

The Legacy of J. Englebert Dunphy

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I was fortunate to have received my surgical training under Dr. J. Englebert Dunphy. Because his influence on me has been so great, I thought I would use this opportunity to revisit the career of this former member of the North Pacific Surgical Association and giant of American surgery.

John Englebert Dunphy was born in Northampton, Massachusetts on March 31, 1908. His father was a dentist, and young "Bert" (as he was always known) was raised in a traditional Irish Catholic family. He considered going to West Point, but instead went to The College of the Holy Cross in Worcester, Massachusetts, where he received his bachelor's degree in 1929. During college he thought he might go into law or journalism or perhaps the priesthood, but ultimately decided on medicine, having been influenced in this choice by his family physician.

As a student at Harvard Medical School, Dunphy was most influenced by Harvey Cushing, Edward Churchill, David Cheever, and Elliott Cutler, and was attracted to surgery. He gained the reputation of a prankster, but he was also an athlete, and was especially fond of baseball (usually playing third base) and tennis. He finished ninth in his class and was a member of Alpha Omega Alpha, and in 1933 he confidently applied only to the Peter Bent Brigham and Massachusetts General Hospitals for a position as a surgical intern. He was shocked to be rejected by both! Dunphy was advised by Cushing to accept an assistantship in pathology, which he did, but as luck would have it, 6 weeks later one of the Brigham interns developed tuberculosis and had to drop out, and Dunphy became a surgical intern. The Surgeon-in-Chief was Elliott Cutler and the Chief Resident was Robert Zollinger, and thus began the friendly rivalry between Dunphy and Zollinger that was to last nearly the next 50 years. In 1936, while Chief Resident at the Brigham Hospital, Dunphy married Nancy Stevenson, who was also from Northampton and who had graduated from Smith College and the Columbia University Nursing School.

At about this same time, Zollinger scolded Dunphy for not having written any papers, and so Dunphy studied mesenteric vascular occlusion, which had intrigued him during his pathology studies. Again as luck would have it, a patient came to the Brigham Hospital with what Dunphy was sure was mesenteric occlusion. Zollinger was skeptical of the diagnosis, but performed the operation, and the patient was the first survivor at the Brigham Hospital with that diagnosis. Dunphy tried a number of variations of his professional name—John E. or J. E.—in these early papers before settling on J. Englebert Dunphy in about 1941.



Figure 1. J. Englebert Dunphy, MD, US Army Medical Corps, 1942.

In October of 1940, the Fifth General Hospital, which was the United States Army hospital staffed by members of the Harvard Medical School faculty, was reactivated, and Dunphy agreed to Cutler's urging to accept a commission as Captain in the Army (Figure 1). In early 1942, Dunphy left his wife and two young daughters to spend the next 3½ years in the war, first in Belfast and then in Southern England in the Salisbury area (which Dunphy described as a "windswept, rain-drenched sexless waste"), where the unit planned and prepared for medical support for the invasion of France. Zollinger and Dunphy each served as Commanding Officer of the Fifth General Hospital during the course of the war. During this time Dunphy wrote a number of papers on the subject of shock that were elementary and simplistic by today's standards, but they did clarify concepts understood very poorly at the time. Dunphy respected the Army, enjoyed the military style, and in later years liked to describe medical situations in military terms.

Lieutenant Colonel Dunphy arrived with his unit in Normandy 29 days after the invasion. The Army had grossly underestimated the need for anesthetists, but otherwise the planning was good. During the month of peak activity, while the Fifth General Hospital was located in Toule, the surgeons treated 712 battle casualties and performed 1,200 operative procedures. In his 1946 paper, "The Problem of Nutrition in the Postoperative Care of Abdominal Wounds of Warfare,"¹ Dunphy provides hints of his future achievements in the areas of wound healing and fistula management, stating:

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The principal cause of the severe degrees of malnutrition encountered in these patients was infection. In every case in which residual abscesses were easily accessible and could be promptly drained, rapid convalescence resulted. To the surgeon of the future it will seem as unwise to fail to feed these patients parenterally from the very moment of operation as it now seems to us to fail to transfuse a patient who has had a massive hemorrhage.

When Dunphy returned to Boston, Cutler was very ill and soon died of carcinoma of the prostate. Francis Moore, who had been junior to Dunphy prior to the war, succeeded Cutler as Surgeon-in-Chief at the Brigham Hospital. During the 10 years after the war, Dunphy plunged into research, began his work in many surgical organizations, maintained a busy practice, and rose slowly up the academic ladder. What may have been a key event in his career occurred in 1946 when Cardinal Cushing asked Dunphy and William Moloney to upgrade the quality of care at the Home of the Holy Ghost, a nursing home in Cambridge devoted to the terminally ill cancer patient. This experience engendered a humanistic philosophy of care that he emphasized the rest of his career; it also aroused his curiosity about cancer's often unpredictable natural course. He wrote:

The occurrence of spontaneous regression renders untenable the hypothesis that "cancer is a progressive, lawless, autonomous growth dependent upon the host only for its blood supply." It implies that some of the many factors that may lead to neoplasia in the first place are essential for the progression of the lesion. The question to be answered is not what makes the cells suddenly grow, but what has held them in abeyance for so long.²

Dunphy's work on wound healing began to bear fruit in the early 1950s, as he explained the effect of a distant incision on local healing and the accelerated healing of a resutured wound. With his research fellows he analyzed for the first time the histochemical sequence of events in wound healing and the effects of ascorbic acid deficiency and protein deficiency. This work culminated in the classic, two-part treatise on wound healing published in 1958.³

In 1953, Dunphy published the first paper in which he described his philosophy of care for the cancer patient, all the more remarkable because he was a relatively young 45 years of age:

The application of...superradical procedures for extensive cancer might be more judiciously applied if the operating surgeon were required to follow these patients personally regardless of the outcome. The role of the surgeon in the palliative treatment of cancer is a most important one. His lack of interest or his withdrawal from the case, when it is evident to all that the battle is not won, takes all hope away from the patient. In the terminal stages of cancer it is a great boon to all if both patient and all members of the family are fully aware of the nature of the

disease. This is not a time to dissemble. Patients are rarely afraid to die. They are always afraid if they are being deceived and seem to be abandoned. A good physician, a sympathetic surgeon clearly visible in the background, a united family, an attitude of aggressive optimism and a determination to control pain intelligently can make these tribulations not only bearable but deeply moving and ennobling experiences.⁴

By 1955, Dunphy was a Clinical Professor of Surgery at Harvard and a Surgeon at the Brigham Hospital. He had been elected President of the Society of University Surgeons. And yet he knew he could not advance at the Brigham, and he very much wanted a chairmanship. He had been offered the chair at Syracuse, Tufts, and Kansas, but he ultimately decided to attempt to reestablish a Harvard Surgical Service at the Boston City Hospital. So in 1955, Dunphy became Professor of Surgery at Harvard and Director of the Fifth Surgical Service and the Sears Surgical Laboratory at the Boston City Hospital. During the next 4 years he struggled to make this service viable, but the competition and bickering among the Boston University, Tufts, and Harvard services was so fierce that no great progress could be made. Probably the best aspect of this time at the Boston City Hospital was the opportunity to continue his basic research and clinical studies with Stanley Jacob, Tom Hunt, David Jackson, Bill Fletcher, and Fred Belzer—all of whom followed Dunphy as he soon made the most important move of his career.

In 1959, after having turned down the chairmanship at Michigan, Dunphy at the age of 51, with wife Nancy and family (which had grown to three daughters and a son), left their native state and came to Portland, Oregon. There he became the Kenneth A.J. MacKenzie Professor of Surgery and Chairman of the Department of Surgery. He loved Portland and thrived on being the chairman. Dunphy became more active in surgical organizations; during the time he was in Portland he was Chairman of the American Board of Surgery and President of both the American Surgical Association and the American College of Surgeons (Figure 2).

Starting in Boston and continuing in Portland, Dunphy along with Stanley Jacob published many papers on the budding science of transplantation. One notable report described the transplantation of a goat's parathyroid gland into a human, with transient improvement in the patient's hypocalcemia.⁵ In 1964, Dunphy and Chapman published a landmark paper on the management of intestinal fistulas,⁶ and the concepts outlined in this paper (and enhanced in two follow-up papers in the 1970s) are still valid.

Dunphy remained in Portland for only 5 years. When he left in 1964 to assume the chairmanship at the University of California in San Francisco (UCSF), many were surprised. The problem was largely financial, in that the departmental budget was small and he was not permitted to have any income from the private practice of surgery. Nevertheless, he was able to depart from Portland—which he truly loved—leaving behind many friends, but without leaving behind any animosity.

Surgery at UCSF had a strong tradition dating back to



Figure 2. J. Englebert Dunphy, MD, President, American College of Surgeons.

Howard C. Naffziger, but in 1964 the department was in disarray due to the illness of the previous chairman and due to rapid growth of the training program. Dunphy was a very talented organizer, and he soon was able to integrate the Fort Miley Veterans Administration Hospital and several private hospitals into the teaching program, which already included the San Francisco General Hospital. He remained on the Board of Regents of the College, but his other organizational commitments tapered off. At UCSF, Dunphy fostered an international approach to surgery, and research fellows and residents were exchanged with universities in Australia, Sweden, France, and especially in England. Dunphy was particularly satisfied by his work as President of the International Federation of Surgical Colleges.

Dunphy had arrived at the peak of his career. He established an annual postgraduate course in General Surgery, he had his own practice and was active in the operating room, and he maintained close contact with about 60 residents. In 1973, he and Lawrence Way edited "Current Surgical Diagnosis and Treatment,"⁷ now in its 10th edition, and of which he was very proud.

Funding for research grew rapidly at UCSF, with emphasis on transplantation, wound healing, and the pathophysiology of shock. Fred Belzer, who had come with Dunphy from Boston and Portland, devised in 1967 a method of successfully perfusing cadaver kidneys for up to 72 hours.⁸ At San Francisco General Hospital, F. William Blaisdell pursued the entity now known as adult respiratory distress syndrome, and he stimulated a generation of surgeons, including Frank Lewis and Donald Trunkey, primarily interested in trauma. And E.J. Wylie continued to develop one of the strongest vascular training programs in the country. Dunphy stopped his own in-

dividual research in wound healing at the Boston City Hospital in the 1950s, but he consistently fostered research programs and emphasized the importance of basic and clinical research.

Dunphy's leadership achievements are almost unparalleled in American surgery. Consider, if you will, what are arguably the top five elected positions in American surgery: President of the American College of Surgeons, Chairman of the American Board of Surgery, President of the American Surgical Association, President of the Society of University Surgeons, and Chairman of the Board of Regents of the American College of Surgeons. Only David Sabiston and J. Englebert Dunphy have held all of these positions. Only 10 individuals have held any four of these positions.

Dunphy was emphatic that one could not be a professor of surgery without attention to three essential elements—teaching, care of the patient, and research. Research is important only to the extent that it ultimately is reflected in the care of the patient. The professor must continue to perform surgery, and he or she cannot allow administrative duties to override that link to the patient. Dunphy felt that students needed to have a fairly fixed curriculum, exposing the future family physician to surgery and exposing the future surgeon to psychiatry. He believed that students need to be able to personally identify with their professor by close, repeated contact in the classroom, operating room, and clinic, and at the bedside. He was fond of quoting Jacques Barzun, who said, "The communication of knowledge needs dramatic form," and Dunphy believed surgery and surgical diseases lent themselves perfectly to that mode of teaching. On ward rounds, Dunphy emphasized warm and sympathetic contact with patients as well as gentle examination.

Although a traditionalist in many ways, Dunphy enthusiastically welcomed women into general surgery. In 1964, he advocated greater emphasis on family practice during medical school, and recommended establishment of family practice training programs and a board of family practice, which was established 5 years later in 1969.

He loved to operate, and although not a technical master, he patiently taught the residents his accumulated skills with his usual good humor. However, he was startled at the widespread use of the electrocautery when he came to UCSF, and was quick to blame wound complications on its use. In later years, however, he was won over to some extent by the speed and reduced blood loss that the electrocautery afforded.

Without doubt, the most important component of Dunphy's resident teaching was the weekly "death and complication rounds," and attendance was mandatory unless one was in emergency surgery. Lessons came in the form of unusual problems or complications, technical pitfalls, and triumphs, as well as horror stories. However, even more important than the lessons was the discipline of candid and forthright description of errors and failings. The act might be likened to confession or putting on the hair shirt. The purpose was an honest discussion of errors of technique and judgment, and although Dunphy might not have been pleased with what he was hearing (Figure 3), the error was accepted with a clear understanding of



Figure 3. J. Englebert Dunphy, MD, during rounds with house staff.



Figure 4. Dr. Dunphy, late in his career.

what one would do in that same situation next time. Dunphy could be harsh, but was fair as long as he sensed a forthright, if not contrite, presentation. And just when the tension would become palpable, Dunphy would often make a humorous comment or tell an anecdote that would lighten the moment. The goal of these teaching rounds was to produce a surgeon capable of identifying and correcting errors and shortcomings internally for the remainder of his or her career.

Of the 143 residents trained by Dunphy over 16 years in Portland and San Francisco, one quarter are in full-time academic surgery, including 6 department chairmen and an additional 24 full professors.

Dunphy had many qualities that elevated him beyond his objective achievements, and certainly his wit and humor were prominent. It is impossible to do justice to his ever-present wit, whether it was while moderating a panel discussion or on rounds. His reputation as a prankster and practical joker dated to medical school days. He had an infectious, distinctive laugh, which Zollinger called fiendish, that one could pick out over the crowd at any occasion. One could write a book of Dunphy stories, but suffice it to say he loved a party.

Dunphy was a very skilled writer and an articulate speaker. His papers were most remarkable for their ability to synthesize and clarify subjects that previously were a muddle of fuzzy thinking. His Jesuit education and life-long love of literature served him well. In 1958, in a Class Day address at Harvard Medical School, he said:

Charles Dickens, in *A Tale of Two Cities*, wrote:
"It is a wonderful fact to reflect upon that every hu-

man creature is constituted to be a profound secret and mystery to every other." We are all mysteries to one another, even to our dear ones. Yet as doctors we are privileged every day to step across the barrier into the hearts and minds of our patients. On the sick bed we see man as he is as well as who he is. He in turn, if we give wholly of ourselves, sees something of the secret in us. Here rather than in our societies, our laboratories, our hospitals, or our universities is our future. We will keep it or lose it on the same field.⁹

Dunphy's most well-known essay is "On Caring for the Patient With Cancer,"¹⁰ and Dunphy's classmates at Harvard Medical School now provide every graduate with a copy. It beautifully summarizes his philosophy at the end of his career (Figure 4). What most did not know when this paper was published was that Dunphy himself had cancer. The diagnosis of carcinoma of the prostate was established in 1974, at which time he had metastatic disease. (In fact, the diagnosis had been suspected clinically in 1964, before he came to UCSF, but he did not want to pursue diagnosis for fear that it might jeopardize his new position.) He underwent radiation therapy, which gave him crippling diarrhea. He recruited Paul Ebert, who was a Zollinger trainee from Ohio State, to take over the chairmanship, and then he retired in 1975. He kept an office at the Veterans Administration Hospital where he continued to write, and one of his last papers concerned the importance and value of the hospice movement. He spent as much time as he could at his second home at Stinson Beach, north of San Francisco.

The story of Dunphy's last months is a sad one, not only

because of his personal misery, but also because with a very few exceptions, his colleagues rarely came to visit, and his medical care and pain control were managed by family members with little professional help. It is as if his professional family had not read or remembered his teachings. He died on Christmas morning of 1981 at the age of 73 and was buried next to a small chapel in Bolinas, near his Stinson Beach home, in a graveyard that was once an Indian burial ground. His grave is marked by a carved redwood marker that he designed. He and his wife Nancy had a remarkably interdependent married life. Nancy, who had been treated for carcinoma of the breast about 12 years earlier and who had done well, went into a profound depression, and then had an abrupt recurrence of her cancer and died 2 years later in 1983.

Let us remember and honor J. Englebert Dunphy—a skilled surgeon, an organization man, a jovial party man, a caring physician, a curious biologist, an enthusiastic teacher, and a profound humanist who left a legacy that consists not only of surgical teachings but also of a body of philosophy about patient care. There is plenty for each of us to emulate. "Surgery, like war, is hard," he wrote. "But it is better than war. It saves lives and binds men and women of good will together in deepest friendship."¹¹

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