him. And it was a great kind of a pleasant service for me to render to him because..

SCHANCHE: What did he teach you?

DR. DeBAKEY: Oh, he was a great clinical surgeon. He was one of my teachers in surgery. And I was extremely fond

DR. DeBAKEY: of him. Wonderful man. A very kind and he was so kind to me and my family and loved them all, you know. We loved him. He and Dr. Ochsner were two people my mother used to say a prayer for every night because they came to Lake Charles. I was living abroad in Leriche's Clinic when my brother who was in medical school at the time got burned during Christmas. And he was severely burned and they had him in the hospital and he was very deathly ill. And they drove to Lake Charles and picked him up and took him back to New Orleans and treated him and got him well, of course. And they.. My father and mother were so grateful, my mother used to say a prayer for them every night because she loved them so much for what they did. And it was a wonderful thing to do.

SCHANCHE: How old was he when he developed the aneurysm?

DR. DeBAKEY: Oh, he was in his sixties.

SCHANCHE: Was this during your early period of..

DR. DeBAKEY: Yeah. Oh, yes.

SCHANCHE: He was one of the first?

DR. DeBAKEY: Yes. Well, I used a homograft. And he used to tell the story --he was pretty cute about it --that his homograft came from a Negro prostitute. And then..you know..of great sex value to him.

SCHANCHE: Was there any truth in the rumor?

DR. DeBAKEY: Uh-huh.

SCHANCHE: It did actually?

DR. DeBAKEY: It did. Yeah. Well, he liked to tell the story. No, you see, we had all the facts about the..where we got the grafts from.

SCHANCHE: How long had you been doing them when he came? Had you done more than a hundred by then or was it still earlier than that?

DR. DeBAKEY: Well, I don't know. I'll have to go back and see. Not many more. You see, once we had reported this first at a meeting. And it's interesting. It's worthwhile going back to the proceedings of the transactions of the Southern Surgical Association. And I need to

DR. DeBAKEY: get that for you, because I have a copy of it. This surgeon from New York had been interested in aneurysms for years and he had sort of made his reputation on what he did with these aneurysms which was to put wires in. And he developed a technique of putting these wires in these aneurysms. He'd thread this wire, you know, yards and yards, of this wire into these aneurysms into the lumen. Then he had or unusually had built a very special electrical transformer contraption that would put into this wire a special kind of current, which supposedly..

SCHANCHE: Negative pull..

DR. DeBAKEY: Yeah, which supposedly would help precipitate clotting. And he had done thirty, or forty, or fifty cases--a large series at that time. And he came to the meeting and this was one of the major papers. Now you can imagine, here he was coming up to this meeting, giving a major paper on a large series of cases; he was a great expert in this; he made his reputation

DR. DeBAKEY: on doing this. And here comes an up-start at the meeting to discuss his paper and in the discussion presents three successful cases of removal of the whole aneurysm and replacement with a graft and shows these beautiful pictures, photographs, showing the aneurysm, showing the graft replacement, and then showing the patient well afterwards. Perfectly normal, you see.

SCHANCHE: That must have been electrifying to the people in the meeting.

DR. DeBAKEY: It was. Of course it was electrifying. Everybody was buzzing all over the place, you know. And here this poor fellow was left.. He never did recover, you know. He subsequently I think had a little stroke and he went into almost a fibrillate from the shock. And his pitiful response to the discussion too was even worse. Instead of saying something nice about it and saying..being in a sense a good sport about it and saying well, there's no question.. Yeah.. He tried to downgrade it by saying well, this might

DR. DeBAKEY: be possible in an occasional case, but I can assure you from my large experience that you simply cannot sew the walls of these arteries. And therefore, it's kind of a trick operation to to." You know.

And Dr. Gage was at the meeting and, of course, he came up to me and told me how proud he was. He said, "The greatest advance since Dr. Matas in this whole field of aneurysms." Dr. Matas had been..had made the only advance in over a hundred years in aneurysms. The procedure that he had developed of endo-aneurysmorically, which was to sew it up from the inside--obliterate it. So, it was kind of electrifying at the meeting. And, of course, it became quickly know all over by the doctors, and..

SCHANCHE: This must have been a year or so before you did Dr. Gage's then?

DR. DeBAKEY: Yes, oh yes. It was I would say several years. I'd have to go back and get his chart. I have his chart. I could tell you exactly when it was done. I would

DR. DeBAKEY: guess it must have been..I would say maybe '55, '54, '55.

SCHANCHE: In these meetings, I notice frequently at the end of a paper that's been delivered there is comment afterwards.

DR. DeBAKEY: Discussion.

SCHANCHE: Discussion.

DR. DeBAKEY: Yeah.

SCHANCHE: Is the author of the paper or address usually informed of what the discussion is going to be.

DR. DeBAKEY: Sometimes.

SCHANCHE: But frequently the man who is discussing will have slides and a..

DR. DeBAKEY: Sometimes and sometimes not. It's done in different ways. There are some organizations where the people who discuss are assigned to discuss it. In other meetings in the great majority, anyone can get up and discuss, if he's recognized by the chair. Now that means the chair must determine the number of people that can because of the time limitations.

DR. DeBAKEY: You know, otherwise, there.. You've got a schedule to keep and if there's time they'll allow you to discuss it, so you can get up and say anything you want. And usually the author has the right to close the discussion. And that's what this fellow did in closing the discussion he made a very, really inadequate and certainly an unprophetic type of comment. You see.

SCHANCHE: Well, you want to go back to the reports now.

DR. DeBAKEY: Well, you know, let's see.

SCHANCHE: I noticed in that same year, '52-'53, on page 40 among your accomplishments, I noticed ..

DR. DeBAKEY: Oh, that was quite of a highlight for me to be perfectly honest with you. That was.. It's kind of an honor to be a visiting professor of surgery at Harvard and the Massachusetts General Hospital. And Dr. Churchill, Edward Churchill, who was professor of surgery there, was certainly one of the great surgeons of this country, had been.. I

DR. DeBAKEY: got to know him well during the war. Again you see the relationship of how important the war was for me. And he and I got to be great friends. We took a great liking to each other. I think, largely because he recognized that I admired him. Intellectually, I think he's one of the great people that I know. And I think he took a liking to me in terms of my reaction to his intellectualism, so to speak. So, he wanted me to come and be a visiting professor. So I went up there and spent a couple of weeks and I lived with the residents in the residency building.

SCHANCHE: Isn't that a bit unusual?

DR. DeBAKEY: Yes, you see, that's right.

SCHANCHE: Being a professor of surgery and..

DR. DeBAKEY: It is. There are supposed to.. They have a V.I.P. kind of headquarters up in the hospital where they keep them, but I told them I'd rather stay at the residents, if it was alright with the residents, I would rather stay in the same hall with the residents.

DR. DeBAKEY: Largely because I wanted to kind of associate with them and I wanted to sort of get close to them and see their reactions and talk to them and so on. And I had a great time with them. In the first place they have unusually good people there. They are very well screened and they're top-quality people. Secondly I enjoyed my stay there largely because the residents were with me. The staff I found was very conservative. You know, it's the old conservative school. And a little stuffy too. I'll never forget when we were making rounds one day and there was a patient there who had gall stones--gall blatter disease--and what's called a hiatal hernia. This is a hernia in which the diaphram allows too big an opening for the esophagus and the stomach slips up, slides up. Now, sometimes the symptoms of a patient with a hiatal hernia and with gall bladder disease is very much the same. Like for example an eruptation of gas, you see, and discomfort in the abdomen. It

DR. DeBAKEY: can be very much similar. Well, they in making rounds and I was making rounds with them.. One of the residents was presenting the case and he said the patient needs to be operated on. And the staff man on whose service it was said, "Yes, it does sound like she needs to have an operation." But he said, "Which one of these lesions should be operated on first? Which one is causing her symptoms?" And he said he really couldn't be sure. And so they got to discussing it. The staff man turned around to me and he said, "What do you think? Let's ask Dr. DeBakey."

SCHANCHE: Hold it, Mike.

END SIDE B.

(END IN MIDDLE OF HARVARD ANECDOTE)