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HISTORICAL LECTURE

A Perspective on the Early Days of Pediatric Surgery

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IN MY WILDEST DREAMS as a surgical trainee, I never thought I would be in on the founding of the surgical section of the American Academy of Pediatrics, let alone be present in its 50th anniversary year.

At the time the surgical section was founded, I was 31 years old and actually had been practicing pediatric surgery at the Children's Hospital of Philadelphia for almost a year. I had been designated as its Surgeon-in-Chief, but was awaiting the final action of the Board of Trustees.

The previous year I had spent as a fellow at the Children's Hospital in Boston at what was a rather tumultuous time. Dr Ladd had retired, Dr Gross had not been appointed yet and the hostility between those two venerable fathers of pediatric surgery in America had not been reconciled.

On the house staff at the time I was a fellow, there was Luther Longino, Bill Clatworthy, Arnie Porter, Bob Bowman, Sandy Bill, and others. Charles Lowe was the chief pediatric resident.

Eleven surgeons came together with one representative of the Academy of Pediatrics for an organizational meeting at Hadden Hall in Atlantic City in October. At

From Bethesda, MD.

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that time, pediatric surgeons were known as child surgeons and the only chair of child surgery in the country was the William E. Ladd Chair at Harvard. Incidentally, its endowment was \$6,000.

By then, there were few in the country who claimed to be child surgeons. Bea Ladd and Tom Landman were retired, Bob Gross and Orvar Swenson were very busy in Boston, Oswald Wyatt was holding forth in Minneapolis and Tague Chisom had just joined him. Bill Potts was in Chicago. Herb Coe was in Seattle and had not yet been joined by Sandy Bill, Henry Swan was operating in Denver, and I was in Philadelphia.

I have a slide taken after dinner at the time of the organizational meeting (Fig 1). In the back row on your left is Henry Swan of Denver who, like many child surgeons of the day, did a considerable amount of general surgery as well.

Bob Bowman was an anomaly of World War II. He was a pediatrician who was exempt from military service for reasons of health and found his way to the house staff at Boston Children's where he was the chief surgical resident during my fellowship. His phone rings once and shuts off. His mail is not answered or returned.

His intent was to practice pediatrics and to just do the more common surgical procedures on his own patients, such things as hernias, undescended testicles, pyloromyotomies, and so on.

Next is Bill Potts who was then at the Children's Memorial Hospital in Chicago.

Next is Jesus Lozoya-Solis, a pediatric surgeon from Mexico City who owned a vitamin factory. I visited with him several times in Mexico where he gave free lectures on pediatric surgery and then closed the meeting with a sale of stock in the vitamin company.

I am next and to my left is a gentleman whom I cannot identify, nor can I find anyone else who can. In the front row is William E. Ladd.

Franc Ingraham is in the center. For those of you who



Fig 1. Founders of the Surgical Section of the American Academy of Pediatrics.

did not know this gentleman, he was an excellent neurosurgeon, operating at the Brigham and Children's Hospital, and was one of the founders of the Supranant company, which manufactured the first polyethylene tubing for medical use. He spelled his name F-r-a-n-c and it was rumored that he told his secretaries not to open any mail that was addressed to F-r-a-n-k. The thing I remember about him was the day that England declared war on Germany, he bought two Jaguars just in case the war lasted longer than some people thought it might.

Next is Oswald Wyatt, and I presume Tague Chisom was home minding the store. Then Tom Landman and, at the extreme right, the representative of the American Academy of Pediatrics who helped us with organizational matters.

Before 1946 I knew very little about the field that eventually became known as pediatric surgery. I was well aware of the fact that children did not get a fair shake in surgery, as was amply proven during my rotating internship and residency in surgery in Philadelphia.

Surgical patients came from the adult world and children had a difficult time in competing with them. Surgeons in general were frightened of children and distrusted anesthetists to be able to wake them up after putting them to sleep—a belief shared by many anesthetists as well! The younger and smaller the patient, the more advanced the hazard.

I wish I could say that because of this knowledge I was determined to make a change for the better. Actually, pediatric surgery was thrust upon me. During the last year of the war and of my senior residency in surgery at the Hospital of the University of Pennsylvania, while I myself was in the hospital recovering from an infection, my chief, I.S. Ravdin, then the highest ranking medical officer in the United States Army, temporarily back from India, burst into my room in the hospital one morning and asked me what I intended to do with my life. Before I could answer, he asked me how I would like to be the Surgeon-in-Chief of the Children's Hospital of Philadelphia.

That day began the odyssey that lasted until 1981, provided me with some of the most wonderful years of my life, and saw a fledgling specialty overcome hostility, establish itself in the hearts and minds of the public and the profession alike, and demonstrate in microcosmic form in 35 years what it took American surgery to become in 200 years.

I had 4 months to prepare myself before going to the Boston Children's Hospital for a period of a year's observation, which was part of the stipulation laid down to me before I accepted the assignment.

The others were to return to Philadelphia at the end of that time, permanently give up the practice of adult

surgery, and endeavor to establish at the Children's Hospital of Philadelphia, under the aegis of the Department of Surgery of the University of Pennsylvania, the best possible academic surgical program for children in the country.

My remarks this morning will not be global in nature. This talk is not meant to be a definitive history of pediatric surgery, it is a personal recollection by a surgeon who probably practiced pediatric surgery as long as anyone and who is recollecting—for a special occasion—from the vantage point of the early years of the ninth decade of his life.

The Children's Hospital of Philadelphia (CHOP) had been founded by a group of pediatricians in several adjacent city homes in 1865; the Boston Children's Hospital was established 4 years later. In the United States and in Europe, where the surgery of children was successfully carried out, child surgery was usually in one of the specialties, especially orthopedics.

In those days there was ample need for such specialization in the treatment of diseases that are no longer major problems: tuberculosis of the bone, osteomyelitis, polio, and the congenital defects that still do occur. Eldridge L. Eliason and Jonathan E. Rhoads had distinguished themselves periodically by a spectacular operation on a small infant. The four general surgeons who looked after the surgery that had to be done at CHOP to save lives had not done it particularly well and certainly had no abiding interest.

On the other hand, the Boston's Children's Hospital had a better legacy. The names of Brown and Langmaid appeared here and there on records as well as various orthopedists, until William E. Ladd appeared on the scene.

Today, many will tell you that Ladd became interested in the surgery of children after the tragic explosion of a munitions ship in Halifax Harbor, to which site he went to care for the injuries and burns of children. Actually his interest in children and their surgical problems began at the Boston Children's Hospital in 1910.

Ladd had established a joint internship in surgery with the Peter Bent Brigham Hospital and the Children's Hospitals, and out of that training there arose Robert E. Gross, whom Ladd took under his wing until Gross—without notifying his mentor—operated on the first patent ductus arteriosus while Dr Ladd was out of town, thereby beginning the estrangement that probably slowed the speed of development of child surgery more than we will ever know.

Nevertheless, Ladd and Gross published in 1941 the first American modern text book on child surgery: *Abdominal Surgery of Infancy and Childhood*. In it, they enunciated a principle that guided child surgeons through

the first decade or so: surgical infants and children cannot be treated as though they were diminutive adult patients.

Thomas Lanman had been a junior colleague of Ladd's, and, in addition, Ladd trained Henry Hudson and Orvar Swenson. He also brought Donald McCullum on in plastic surgery, doing primarily cleft lips and palates, after his training with two of the preeminent British plastic surgeons of that era.

When my chief, I.S. Ravdin, made arrangements for me to go to Boston, Ladd was the chief; by the time I got there he had retired and Gross was the heir apparent. But because of the antagonism between Ladd and Gross, the former made it as difficult as he possibly could for the latter to ascend to the chair that bore his name.

In the interim, Franc Ingraham was the acting surgeon-in-chief. It was to him I reported, it was Gross who ran the service, but it was Orvar Swenson and the residents who taught me what I went to learn.

I actually learned a few surgical techniques and a great deal about surgical pathology, but inasmuch as I already had more surgical training than any of the current house staff under Gross, I was somewhat disappointed in the role of an observer.

My most valuable experience was the 6 weeks I substituted as the "pup"—the lowest man on the totem pole on the medical pediatric house staff. Because of that grueling experience, I never had to ask anybody to perform something for me on a baby that I didn't already know how to do myself.

Even though Ladd had published a number of papers on his individual experiences, and even though with Gross he had published the aforementioned textbook, there was very little written about the surgery of infancy and childhood. Surgery was done in most places by general surgeons or by anatomic adult specialists, such as urologists, in what in retrospect seemed like a most haphazard way with high mortality rates and even higher morbidity.

In most hospitals, the mortality rate for a simple colostomy was in the range of 90%. The surgical patients in the Children's Hospital of Philadelphia were either orthopedic or otorhinolaryngological, with tonsils, middle ear infections, and mastoiditis being the major admission diagnoses.

As I said, the field I was about to enter was called child surgery. Some credit me with first using the term pediatric surgery, but it can't be proven. In 1946, you could say Boston had two full-fledged child surgeons—Gross and Swenson. Minneapolis had Oswald Wyatt, Seattle had Herbert E. Coe, and Philadelphia had Koop. Coe had begun as early as 1919 and Wyatt in 1928, so I was a relative newcomer in 1946.

All of us had exactly the same problems in getting started—hostility from the medical community but espe-

cially from the surgeons. A prominent Boston surgeon once told Ladd that anyone who could operate on a bunny rabbit could operate on newborns.

World War II had splintered the log of general surgery considerably. Pediatric surgery was the last of the newcomers and suffered accordingly. Surgeons didn't want to see any further fracturing of general surgery, and they were particularly incensed that there were now some upstarts in the surgical world who said that they could do any type of surgery in infants better than the designated anatomic specialists whose practices were centered around adult populations.

On the other hand, pediatricians were fearful of surgery because of the high mortality rate from anesthesia. Each referring pediatrician had his own safe-age at which to refer a patient with, say, an inguinal hernia to the local anesthesiologist.

There were other surgeons in America that had a surgical concern for children such as Penberthy in Detroit. One of Penberthy's proteges, Clifford Benson, became one of our beloved colleagues as he confined his surgical activities more and more over the years to the care of children exclusively. In Los Angeles, two general surgeons performed a lot of surgery at the Los Angeles Children's—Snyder and Chaffee. The first successfully corrected *volvulus and malrotation of the colon* was performed there.

The first day I arrived at the Philadelphia Children's Hospital in January 1946 for a 3-month probation period before going to Boston. I was given several clear messages: "You're not wanted here. You're not needed here. Why don't you go back where you came from?"

That message came from many. But this word came from the physician-in-chief and chair of pediatrics at the University of Pennsylvania: "All patients that come to this hospital are admitted on my service, and when I think they're ready for operation I will call you and take over the care of the patient immediately after it comes from the operating room." He was merely informing me of the custom of the day. I was pretty brash when I told the famous and venerable Joe Stokes that I had come to change that.

Although the then-provost of the University, A.N. Richards; my chief, I.S. Ravdin; and his associate, Jonathan E. Rhoads were very supportive and actually made the bed in which I would lie. I have to say that the University, the Children's Hospital, and the city, especially its surgical fraternity, were hostile to the arrival of someone who called himself a children's surgeon.

Second, pediatric surgery was not a traditional, vertical, cradle-to-the-grave anatomic specialty. We in pediatric surgery claimed that we could take care of infants and children better because of their physiological differences, their limited reserve, and their special pharmacological

needs than could the anatomic specialists. It was not a popular position.

So we in child surgery were actually surgeons of the skin and its entire contents. Of course, for someone trained in general surgery it was pure heaven.

I'd be operating on the skull and in the neck in the morning, perform a thoracic procedure in the early afternoon, spend the rest of the day in the abdomen, and clean up with fractures and injuries of the extremity.

The Children's Hospital of Philadelphia was not accustomed to long surgical schedules. The first day I scheduled 13 procedures, the operating room staff quit. That was not nearly as dismaying as the occasion when I admitted my first black patient to what was called the "private floor" and the head nurse resigned.

Visiting hours for parents at the Boston Children's Hospital when I was there had been 1 hour every other Sunday, and when I returned to Philadelphia they were 1 hour every Sunday.

It was not easy to get from that point to the day in which all patients' families had access 24 hours a day—not only to be with their children, but to sleep in the room with their children or next to their bed in the ward if they so desired.

Because I had been declared essential to the University of Pennsylvania for the duration of the war and had been commissioned a second lieutenant in the Office of Scientific Research and Development to work on plasma substitutes, I had not seen combat and had been able to continue my residency in the midst of my other assignments.

So when I took over the post at the Children's Hospital (acting as surgeon-in-chief until I passed my American Board of Surgery exams in 1948), I found most of the pediatric house staff to be older than I.

I look back on those days with a sense of awe when I realize that pediatricians, now the great experts in electrolyte and fluid balance, used to come to me, the surgeon, to help them out of their tighter spots. The same had been true in Boston.

The technique of administering fluids in those days was abysmal. I recall when one of my own children became dehydrated while I was in Boston, he was treated at the Boston Children's Hospital with a clysis of saline injected all at once under the skin between his scapulae. He had a "tumor" on his back as big as a grapefruit.

To insert a needle into a scalp vein in those days wasn't too difficult, but to keep it in place so it didn't infiltrate required some of the skills of a genius. We had only steel needles, detachable from glass syringes of large bulk, and it was therefore necessary to build up mountains of gauze pads and attempt to secure the needle and syringe to them in such a way that the baby's head movements, after we

had strapped the child to the mattress with adhesive tape, would not dislodge the needle.

Obviously, in surgical procedures or in patients whose veins had been damaged by multiple attempts at infusion, we had to use something more reliable. Therefore, the "cut-down" became one of the standard procedures that all surgeons and some pediatricians had to master.

We started by cutting down on a branch of saphenous vein either anterior or lateral to the medial malleolus of the tibia, and after we had exhausted those sites—usually by thrombosis—we then went to the wrist, then the antecubital, and sometimes even the cephalic. Subclavian lines, of course, didn't come in for three decades thereafter.

I wish I had time to go into detail about what a different world it was before the introduction of plastic tubing in the care of surgical patients. Even the early plastic tubes were not made of vinyl or polyethylene.

One of the early materials we used was tygon and one of the first applications was running a tygon tube from the ventricle to the peritoneal cavity for the relief of hydrocephalus. Exposure to spinal fluid changed that once flexible tube to the consistency of a piece of uncooked spaghetti. If a child fell downstairs, he might break his conduit in three or four places.

Supportive services such as bronchoscopy, a monopoly of bronchoesophagologists were hard to come by, expensive, and did not produce great results. Those of you who have become used to flexible scopes with Hopkins optics will have difficulty appreciating the all-metal laryngoscope, esophagoscope, and bronchoscopy made of rigid brass.

The patients were never anesthetized. The distance from the eye to the object in question could be the length of the baby's thorax, and the visibility was not only hampered by poor lighting but constant explosive splattering of saliva and other secretions over one's face and glasses, if we were fortunate enough to wear them.

I have said that the children's hospital was hostile. They didn't even find me an office until I had been there about 9 months. I then had a small cubicle on the fifth floor and shared a waiting room and the services of one secretary with five pediatricians. My overhead was \$70 per month and I never made that much money in one month until the 15th month that I was in practice.

In the days when I sat in the library—in lieu of an office—patients with surgically correctable lesions died on the wards of that hospital in the hands of competent pediatricians without even the benefit of a surgical consultation. That is merely a measure of the lack of confidence that pediatricians in the late 1940s had in reference to the ability of anesthetists and surgeons to deliver a patient back to the family.

One of the first things I did in my relatively leisure

days in that institution was dig out old records of patients with tumors. To my amazement, I found that a patient with a Wilms' tumor rarely survived, that patients with such tumors as rhabdomyosarcomas underwent biopsy and were allowed to die; but there was one malignant tumor—the neuroblastoma—which although inadequately treated, patients seemed to survive in spite of the treatment or lack thereof.

This began my lifelong interest in the neuroblastoma and led eventually to my very unpopular stand that this tumor required not the usual modalities of postoperative therapy; indeed they might be detrimental to the health of the patient.

My observations on young infants with a primary neuroblastoma, metastases to the liver or skin, inadequate surgery, no radiation, and no chemotherapy led eventually to the acceptance by the developing specialty of pediatric oncology that there was a group of neuroblastoma deserving of its own class—IVS.

Another early observation was that a large percentage of the patients who came to me privately or to my surgical clinic had neurosurgical problems—primarily spinabifida and hydrocephalus, or urologic problems associated with various types of anomalies of the genitourinary tract usually with accompanying infection.

I realized that we needed surgical specialists to devote their lives to pediatric neurosurgery and pediatric urology and proceeded immediately to find such persons. That began a drift of my personal opinion, and that of the Children's Hospital of Philadelphia, away from the philosophical mainstream of the developing specialty of pediatric surgery and that pediatric surgeons were indeed surgeons of skin and its contents.

Shortly after I left Boston, Willis Potts became the Surgeon-in-Chief of the Children's Memorial Hospital in Chicago and Tague Chisholm went out to join Oswald Wyatt in Minneapolis. Alexander Bill went to Seattle not long after and eventually became Surgeon-in-Chief of the Children's Orthopedic Hospital when it affiliated with the University of Washington.

Bill Clathworthy went back to the University of Ohio and to one of the few general academic surgeons other than I.S. Ravdin who was disposed in a kindly fashion toward pediatric surgery, Robert Zollinger. There he established for himself a wonderful career at the Children's Hospital of Columbus.

I began my training program the year after I returned from Boston and watched it grow and expand and become one of the better programs in the land. I graduated one trainee every June from 1948 until I left to become Surgeon General in 1981. Originally the training period after general surgery was 1 year, then 18 months, then 2 years.

When I say I departed from the mainstream, I mean

that I thought to do the best for children, pediatric surgery would have to be patterned after general surgery with pediatric specialists in all of the surgical fields.

This was in contrast to the Boston Children's Hospital early concept of being a surgeon of the skin and all of its contents. Eventually the sheer weight of evidence that, just as adult surgical specialists had brought great innovations and improved outcomes to adult surgery, so pediatrically oriented surgical specialists could do the same for children carried the day.

I set my mind to the task of building the most comprehensive group of such pediatric surgical subspecialists in depth. I accomplished my goal after more than 30 years and announced it to the Board of Managers when I had 28 surgical subspecialists in nine divisions, which included dentistry and oral surgery.

I can't say that I became bored after that; but I did lose some interest after achieving that goal, which seemed unattainable for so long, and was pleased to be called by Ronald Reagan to be his Surgeon General.

Pediatric surgery blossomed insofar as results were concerned. Survivals of newborns with esophageal atresia, diaphragmatic hernia, malrotation of the colon, atresia of the small bowel, imperforate anus, and omphalocele and gastroschisis first began to occur, sporadically until it began to reach parity with losses, and eventually we turned the almost 100% mortality statistics into survival statistics, except for diaphragmatic hernia.

For example, when I left practice in 1981—with the largest series of esophageal atresia, 475 or so—I had not experienced a death of a full-term infant in 8 years, and my survival rate for prematures was 88%.

It has to be said that without the development of pediatric anesthesiology, pediatric surgery would never have gotten off the ground. Indeed I spent as much time in the first year and a half working with Dr Margo Demming perfecting anesthesia techniques in small infants as I spent on surgery.

There was no equipment to be bought; we made our own. The night before surgery we would fashion endotracheal tubes out of red rubber catheters, file the edges with emery boards to prevent injury to the tracheal mucosa, boil them over a bent wire, hoping they would retain some memory of a curve, and then began to experiment with anesthetic gases as well as preoperative medication.

I was convinced early on that we needed a cadre of nurses to look after neonatal surgical patients and found that very difficult to sell to the hospital. I made my plea to the Children's Bureau of the Public Health Service on three separate occasions and only managed to get a grant to establish the first neonatal intensive care unit in the United States when Andrew Ivy, a competent plastic surgeon in Philadelphia with a special interest in cleft lips

and palates, vouched for me at the Children's Bureau, and I got my grant.

The first neonatal unit in 1956 had three isolettes, originally developed at the Children's Hospital of Philadelphia, a refinement of the original chappell incubator. Even with those few beds, morbidity and mortality rates began to decrease.

We expanded to 15 beds, all surgical, and eventually combined a medical and surgical pediatric neonatal intensive care unit at the old Children's Hospital to be greatly expanded when we moved to our new building on the campus of the University of Pennsylvania in 1974.

In 1948, we seemed to have everything going for us. We were improving techniques, anesthesiology was coming along, survival rates were improving, but the hostility persisted, we had no recognition, and we really had no organization behind us.

One of the most important things that happened was the meeting in Atlantic City (in October of 1947) that I have described to you. The Surgical Section was the first such in the Academy of Pediatrics. Their experience was so favorable that it became the practice as the Academy has grown and developed to 70 sections.

I have always felt particularly grateful to the Academy of Pediatrics, and repeat it on this occasion that when no surgical society would really have anything to do with us, the pediatricians and the Academy were our first and strongest supporters.

As early as 1941, Dr Ladd had expressed an interest in seeing some kind of recognition for child surgery. Out of the founding meeting in Atlantic City, the American Academy of Pediatrics took us under their wing, with the stipulation that those who aspired to membership would have to certify that they devoted 90% of their surgical practices to the care of children.

As pediatrics expanded its own field to encompass those youngsters who frequently fell through the cracks—adolescents—the field of pediatric surgery ever lengthened. The time was right to ask for specialty recognition. Accordingly, I made the first proposal on behalf of the surgical section to the American Board of Surgery in 1956.

It was not accepted with enthusiasm, but who knows how far it might have gone in a pedestrian way up the bureaucratic ladder had it not been for the unbelievably vehement opposition of the Society of University Surgeons and the American Board of Urology.

Because of this opposition, in 1957 the American Board of Surgery, which had previously agreed to sponsor us and to whom I had appealed early on, withdrew the proposal that they had made on our behalf to the Advisory Board on Medical Specialties.

The American Board of Surgery itself suggested that we make the surgical section of the Academy the arena

for our certification. This was easier said than done, but the principal concern that I had—and it was shared by others—was that we were very pediatrically oriented, but we were surgeons and deserved to have recognition among surgical specialists.

A second attempt through the Board of Surgery to the Advisory Committee on Medical specialties was made in 1967 and was rejected about 6 months later. In 1965, perhaps the single greatest event took place that enhanced the future of pediatric surgery—the beginning of the *Journal of Pediatric Surgery*.

No less an authority than Robert E. Gross said that the appearance of the *Journal* was the turning point in recognition. The *Journal* was the brain child of Stephen L. Gans, and he enlisted my help early on. The problem was that most journals were the publication of a society, and we were seeking a publication without societal support.

Dr Henry Stratton, the president of Grune & Stratton, was enough of a visionary to publish our journal. The first issue was published in February 1966 with me as its Editor-in-Chief, a post I held for 11 years before turning it over to the capable hands of Steve Gans, who managed it until his recent death. Shortly after we were in business, we were adopted as the official publication of the Surgical Section of the Academy of Pediatrics.

In the next year the British Association of Pediatric Surgeons afforded us the same honor. We had become an international journal.

It was not pediatricians who sought a specialty of child surgery. But as they learned what we could do, their support grew, and after the Academy took us under their wing, pediatricians eventually but slowly became our very strong supporters.

Success sometimes turns on small events. For me it took a well-respected pediatrician, Emlen Stokes, to start a private practice coming my way. When I repaired bilateral inguinal hernias on an infant patient of his, he started sending me three hernia patients a week out of the 40 he was sitting on in his practice—waiting for them to grow up so the surgery would be “safe.” He also advertised me to his pediatrician colleagues—thus began the parade of inguinal hernias that eventually reached 17,000.

You younger surgeons really will find it hard to picture what was considered good care for an inguinal hernia in the era of which I am speaking. For small infants, there was something called the yarn-truss. The pediatrician would make a loop about 18 inches long of perhaps 30 strands of yarn, twist it, and then wrap it around the youngster’s abdomen and the groin on the affected side in such a way that the knot that tied the two ends together came right over the internal inguinal ring. These trusses became saturated with urine and encrusted with feces and

inasmuch as parents were afraid of incarceration or strangulation of the hernia, they were not removed until the odor was unbearable.

For older children there were miniature models of adult trusses composed of steel bands, leather covered with an adjustable cushion to be placed over the internal inguinal ring. In the early days of my practice, I used to throw all of the old trusses into a closet in my office, and it eventually looked like the healing shrine at Our Lady of Lourds in France.

Long after I was fixing hernias as described, elsewhere in Philadelphia small babies were undergoing adult lacing procedure through 3- to 4-in incisions, wrapped in muslin binders, and hospitalized for 10 days. These patients were discharged to worried parents who tried to keep them from crying to prevent recurrence.

By the 1970s we had tried twice for certification unsuccessfully under the wing of the American Academy of Pediatrics and saw the safe launching of the *Journal of Pediatric Surgery*. The next thing seemed to be to bring some order out of the chaos of the training programs.

Bill Clatworthy took that under his aegis and began, with the Academy’s approval and that of the Surgical Section, a thorough investigation and site visit of the 25 programs then extant. Eleven of them were approved.

It was inevitable that eventually some of us would want a purely surgical society separate from the Academy of Pediatrics. In the fall of 1969, at an Atlantic City meeting of either the American College of Surgeons or the American Academy of Pediatrics, Tom Boles, Lucian Leape, Dale Johnson, and I met at a fish restaurant and talked over the possibility of an American Pediatric Surgical Association. We were all in favor of it to be sure, but we also didn’t want the Academy of Pediatrics to think that we were looking a gift horse in the mouth after the wonderful way that they had supported us since 1948. They graciously acknowledged that they understood our position and that the times called for such a surgical organization. It is interesting to note that, in spite of the fact that we had no recognition as a specialty from a surgical board, by the 1970s there were more than 50 departments or divisions of pediatric surgery in academic centers and teaching hospitals. Indeed, by 1969, the American Board of Surgery (ABS) acknowledged that there was a body of knowledge concerning the surgical problems of children that should be the understanding of all surgeons and that those subjects would be included thereafter in the ABS exams.

In 1970 the Advisory Board on Medical Specialties became the American Board of Medical Specialties. We tried once again for a crack at accreditation, and this time it was Harvey Beardmore of Montreal who carried the ball. Largely through his persuasiveness and the gracious understanding of Keith Reetsma, then on the ABS and

who had been one of my proteges back in his surgical residency at the University of Pennsylvania, accommodations were reached and eventually pediatric surgeons were granted, through an examination, a special "Certificate of Competence in Pediatric Surgery" under the American Board of Surgery; this was 1973. Although it took from 1955 when I first tried until 1973 for us to get certification, we had come the full length of general surgery in a period of less than 20 years.

The Bible tells us that a prophet is not without honor save in his own land. When the British Association of Pediatric Surgeons sought recognition from the Royal College of Surgeons in the United Kingdom, they were also unsuccessful. I took up the cause for them, and after some persuasive meetings with the brass at the Royal College of Surgeons of London and the Royal College of Surgeons of Edinburgh, our British colleagues were afforded recognition in the National Health Service as consultants in pediatric surgery. A very much appreciated reward for me was an honorary doctorate of medicine

from the University of Liverpool. It took an American to help the British and it took a Canadian, Harvey Beardmore, to plead the cause for his American cousins so persuasively that we finally won the recognition we felt we well deserved.

I will never forget the day at a meeting of the American Pediatric Surgical Association when Harvey Beardmore reported in detail his odyssey from start to finish. He ended it dramatically with words that still ring in my ear: "Gentlemen, you have your boards!" It was a great day. The hairs on my arms stood on end, and I felt we had achieved all we needed in our dynamic specialty.

Although we have never rewarded Harvey Beardmore as the British did me, I hope you young folks never forget what Harvey Beardmore did to secure us the recognition we now enjoy. We have never suitably honored and thanked Harvey Beardmore for the tremendous favor he did us with his persuasive way in convincing former antagonists that we were indeed surgeons worthy of recognition.