

B: I'm at the offices of the Bayfront Health Foundation in St. Petersburg, Florida. My name is Alan Bliss. This is the oral history interview of Dr. John Crayton Pruitt. Dr. Pruitt, thank you for consenting to this interview. Please tell us, if you would, where and when you were born?

P: I was born in Jefferson, South Carolina, on November 23, 1931.

B: And who were your parents?

P: My parents were Helen Gregory and Joe Major Pruitt. Helen Gregory's father had been a general practitioner who graduated from the University of New York Medical School back about 1880. From the time I was born, I never heard anything except that I was going to be a doctor. My mother didn't let me even consider anything else. By the time I was six, I agreed that's what I wanted to be, and I never wavered.

B: Did you know that doctor, your grandfather?

P: No, he died before I was born. They had auctioned off his office equipment and supplies when I was about eight years old, and I had bought his medical books. All through my childhood I used to try to look at those books and think about being a doctor. We lived in Columbia, South Carolina, until I was in high school, and then we moved to Anderson, South Carolina. My father worked for the Federal Land Bank, which lends money to farmers. When I graduated from high school, I wanted to go to a university that had a good record for getting people into medical school, and Emory University in Atlanta, Georgia, was about 120 miles away and had that reputation. So, I applied there and was accepted. I also was accepted at the University of South Carolina Medical School, called, well at that time, it wasn't called the University of South Carolina Medical School, but it was the state medical school in Charleston, the College of Charleston in Charleston, S. C.

B: Is there still a medical school affiliated with the College of Charleston?

P: Yes there is, they have a South Carolina Medical School and also the College of Charleston. It's at Roper General Hospital. And of course, Emory is still going strong and a very distinguished medical program there. So when I finished medical school, and the professors were all saying, well, you probably ought to take your residency at a teaching center. But there was a friend from St. Petersburg, his father was a doctor in St. Petersburg, Dr. Franklin Roush. His father had started practicing in this hospital and in St. Anthony's when it first opened its doors and had been here for years. Frank Roush Jr., during World War II, went into the V2 program, a sped-up program to get people through medical school quickly, and when he graduated he was sent to Ft. Jackson, in Columbia, South Carolina, when we still lived in Columbia. He rented a garage apartment from my parents and brought his bride there. He and I became close

friends. After he got out of the army and came back here and went into practice of internal medicine, he would invite me to St. Petersburg to spend a week with them during the summer. I would make rounds with him, oftentimes here in this hospital.

B: This is while you were still finishing at Emory?

P: Actually, even when I was in high school.

B: So you have a longstanding St. Petersburg connection.

P: Yes, and when it was time to choose my residency, I admired Frank a lot, and he said they had a very good rotating internship at Mound Park Hospital, and if you take a residency in surgery, which is gonna take you about five years after your internship, you'll have plenty of time to be in a teaching center, and it wouldn't hurt you to have a rotating general internship in a place that's got both welfare patients and private patients, to learn how to talk to both.

B: Let's back up for just a second. I want to ask you about the rotating internship, but back up for just a moment to your decision to go to Emory. Your mother imbued with you this ambition to become a medical doctor and it was not something you say you ever dissented from. You followed through on that and kept it in mind, but I see from your CV (curriculum vitae) that you chose English as your undergraduate major at Emory. Why English?

P: I like to read books and I was making A's in Chemistry and Biology, but I still like to read a lot, so I just chose English. I wasn't really fired up about any particular scientific program, except just to get my medical degree and learn how to be a surgeon.

B: You didn't see any of the biological-related sciences as being really necessary to get you on the medical school track?

P: I knew I'd get that in medical school.

B: Okay, fair enough.

P: In pre-med they require a lot of that stuff anyway, whether you choose it or not you have to take it.

B: So you came to Emory Medical School pretty thoroughly grounded in Biology and the related programs. All right, not to get too far ahead of ourselves, but I see you published pretty extensively later in your career and I wonder if your English preparation as an undergrad helped prepare you for good writing.

P: It probably did.

B: Well, moving ahead then, you're at the point now when you finish up at Emory of making a transition to what you call a rotating internship. Could you explain what a rotating internship is?

P: Yes. You spend a month or two on surgery, a month or two on internal medicine, one month on urology, one month on ENT, you rotate through all the different specialties to see if there's one that you particularly like more than others that you might want to go into a residency of. And if you're going into general practice, it's also good to have been exposed to all of those things.

B: Is it typical for all that to happen at one hospital or one institution?

P: Yes.

B: Now, before you came to St. Petersburg to do that, to go through those rotations in different specialties and fields, did you already have an idea of what it was you wanted to do in your medical practice, in your career?

P: Yes. I had worked in the little county hospital in Anderson, South Carolina, and in that hospital there were a couple of surgeons who let me assist them in the operating room quite a bit, and I had become fond of surgery. But I hadn't made up my mind definitely for surgery, but I was leaning toward surgery already when I came here.

B: Were there any other fields that were kind of calling out to you then?

P: Yes. In medical school, polio was rampant at that time, and we did not have a polio vaccine.

B: This would have been in the early 1950s?

P: Right. So as a medical student, I had the idea, well, actually what happened, I read one day that blood banks had started in Russia. Right now the "Iron Curtain" was down and there was no literature coming out of Russia since 1930 and this was about 1952. I read that blood banks had started in Russia and when they first started the blood banks, they were using blood from people who had died suddenly, sudden death. They took the blood out within a few hours of death.

B: Now, you're referring to blood banks for emergency transfusions and the like.

P: Blood banks for any kind of transfusion. So, I said, well, my gosh, I didn't know that. I had no idea that blood banks started in Russia, number one, and I had no idea that you could give blood from people that were dead to living people. If you can give them a whole blood transfusion, I bet you could get the gamma globulin that they were using extensively in cities where they had a polio epidemic--they would give everybody an injection of gamma globulin. But there was a tremendous shortage of gamma globulin, they didn't have enough of it. So my idea was, well, there ought to be enough of it in these dead people right up until they die. So, I applied for a little grant there at Emory, and we got about a \$2,000 grant and Dr. Papageorge, a female doctor, was kind enough to let us use her laboratory at night to do our research on dogs. So we designed an experiment where we killed the dogs with injections of nembutal, and then we took blood from the dogs at one hour, two hours, three hours, four hours, five hours, six hours, seven hours and eight hours after they died. Then we sent all that blood to the laboratory for large numbers of tests, including serum electrophoresis and bacteriological studies. It turned out that for the first six hours we couldn't see any changes, depending upon the temperature. If it was not too hot, the blood seemed to be good for six hours almost just like it was when the person died.

B: If it was not too hot, meaning the ambient temperature in the lab?

P: Right. When the temperature went up, you had less hours to get the blood out.

B: Was the lab not air conditioned at that time?

P: Yeah, it was, but we turned the temperature up as one of our variables. So, we wrote a paper and it won the AOA research award.

B: AOA?

P: Yeah, that's an honorary medical society at all schools. Alpha Omega Alpha.

B: That would have been in about 1954 or 1955.

P: It's in there that we won the award. So I was interested, because of that, in research a little bit. Also, I had learned a little bit about hematology doing that, those studies. I came on here in my general rotating internship, and by the way, there's a council that goes around and evaluates all residency and internship programs and grades them. There are about four men on this committee that evaluates internships and residency programs, and it still does it. The son of the guy the was in charge of the committee interned with me here at Mound Park.

B: Where had he gone to medical school?

P: University of Michigan, I think.

B: So you were colleagues as interns here at the time.

P: Right. The internship program had a very good reputation for the son of the man that evaluated them, for the father to let his son come here.

B: Right. That speaks well of the program. What was his specialization later? Do you recall?

P: No, I don't know.

B: Do you recall his name?

P: No. I don't, but if you looked in my class, I was in the class of [19]56 that was when I interned here. I could pick him out of a picture.

B: It was 1956 and 1957 that you spent apparently one full year doing rotating internships here and went through several specialties.

P: Right. Everybody went through essentially the same ones.

B: That didn't change your thinking about your inclination toward surgery, I guess?

P: No. Except I was still also liking research and hematology to some extent, but I was primarily leaning toward surgery.

B: Which surfaces later in your career, but surgery stays front and center.

P: Right.

B: I'm curious to know, you said that you had assisted in surgery at the hospital in Anderson, [S. C.], actually before even going to medical school. Meaning, how much assistance, did you scrub up and actually participate?

P: Oh yeah, they taught me how to do all that. They called me an 'extern'. I was a surgical extern, they called me. Mainly I was holding retractors, but gradually they let me do more and more. I didn't do the actual operations, I just was listening to them tell me about the diseases, and what they were doing and why they were doing it and what was better to do than what else was a comparative way of approaching things.

B: These were surgeons who did general surgery, whatever was necessary at the

hospital.

P: General and thoracic. Both there. They were very well-trained and good surgeons. I became close friends with them. I really learned some good things from them. The hospital, Mound Park, had some very outstanding, good teachers here. There was one Jewish fellow who was in charge of the radiology department, Lenny Freed. He died a couple of years ago, but Lenny Freed was a genius, no question. He liked the interns. He used to take us out to eat at night and so forth and have parties with the interns. He spent a lot of time trying to teach, and he brought over a lot of students from other countries and had them working in his X-ray department.

There was one that he brought while I was an intern, named Martin Donner. Martin Donner had been, he had boards in internal medicine and radiology in Germany before he came to the United States. But you can't come to the United States and do what you were doing over there. You have to start all over when you get to the United States, not medical school, but in your residency. So he was getting some credit for time spent here, but he was limited in what he could get here. So he left here, and he went to Johns Hopkins. The year I finished my internship he left and went to Johns Hopkins to take a radiology residency. Of course, he had already had it earlier in Germany. And when he finished the program there, they made him the chief of radiology at Johns Hopkins.

B: That's a pretty dazzling transition.

P: I know. Well, he was brought here by Lenny Freed, and he was here with me. He helped to teach the residents here during my internship.

B: You say Lenny Freed made a practice out of bringing students in from other countries. Any idea how that came to be?

P: No, I don't know. But as I say, he was practically a genius. He was also a good businessman, and he later, Lenny talked some doctors here into making some investments with him. Some of them hit good, and some of them hit bad, but ultimately there were a good many people that got mad at Lenny. So he sort of went nearly bankrupt himself from one of those investments, and for about three years you didn't hear anything from Lenny. Then he came back to town and a newspaper article came out and said Lenny Freed was going to build a hospital in St. Petersburg, a private hospital. Everybody was laughing around here saying, that darn Lenny Freed, he's never going to be able to pull that off, he doesn't have two cents, and he's going to be running around here trying to get us to invest in this harebrained idea, and we're not going to give him anything. So everybody was kind of giggling around behind his back, and next thing we knew,

he never did ask anybody in St. Petersburg to put up any money for it. He had outside investors from Philadelphia and around and they built what's now St. Petersburg General Hospital. It was highly successful, and he became the radiologist there as part of the deal. Bayfront didn't want to hire him back, so he just built his own hospital and became the radiologist there. He was one of these guys you just can't hold down. He ultimately built, in addition to that hospital, he built another hospital, I think Seminole Hospital. But, he was quite a guy.

B: When you came to Bayfront, well, it was Mound Park at the time when you came here as an intern in the 1950s, you say you'd had experience at the hospital in Anderson. Of course you'd had some experience in the facilities connected with Emory in Atlanta. So you had a couple of institutions to compare Mound Park to. How did you think Mound Park stacked up in comparison to the other places where you'd seen medicine practiced?

P: Very good. Very good. One outstanding difference, then and now, that is an important difference and it's not a good difference, is that at that time, every Saturday morning at Mound Park Hospital, the chief-of-staff presented every death that had occurred in the hospital, and the doctor that was in charge of that patient had to come up there and talk about the case and explain what happened. The pathologist showed the slides and he explained what the cause of death was, and we discussed what you could have done better or different.

B: This would have been a meeting of the entire medical staff?

P: The entire medical staff. Every doctor knew every other doctor in St. Petersburg. Everybody was sometimes up there presenting a case that had died. We weren't tearing each other apart, we were trying to see what we could come up with to keep that from happening next time. There was no worry about malpractice suits and so forth. But then as malpractice became a worse problem, the doctors quit asking for autopsies. Pretty soon, there weren't any autopsies, and then we weren't having any meetings on Saturday morning, and the teaching opportunity for all of those deaths disappeared. That was not just at Mound Park Hospital, that was in the whole country.

B: That practice of reviewing and critiquing treatment that led up to a death, was that something customary in a lot of hospitals at

the  
time?

P: Yes. To some extent they try to do it now, but it's not the same because malpractice is on everybody's mind, they can't really say anything.

B: Sure. Over what period of time would you say that came to be, that transition you described between being a pretty routine critique to the point where people were reluctant to even face the . . . .

P: Over a ten year period of time.

B: So by what, would you say, the end of the 1960s beginning of the 1970s?

P: Right. It's gotten worse and worse all the time.

B: Do you remember any other people connected with Mound Park while you were here? You mentioned Lenny Freed, any other personalities stand out that you recall?

P: Well, Frank Roush was an extremely busy internal medicine specialist, and he had a partner called Claude Murr who was very good. There were some very good cardiologists. I'm having a little bit of trouble with their names. One of them was a red-headed guy, he was really good. It's on the tip of my tongue, but I can't get it out.

B: I've talked to one cardiologist who was practicing here at the time, and that was Sidney Grau, I guess he was around here at the time.

P: Sidney Grau is still practicing, I think, or he's just finished in the last year.

B: He retired about three years ago.

P: Did he? Well, he was very good as well. They've had some--George Wood was a Mayo Clinic, board certified heart surgeon that was here. He was doing heart surgery when I was an intern here, not open-heart, we didn't have open-heart at that time. He was doing mitralvalulotomies and that kind of thing, a very outstanding surgeon. The quality of care was outstanding.

B: How about the facilities, in terms of the physical plant and the equipment and resources. Would you say that compared favorably, competitively to other hospitals?

P: Yes, except the hospital was not air-conditioned at that time.

B: So I've heard.

P: So sometimes in the operating room, it was really hot in there. We had fans going.

B: Was that unusual for hospitals in the South in the 1950s to be . . . ?

P: No, it wasn't unusual. There were not even any telephones, as a matter of fact, in the hospital. I mean, in the patients' room, and of course no TV.

B: I've been told by some of the nurses that I've interviewed that if a patient wanted a fan in their room on the floor, they had to bring their own?

P: Yes. The hospital was so crowded in the season, that in the hallways we had beds lined up down the hall with curtains around them.

B: Now, there was a new wing under construction when you came, I understand, that was about to add some more floor space. Did that open while you were here?

P: Yes, it did. But we still had people in the hall.

B: That must have been a big difference from your previous experience. At least where there was this big seasonal pulse of a population?

P: Yes, I hadn't seen that before. Right. But the nurses did a darn good job. They were good.

B: Did you ever have any experience with any of the facilities at Mercy Hospital at the time?

P: Oh yeah. The interns rotated through Mercy Hospital for a month, and we delivered all of the babies over there and helped in surgery, took care of the patients in the clinic. They had really good food there, and we sort of enjoyed going over there. The hospital, they built a new Mercy Hospital and it was actually, for a while, nicer than Bayfront. But then Bayfront improved and became better than Mercy.

B: When you say nicer, do you mean in terms of the . . . ?

P: It was a newer facility.

B: The general physical plant?

P: Right.

B: How about in terms of the equipment and specialized resources, would you say it was nicer?

P: It was about the same. They didn't have everything over there, but they, it was a pretty well-equipped hospital. But when I went off for my surgical training and I came back, they were still using Mercy Hospital, and it was still segregated. I had been here less than, of course, during my residency training it was not segregated. That was at Bowman Gray [Hospital], Winston-Salem, North Carolina.

B: Okay, Winston-Salem had integrated its healthcare facilities by then?

P: Right.

B: Oh, that's interesting. I'll ask you about that in a moment.

P: I came back and I'd been here about ten months, and one night I got called in the middle of the night, I was on call, this was before Medicare, and we had a rotation list where, when we rotated being on call for the emergency room at this emergency room, and at Mercy and we did all the welfare work the night we were on call. We just didn't send a bill to those people at all and it worked fine. I got called up there to see a patient about 11:30 at night.

B: At Mercy?

P: At Mercy. We had what I thought was an acute abdomen, something bad going on in the abdomen, and I needed some X-rays before I could take him to surgery. I thought there was a ruptured ulcer, a peptic ulcer. But I needed the X-rays. Cliede, the girl who was the radiology technician there. She was a very intelligent girl. I had worked with her for years in my internship and then when I came back for ten months. I knew she knew what she was doing and she couldn't make the X-ray machine work.

B: They had a machine at Mercy.

P: Yes. But she took three [x-rays] of them and it was now about 2:00 in the morning and none had turned out good enough to take somebody to surgery. By this time I was, my patience had worn out and I said, "We're putting this patient in my car and I'm going to take them to Bayfront and do this case." I called over here and said, "I'm coming over there." They said, "You can't do that." I said, "I'm doing it." I put the patient in my car and brought him over here, got the X-ray, and it was a ruptured ulcer and we operated here. It wasn't

too much longer after that they integrated.

B: Somebody in radiology resisted the idea of bringing a black patient over from Mercy to be treated here?

P: I don't think it was them, I think it was the admitting office here. But I didn't listen to them, I just did it.

B: That would have been probably about 1964 or 1965, and the actual transition occurred in 1966?

P: 1964. It would have been 1964.

B: When this incident happened?

P: That's correct. At any rate, when I was toward the end of my internship, we still had a doctor draft. The United States was not fighting any wars at this time, after the Korean War, but they still had a doctor's draft. They weren't drafting anybody but doctors. Doctors still had to serve two years.

B: Meaning you'd register with the selective service and declare your specialty and they'd just, they would call you up sometimes?

P: Well, you had a choice, you could go ahead and enlist, and you'd go in as a, I think it was a second lieutenant as a doctor, maybe it was a first lieutenant.

B: In any branch?

P: Right. Or you could go ahead into your residency or to practice and worry about were they going to draft you for two years. So all the interns were talking, what are you going to do? Are you going to go? Some of them were going into practice and some of them were going to go ahead and enlist and get the two years out of the way and then come back and go into practice. But there was one other possible alternative, and that was the National Institutes of Health, which is a part of the United States Public Health Service. The NIH has a huge hospital in Bethesda. If you went there, if you could get in there, it was hard to get in, but if you could get in there, if you spent two years there, you would usually be able to get one year of residency credit in whatever residency program you went into. A lot of people were trying to get in that. I tried and because of having done that research on the cadaver blood they considered me a research prospect and took me there. So I went into the United States Public Health Service when I finished my internship and was sent to Bethesda.

B: So you went straight from St. Petersburg to Bethesda, not going straight to your residency program at Bowman Gray in Winston-Salem?

P: That's correct.

B: Let me ask to clarify this now, was this residency at the National Institute of Health supplemental and sort of running congruent or concurrent to your Bowman Gray residency, or did the two stand completely on their own?

P: They stood completely on their own. They were not planning to send me through my residency. When they took me in, they assigned me a research project in hematology because of my work on the blood before had been hematology. We were studying how cancer spread in the blood from one site to another. So I wrote several papers, as you can see, while I was there. At the end of the time that I was there, the research had been very promising. We had found a way of identifying cancer cells circulating around in the blood. The idea was that if we . . . this might be good enough to be a blood test for cancer. In other words, if you did a screening test on people and you found cancer cells in their blood and you knew they had cancer somewhere and you'd bring them in and study them more.

B: Had there been no such thing up until then as a blood test for cancer cells?

P: No. This turned out to be not good enough for that. There were too many false negatives, but it was good enough so that you could find out the answers to certain problems, like say a surgeon is operating on a cancer of the colon. How important is it to tie off all the blood vessels that are draining that tumor before you squeeze that tumor or manipulate it in any way? Are you knocking off cancer cells when you're trying to take it out? Does surgery increase your likelihood of the cancer spreading? Are you doing bad things when you're operating? And how much effort should you make to isolate that tumor's blood supply before you touch it? To do that, they needed a surgical resident, somebody that was in the operating room, scrubbed in, so he could take the blood from the veins draining the tumor and also from arm before anybody touched that tumor, then when they're halfway through dissecting it out, and at the end and then from the arm for several hours afterwards so we could see how many cells we were knocking off and how long it took for them to disappear from the blood and all of those things. Since I had been doing this at NIH and my two years was up, they offered to pay for my residency in surgery, let me go through as a, like a captain's rank.

B: Meaning the NIH offered to pay.

P: Yes. The United States Public Health Service. For me to continue doing the research during my residency. They had an arrangement with North Carolina Baptist Hospital and Bowman Gray School of Medicine and they took me down there and introduced me to the chief of pathology there and the chief of surgery

there, and they worked out a deal where I had a laboratory there and I had seven technologists to study the blood and help me. I had an, ultimately, a Ph.D. immunologist and it became a big thing there. But, NIH sent me there and I continued to do the research for them throughout my residency.

B: How long were you at the NIH hospital in Bethesda?

P: I was at Bethesda for about six months and then they sent me to, they had a laboratory in Hagerstown [Maryland], which is about thirty miles away, forty miles away. I had bigger laboratory facilities and I had easier access to patients in Hagerstown than I did in Bethesda.

B: Why is that?

P: Well, the NIH hospital is not primarily a surgical hospital, so I was going all over Washington D.C., trying to, chasing down surgeries. Up in Hagerstown it was easier to do. I was at NIH for six months full time, and then the rest of the time I was in Hagerstown.

B: That took you through a two year obligation to the Public Health Service?

P: Right, and Bowman Gray agreed to give me one year of surgical residency credit for the two years that I had spent there.

B: Okay, so you did part of the time at Bethesda, part of it in Hagerstown and part of your two year commitment you finished off at Bowman Gray?

P: No, I finished up the two-year commitment at Hagerstown. Then I came to Bowman Gray into the residency training program and continued the research.

B: Where you started with a leg up, having received credit for part of your residency obligation at the NIH.

P: That's correct.

B: So your choice of Bowman Gray as a place to do the balance of your residency, that wasn't entirely your own choice, it was influenced by the NIH?

P: Right.

B: How come they had that relationship with the people at the North Carolina Baptist Hospital?

P: Well, NIH is set up, they get a tremendous amount of money and the senators don't want to spend all the money in Bethesda, they want to spend it all over the

country. So they have one big branch that handles the research in all the hospitals in the country outside of Bethesda. So it was that branch that was supervising my work.

B: So there are various hospitals around the country that have . . . ?

P: They've got research in a lot of them, yes.

B: Maybe each one has its own particular research strength and that's what the NIH helps them with?

P: Right.

B: While you're doing this in Bethesda and Hagerstown and Winston-Salem later, what were you thinking about for the future, after you finished your obligation to the Public Health Service and finished your residency? Did you have a design or an idea in your mind?

P: Well, I got really interested in the research. I was very enthusiastic about it, as you can see from the papers that I was writing on it. Then at Bowman Gray we got interested in the fact that a lot of these cancer cells that we saw circulating around didn't ever grow somewhere else. We didn't know how the body was protecting itself from those cells and not letting them grow somewhere else. The fact that there were circulating cancer cells didn't mean that they were going to stop and grow. That was interesting. Why did they grow in some people and not grow in other people? So we got a Ph.D. immunologist down there and started doing a lot of human cancer immunology. We had a program going where we'd have a patient, say they'd have melanoma, and we would grow his cancer cells in tissue culture. Then we would take time lapse cine-photomicrography, where would take a picture of these cells microscopically every three or four hours. It would end up with what looked like a movie, where these cells are moving around. You could see the mitochondria doing its work in there and the nucleus moving around and the cell would be crawling across the slide. Then we would take some of the patient's blood and spin it down and take the white cells off the top of it and put it in the tissue culture chamber and keep on taking our pictures. We saw that some of these white cells would attack the cancer cells. That was very interesting. They call it imperoposis, when a white cell actually hits the cell wall and pops right through the cell wall. It crawls right through the membrane of the cell wall and gets inside the cytoplasm. Looking at it every five minutes, that thing, that white cell is churning across there like a motorboat going through the cytoplasm of the cell. If just one white cell would get in there, the cancer cell would pretty soon kill it. But if ten or fifteen white cells got in there, the white cells would kill the cancer cell. So we said, gosh, well, we need to see if we can make these white cells a little more aggressive. So we started making vaccines out of the patient's tumor. We'd

grind it up and mix it with things they call adjuvants, which make a vaccine more antigenic. That's tuberculin and talcum powder. Then we would inject this vaccine into this patient several times. After we gave a series of three of these vaccines, then we would take a known number of white cells from that patient and put it in there and check and see if those cells were any more active, those white cells were any more aggressive and could kill the cancer cells any better. Then we decided, you know, this patient might be overwhelmed by his cancer, we might better find somebody that's got the same blood type and inject the vaccine into them and then put their white cells into this thing.

We did a lot of research on that to be sure that we couldn't give the person cancer by injecting this stuff into them, and some work had already been done in the past that showed immunologically that you couldn't inject cancer from one person into another. It wouldn't grow, just like a heart, you can't transplant organs without giving immunological medicines to suppress the immunologic system. We decided it was safe, so we injected our vaccines into somebody with . . . we only used doctors and nurse volunteers, people that could understand the research, who could sign a release and say, I understand what you're doing, and I'm willing to do it. In all of these studies we would use the same number of white cells so that it was a comparative thing. We had white cells taken from the patient before we grew it in a tissue culture and before we gave the patient vaccines and from the volunteer before we gave him vaccines and then afterwards. We had all of controls going, and it turned out that in melanoma, when you injected the vaccine into that person and stimulated some resistance and then put those cells in the tissue culture chambers, those white cells really were aggressive and they would attack those melanoma cells and kill them off in droves.

B: Must have been a pretty exciting thing to observe.

P: It was. We made a big video of that, and I presented it at the Third International Cancer Congress in Montreal. The audience was filled with maybe 500 people. That research has held up over time. When I finished my residency and turned this over to someone else to continue with it, that's where we were, I had just given that talk in Montreal. It has turned out that there is a cellular resistance that can be stimulated in melanoma. You can do it a little bit in the other tumors but not nearly as much as in melanoma. That's held up and now they are giving vaccines to people to help treat melanoma. Duke University has a big immunologic program for that. There are companies now that are multi, multi-millionaire, million-dollar companies that are working in human immunology for cancer, but I had no ideas of any of that. I was doing it just to further science and to write the papers about it. I wasn't trying to get any money from it.

B: Did it tempt you to follow a career path in the direction of immunology and

cancer research?

P: Yes. When my residency finished, they offered me the job of being second in charge of the surgery department at NIH in Bethesda.

B: Back in Bethesda, where you were . . . ?

P: Right. But I had had a thoracic surgical residency as well as general surgery residency.

B: At Bowman Gray?

P: Yes. Thoracic and cardiovascular, as well as general surgery. At NIH, at that time, they were not doing any thoracic or cardiovascular surgery. My father didn't like the idea of my being trained to do that and not doing it. He also, he preferred for me to go into private practice. When you're working for the government, for example, the NIH completely reorganized three times during the five years that I was working with them.

B: All during the 1950s?

P: [nods head] Each time they'd reorganize, the new guy came in there and he stopped all research until he could evaluate everything. And all my people were sitting on their hands for a couple of months, not knowing if they were going to still have a job, not knowing if our project was going to continue. My dad heard me complain about that three different times. One time it was a terrible thing, the guy that was in charge knew about my human injections of cancer vaccines and he was fine with it, but then the new man that came in, he was scared to death of it. There for several months I thought they were going to close that down. Ultimately he let me continue, but it was nerve-racking. The other thing is NIH at 5:00 p.m., if you're standing between the steps and the door, you get trampled. Man, at 5:00 p.m. everybody's out of there. I said, well, Dad, I'd like to go do it, and if I don't like it, in a couple of years I'll go on into practice. And he said in two years of working eight to five you're not going to be worth going into practice.

B: You'll be ruined.

P: You'll be ruined. He said, you've given them seven years now, and you've done your best. Turn it over to somebody else and go on into practice and do what you were trying to do. So, I thought it over for a long time. I actually wrote a letter accepting the position at NIH. I almost dropped it in the mailbox, then I changed my mind at the last minute and didn't do it. Dr. Roush wanted me to come back to St. Petersburg and rent office space from him.

B: You had stayed in touch with your St. Pete friends all along.

P: So I came here and rented from Dr. Roush, and Dr. Roush had been telling his patients for three years if they had things that needed surgery but it was not an emergency, he'd say, you need a hernia fixed here, but I've got this fantastic surgeon coming. You just wait, we'll get it fixed soon. He had a long list of people that needed surgery. When I hit town, I never stopped running.

B: So he had a backlog all saved up for you when you got here.

P: Right.

B: Well, you had been doing all this research at Bowman Gray and the NIH, but you also had a residency in thoracic and general surgery.

P: You go through general surgery residency first and then thoracic surgery. Then when you finish that you can get board certified in both of those.

B: So you had been actively pursuing that board certification through your residency?

P: Yes.

B: That didn't trample on your research work with this\_\_\_\_\_

P: No. As a matter of fact they needed somebody with those credentials to do the research.

B: Because you're the surgeon as well as the one overseeing this research project in these cases.

P: That's right.

B: You were training, I guess, you had assisted in surgeries earlier at the hospital in Anderson. I assume that when you did your internship here at Mound Park you assisted in surgeries as an intern, especially on your surgical rotation here.

P: Right. But the doctors here, they knew that I interested in surgery, so they would oftentimes stand there and talk me through simple operations. I remember one night, I did five appendectomies.

B: Five in one night?

P: Right.

B: Good grief. That's a lot of time on your feet over somebody.

P: The surgeon, you know he was standing right there watching everything I did, and stopping me if I wasn't going to do it just right. But they let me do quite a lot because I was interested in it and already had.

B: This is while you were an intern?

P: Right.

B: Who would participate in a surgical procedure at that time? Would you have what we call physician's assistants now?

P: No. We didn't have any physician's assistants at that time. We had surgeons and nurses. We didn't even have OR techs at that time. The nurses were all RNs in the operating room.

B: So there were nurses who specialized, well, I don't know . . . .

P: They were surgical nurses.

B: Surgical nurses. They didn't do any work on the floors, they didn't do any patient care, they were in the operating room?

P: Most of the time that's true. That has undergone quite a change. It went from, RNs to LPNs and then to surgical technologists, people off the street with six months training. People like me were screaming that we didn't think that was going to work, but it did work.

B: Really?

P: It works good. Some of those people are fantastic.

B: Surgical technologist is a level distinct from physician's assistant?

P: Right.

B: But still has training in some of the specialized tasks that go with supporting a surgical procedure?

P: Yes.

B: Well, you'd been working in doing surgeries for quite some time by the time

you finished up at Bowman Gray.

P: Oh, yes.

B: Had you dropped that letter in the mailbox to the NIH, you would have taken a very different path away from surgery, but on the other hand . . . .

P: No, I would have been doing, this was the surgery branch of NIH. I would have been doing surgery at NIH, but not thoracic surgery. It would have been cancer surgery. It was surgical cancer surgery and I would have been supervising my human cancer immunology research there.

B: Was there a particular type of surgery that you were most interested in, most engaged by?

P: I liked all of it. I liked all of it. Ultimately, St. Petersburg is a city of elderly people. So vascular disease was the most prevalent thing. It ultimately ended up that about 75 percent of what I did was vascular surgery. I brought you a copy of a book I wrote.

B: Yes, I saw the publication information on this. University of Tampa Press published this in 2000. [Dr. Pruitt is showing me a copy of his book titled, *A Crusade for Stroke Prevention*]. As I say, published by the University of Tampa Press in 2000. The subtitle of the book is, *A Program for Immediate Aggressive Utilization of New Knowledge and Technology that Could Reduce Strokes by 90 Percent*. So your interest in vascular disease has apparently led you to a particular enthusiasm and concentration on surgery to deal with the heart, circulatory system. Would you say heart surgery particularly?

P: Well, in my residency I was board certified for doing open heart surgery as well, but when I came to St. Petersburg, there was not a heart-lung machine in St. Petersburg.

B: When you came to St. Pete as an intern, or back here as \_\_\_\_\_?

P: No. After I finished my training. When I came back here in 1963. There was still not a heart-lung machine in St. Petersburg, and there were five people that were trained, as well as I, for doing it.

B: When had the heart-lung machine been perfected and came into general...?

P: Well, probably five years before that, but they were just doing valve surgery and closing holes in the septums of the heart and replacing valves. But the big operation that made heart surgery jump to the forefront was coronary bypass.

B: When was that perfected?

P: About the same year I came into practice.

B: Okay. When you finished your residency.

P: I was not well-trained in that. To do that, I was trained good for valves and septal defects, but I was not trained well for coronary bypass and that was the main deal. So I would have needed to go back for additional training to do that.

B: Can you explain for the layperson what the difference is between just doing valves and actually doing a coronary bypass procedure?

P: The coronary bypass, you sew either an artery or a vein above and below an obstruction in a coronary artery.

B: All right.

P: To replace a valve, or fix a valve you're working on one of the valves that lets the blood go through the heart chambers, the four chambers.

B: What had been the obstacle to making that advance and to doing coronary bypass procedures? Apparently this was something that had been coming for a while, but . . . .

P: Yes, it had been coming for a while, but they hadn't proved its benefits until then.

B: Who did that? Or who would you say was responsible for kicking that into action.

P: I think probably the Cleveland Clinic and the Mayo Clinic results and Dr. [Michael] DeBakey, those three, and [Denton] Cooley, those four. They proved that coronary bypass was the way to go. Up until then they were doing a procedure called a Vineberg procedure, which they would tunnel an internal mammary artery through the heart muscle in the area where there was not enough blood and then let mother nature develop little new branches, which was a time consuming thing, and sometimes mother nature did a good job and sometimes she didn't. It was an iffy thing.

B: It was long recovery and uncertain.

P: So I was doing those heart operations here at Mound Park. And I was doing mitralvalulotomies like Dr. Wood had done. But not open heart surgery.

B: Was the heart-lung machine necessary for open heart surgery?

P: Yes.

B: Okay.

P: Then we got a heart-lung machine. So the six of us that were trained for it started doing some dog work to try to get tuned up to consider doing it.

B: Here at Mound Park?

P: Yes. Either at Mound Park or at All Children's. The heart program is at All Children's now, they ultimately decided to put it there. We did some dog research and then I think one or two open hearts were done by other surgeons. Then surgeons started coming to town who had been trained good for coronary bypass in their residency.

B: Any names come to mind?

P: Yes. The doctor that had been chief of cardiac surgery at the University of Florida came here. Then later the guy who was at the University of Florida in charge of pediatric cardiac surgery came here. They were so much better trained than any of us that all of us just did vascular surgery and chest surgery, but not open heart. We just let them do it.

B: Well, you came to St. Pete and didn't actually join the practice of your friend Dr. Roush?

P: No, I just rented office space from him.

B: So you were on your own as a general surgeon and joined the surgical staff?

P: General and thoracic. Yes, I was doing a lot of thoracic.

B: Now there was more than one hospital in St. Petersburg, but you did all your procedures at Mound Park, is that right?

P: Well, my office was across the street from Mound Park, and so though I was on the staff at St. Anthony's, that was, St. Anthony's and Mercy and Mound Park were the only three when I came back.

B: Okay.

P: I tried to put everybody at Mound Park, because it was more convenient for

me.

B: Was it very routine for a physician coming into practice to be admitted to join the staff at all the hospitals, at St. Anthony's and Mound Park?

P: Yes, it was commonplace.

B: Okay.

P: Then I got in bad trouble one time. St. Anthony's, at that time, they sometimes would send my surgical patients from the operating room back to the floor and have the recovery room nurse recover them on the floor but not in the recovery room, and I didn't like that. So after I'd been here for a little over a year, one time I had told a patient I wanted to put them at Bayfront and they said they wanted to go to St. Anthony's and I said well, I really would rather you go to Bayfront, because they sometimes don't recover you in the recovery room. That patient called a sister and told her I said that. I thought that sister was going to kill me. She called me on the phone and she said, Dr. Pruitt, I want you to know that we can take care of the sickest people in this world as good as anybody, and I don't want to ever hear tell of you telling anybody anything different than that. And boy she meant it, too.

B: Did that inspire her to change their procedure?

P: Ultimately they did.

B: Yes. Well, you got to St. Petersburg in 1963. The year of John F. Kennedy's assassination.

P: That's correct.

B: Do you remember where you were and what you were doing?

P: Yes. I was in my office seeing patients.

B: Here in St. Pete?

P: Right across the street.

B: How did you happen to hear the news?

P: Dr. Roush's secretary heard it on the, we had a radio that broadcast music all during the day and they interrupted programming and announced it.

B: I ask that because it's interesting to note that almost anybody who was of

thinking age at the time has a pretty vivid memory of the day and the occasion.

P: At that time, interesting, as we mentioned, we didn't have Medicare at that time. Most everybody had some kind of medical insurance, most often Blue Cross Blue Shield, except for the indigent patients, and they didn't have any. So the way it worked, Blue Cross Blue Shield didn't pay for office visits, they only paid if you came in the hospital, but an office visit was only \$15. Everybody paid for office visits when they were there. If it was a poor person we didn't even charge them, we just did it, took care of them, that was it. As far as the surgery was concerned, we rotated doing that, the welfare. I would be on call for doing all the welfare surgery for one month and then another surgeon. They had a printed list, so if you're in your office and you saw a person who didn't have any insurance and didn't have any money and they needed a gallbladder operation, you would look at your list and see which surgeon is supposed to be doing the welfare this month and just send them over there and it would be done free. There was no quibbling, no problem with it, same with emergency room care and everything.

B: When you say free, you mean free as far as your charges as the surgeon was concerned?

P: Yes. The hospital of course had a different problem.

B: Right.

P: But the city helped reimburse the hospital for the care that they gave the indigent people.

B: Were you obliged to purchase malpractice insurance at the time?

P: Oh yeah, we had it, but it was not that expensive. It was like, \$8,000. But ultimately it went to where I was paying \$180,000.

B: Sure. That was what, toward the end of your active career?

P: Right.

B: Well, it's interesting, I guess, to a certain extent, to consider how far we've come in the terms of the way we take care of sick people and where the money comes from for that these days. The debate goes on, and I was saving this question for the end of our interview, but since we're on the topic I guess, I wonder what your view is, having seen this transition from the day when a surgeon like you could just make a decision, this is somebody I'm going to treat and not charge, to the point now where we have a big sector of economic activities surrounding healthcare in terms of health insurance industry,

pharmaceuticals, practicing physicians and the debate over government subsidized healthcare, the so-called "single pair system." Do you have an opinion about which way the United States should be moving in this?

P: I've put a lot of thought to it, because our system is badly bent right now I think. One thing that's wrong with our system now is that referring doctors have to refer these patients to somebody on their plan. When I came into practice, the referring doctors could refer them to whichever surgeon they thought would do the best job for that disease.

B: Sure.

P: But now that has nothing to do with it. You have to go to the guy in your clinic and you've got to go to the guy on your plan. That's not good. The cost has gone up exponentially. Instead of total charge for an office visit being \$15, the co-pay is \$25. Plus, the main part being paid by Medicare or the insurance companies. There's a huge amount of waste in all this documenting so that you can upcode or downcode, or whatever.

B: Yes.

P: You have to have code experts. Then the insurance companies have a plan whereby they don't pay anything when you send the invoice to them with the code number on it. The answer is always no, first.

B: They have code breakers.

P: Then after three months, when the surgeon finally wakes up and finds out he hasn't been paid anything, then his secretary starts trying to call them and see what's the problem. Then their telephone's busy for two days and they can't get through to them. I mean, the amount of waste that's going on here is just phenomenal. When I came here, you sent your bill to Blue Cross Blue Shield and they paid it. There was never any discussion about it. They spot checked it, they'd come to the medical records room and look at the op [operating] note and see if you did what you said you did. Then there were big fines if you didn't, but the way they're doing it now is the most expensive way possible. It's not all that successful. But, it's not quite broken, and 60 percent of people still today have . . . well, if you're on Medicare, you're fine. If you're on Medicaid, if you're poor and you're on Medicare, you're fine.

B: Those systems work?

P: Those systems work. If you're medically indigent, you can be on the Medicaid. But if you make a little too much to be medically indigent, but not

enough to pay the high rates that you have to pay for medical insurance, you're really medically indigent. But, those people, there's enough of them that it's about to break the system. I designed a program and got somebody that knew Jeb Bush [ (R) Florida Governor, 1998-2006] well, and he called up there and made an appointment for me to see Jeb Bush, and I flew up there with him and we met with Jeb Bush and I presented a proposal to him to try to fix that problem. He said he liked my plan, but I never heard anything about it. I was hoping that he would give it to his brother, is what I asked him to do. By my plan, everybody would suddenly be covered.

B: Everybody meaning everybody who fell out of Medicare and Medicaid.

P: Yes. Those people that are medically indigent, we would give them a medically indigent card that's good for one year. It would have to be renewed every year. And you have to document that you fit into that group. If the doctor treated somebody who had a medically indigent card, nobody would pay the doctor anything, so it wouldn't cost the government anything up front there, but the doctor would write down the same code number for the office visit, or if he did surgery, the same code that he uses for Medicare patients for a code for a gall bladder operation, the Medicare charge, the approved charge that Medicare does . . . .

B: What they would pay?

P: But then Medicare wouldn't pay it, but we'd call this indigent card, it would be that code with an "I" after it.

B: Okay.

P: And at the end of the year the doctor would be able to add up all those things and deduct that amount that Medicare would have paid him, had he been a Medicare patient, and he would deduct it from his income tax.

B: Would that be a deduction from his tax, or a deduction from his adjusted gross income?

P: No. In other words, if he's in the 30 percent bracket, he would get \$0.30 on the dollar. So it's very cheap for the government. The government, instead of paying what they would have paid if it was a Medicare patient, the government's paying 30 percent of that amount.

B: That takes a big bite out of the doctor's [fee].

P: But right now they're not getting anything.

B: And they're treating these people anyway.

P: So I talked it over with fifty doctors. They would be willing to do that.

B: Really?

P: Yes. So I told Jeb, Jeb, I don't think you all realize it, but doctors would be glad to do this. Because right now they can't deduct it, and they're not getting paid anything for these people, we're treating them anyway.

B: Would the doctors, would the malpractice insurance cover her or him in this scenario?

P: Yes.

B: Okay.

P: The other really good thing is, you wouldn't have to hire one person to operate this system, because it's already in place. You use the same code numbers you use for Medicare. You do your CPA calculations at the end of the year. It's documentable, you can check on it. You can see if you did that operation or not. Is there an op-note in the patient's chart?

B: Well, somebody would have to administer the process of verifying that people who claim to be medically indigent still were, at least every year?

P: Well hopefully, but I don't think it'd take much. If they want to be on the program, they have to bring the documentation into an office and make it obvious that they are. So it wouldn't cost very much to operate this thing and the government would get off for \$0.30 on the dollar, which is, it's ridiculous for them to think that they should get by any cheaper than that. Suddenly, tomorrow, everybody in the United States would be on insurance.

B: When you say medically indigent, I'm wondering how hard it would be to define that. One of the critiques of health insurance is that you can make \$40,000 a year and still have a hard time paying for halfway decent health insurance.

P: Well, in my write-up, I had done research on what should be called medically indigent, generally, what other people think it is. The cutoff for Medicaid, if you made 25 percent more than that, then you're expected to buy your insurance. If you don't make more than 25 percent more than the Medicaid cutoff level, then you're medically indigent.

B: So you've tracked that sort of definition?

P: But I never did even receive a letter back from that son of a gun at health and human resources. He was the same guy that got in trouble that didn't have the vaccines. What was his name?

B: I know you who mean, but I'm not remembering this now either.

P: Anyway, I expected at least to receive a letter from him saying, I got your suggestions and we're looking at it, or something. I never received a word out of anybody.

B: One sort of broad brush, sort of radical sounding alternative to this I've heard advanced is to resolve the gap in health insurance by just taking the age restriction off of Medicare and giving people the choice to be covered by Medicare, if they want to be, no matter how old they are, not make them wait until sixty-five. Is that an idea that sounds far-fetched?

P: You mean let the young ones pay for it?

B: Yes.

P: Well, no, I think that would be, they could probably figure out that. But Medicare is very expensive. I'm trying to get everybody on it tomorrow at no big expense to our country.

B: Okay. Medicare is expensive for the government to run, or expensive for the taxpayers to pay for it to operate.

P: Right. My way would be cheaper.

B: Do you think Medicare is efficient, compared to private health insurance?

P: Yes. I think Medicare is good. If you're on Medicare or Medicaid, you're okay.

B: I mean, as an administrative process to run and get people covered and reimburse hospitals and doctors, Medicare works.

P: Yes. I like it. But I'll have to say that before we even had it, people got just as good of care.

B: Well, yeah, it's pretty interesting, I mean, in the days when you came to Mound Park as an intern, as you point out, people who didn't have health insurance through the major carrier like Blue Cross or Blue Shield got treated, the city of St.

Petersburg chipped in some to help run Mound Park Hospital, and physicians did pro-bono work, I guess, as the lawyers call it, indigent care, didn't expect to get paid, and somehow the system managed to collect enough from those who could afford to pay to make sure that people who needed it got it.

P: But now they've fixed it, if an indigent patient comes into my office and I want to do his operation free, I can't. If I do his operation free, Medicare lowers my profile.

B: How's that?

P: Every surgeon has what they call a Medicare profile. You're required to stick with your profile. In other words, if I charge \$600 to do a gall bladder operation and three months of post-op care, I have to charge everybody that amount. If I get Rockefeller in here and he's willing to pay me \$6,000 instead of \$600 and he wants me to babysit him twenty-fours a day, it's okay to do that. No way. I can only charge him \$600, just like everybody else.

B: Otherwise they won't pay you the way that they had. It would change your reimbursement from Medicare, is that what you're saying?

P: Every time you charge a different amount, it modifies your profile. They've got a formula for modifying the profile. If you do one free, it, instead of \$600, now, from now on, all Medicare patients, you've got to charge \$550.

B: I see. And if you do to many of them for free, the next thing you're doing it for \$400?

P: Right.

B: Got you.

P: We have to bill people we don't even want to bill. It's illegal not to. It's ridiculous.

B: People a lot smarter than me are really uncertain about how this is going to play out, but I think it's one of the great problems facing American society.

P: I definitely do too. We need to get rid of the people that don't have any coverage as quickly as possible. We need everybody covered.

B: Yes.

P: Doctors want them to be covered. The malpractice is the big problem. That

was the other part of my plan. After the doctors had been proven to the world that they were doing all this indigent work for \$0.30 on the dollar for a couple of years, then the government needed to put the finger on the malpractice people and say, look, we're not going to allow you all to keep running over doctors like you've been doing, this isn't right. And reduce our fees, malpractice fees. But I think you could get the public to be on the side of reduction once they saw the sacrifice that the doctors are making. People don't understand that doctors do all this welfare work.

B: I think people have a broad perception that doctors are very, very affluent and that they never have to worry about the financial side of things. The reality, of course, is always a big surprise to people.

P: Well, yes. By the hour they get paid about minimum wage. They are affluent, but they've got a lot more hours in there than most everybody else.

B: When you were at the height of your surgical practice, how many surgeries would you say you would do in the course of a year? Can you pick a number and say that you might do, what, a few hundred, several hundred?

P: At the height of my surgical career, I did probably fifty operations a week. I commonly did twenty-two operations in a day. But I was often working nearly eighteen to twenty hours a day. Every Wednesday, one hospital, St. Pete General Hospital gave me two operating rooms and two anesthesiologists and two OR teams, so that when I'm sewing this patient up, they're putting this one to sleep. I go here and operate on this one, and when I'm sewing this one up, they're putting the next one to sleep. I would just walk back and forth. In all the other hospitals, I'd finish doing this operation and then have to wait forty-five minutes for them to clean the room up and get my next patient in there and get them to sleep and so forth. So, on Wednesdays, when they would give me two rooms, I commonly did twenty-two operations. I'd work from early in the morning until 3 or 4 a. m. the next morning. Otherwise I couldn't get it all done in a week.

B: Could you keep up that kind of a pace here at Mound Park or Bayfront?

P: No. I never was able to get them to do that as efficiently. They tried to do it, but it required an awful lot of cooperation with the anesthesiologists and also, other surgeons resented it, to some extent. It wasn't really possible to do anywhere else.

B: How many surgical suites were there at Mound Park and Bayfront, say over time, from when you started until . . . ?

- P: I think it was six when I first started and there are probably sixteen now.
- B: But there are surgeons from a variety of different fields that are all, I guess, trying to use the same facilities and they keep those facilities pretty busy, I guess routinely?
- P: Right. Always.
- B: Always have?
- P: Always.
- B: You were talking about the tremendous volume of surgeries that you were performing, sometimes twenty-two procedures in a long day's work. It's got to be pretty extraordinarily physically demanding. Could you do that day after day?
- P: Well, I didn't do it day after day. It was only one day a week that I did that. Every Wednesday, but for a long while I operated every morning and saw patients every afternoon. Ultimately, I had so much surgery to do I tried to just see patients in my office for new patients and follow-up for a day and a half, and then I spent all the rest of the time in the operating room. But I was going to Bayfront Medical Center, Palms of Pasadena, St. Petersburg General, Ed White, and occasionally St. Anthony's, and for a while even All Children's. I was going to a lot of places, and my secretary had a really hard job trying to keep me from spending all my time in a car. She needed to organize it so that when I got to a hospital, I would do all the cases I needed to do that day in that hospital before I went to another hospital. I was working late at night most nights, and ultimately, my wife got fed up with that, and after thirty-five years of marriage and four children, she divorced me.
- B: Not an uncommon thing in your business, I understand.
- P: Right. We're still on good terms. I thought I was pretty happily married, but she wasn't satisfied with the situation.
- B: My oldest daughter is getting ready to marry a medical student, and as he contemplates his specialty, one of the things they've discussed is that surgery is likely to pose a big demand on family life, and it's an issue of some contention for them.
- P: Well, until the last few years, the referring doctors could chose who they were sending the patients to, and I was really, really busy. The same referring doctors would send you all their patients. It didn't make any difference if the patient was a paying patient or a non-paying patient or if it was 1 a.m. or 10 a.m.

if Dr. Dawson referred me a patient, and he's been referring me a patient for twenty years, all his surgical patients, I can't say, Bob, it's 1 a.m., send this one to someone else. You have to get up and go.

B: That's your patient now.

P: But you've lost that with today's system. Today, if you're the surgeon for the Suncoast Medical Clinic, they have to send the patients to you. You can call the emergency room and say, I'll be there at 8 a.m.. You don't have to get up at one [o'clock] to come all the way over there. Nobody's going to check and see. If I had not come in at 1 a.m. and saw Dr. Dawson's patient, he would be upset. But under today's system, surgical patients are sent to whoever is in their clinic. Whoever is in their clinic is the surgeon who has to do the case, and he doesn't have to get up at 1 a.m. if he doesn't want to, he can just come in there when he gets to the hospital. That's not always in the patient's best interest.

B: Of course. In terms of when they get seen, for one thing, and in terms of who does the procedure, for another thing.

P: Right. That part is definitely not good.

B: Well, you have a reputation for being an exceptionally gifted surgeon. Would you say that stimulated or propelled a lot of doctors to refer patients to you for surgery?

P: Well, I like to think they sent them to me because they thought I was going to do a good job.

B: Some people see surgery, when it's well done, I guess I should emphasize, as a thing of beauty, as a work of art. Is that how you see surgery when it's well done?

P: I do. I never felt like I was working, the whole time I was in practice. I didn't.

B: That makes you a very lucky person.

P: Yes, I was extremely happy with it. My father had a stroke when he was fifty-six. His first stroke. A couple of years later he had another stroke.

of tape]

B: Dr. Pruitt was just starting to talk about his father's stroke, which occurred when he was at the age of fifty-six. What point were you at in your career when that happened, by the way?

P: I was in medical school.

B: All right.

P: No, I was in my residency. Just starting my residency. When I finished my residency, they thought that most strokes were caused by hardening of the arteries in the brain or cerebral hemorrhage. They thought that a few strokes were probably caused by blood clots forming in other arteries and washing up to the brain, particularly the carotid arteries, but this was thought to be a very rare thing. Then, by 1960, they had developed cerebral arteriography. A Spanish radiologist had done an arteriogram on himself. He got a Nobel Prize. Anyway, they started looking at carotid arteries on x-ray when they were doing cerebral arteriograms and they noticed that in people that were having strokes, often times the carotid artery was partially blocked with hardening of the arteries. It was interesting that they never had done many autopsies on carotid arteries, because the undertakers use the carotid arteries and the jugular vein to put their chemicals in when they embalm people.

So the undertakers didn't want them to bother those arteries, so they usually didn't do any autopsy on those. So here we were in 1960 and didn't know that the primary cause of stroke was obstruction in the carotid artery and blood clots forming there and washing up to the brain. Those clots that we had been finding for years didn't form in the brain, they started here and washed up to the brain. When I came into practice, carotid endarterectomy was a new operation. I had done two of them in my residency. But then in St. Petersburg, with all of these elderly people, I'd put my stethoscope on the neck and you'd hear, "[sound effects of blood rushing] Sphew! Sphew! Sphew!" Blood squeezing by this tight place. Then you'd do an arteriogram and it would show, often times, 95 percent blockage. The patient's fine, except they're a time-bomb because tomorrow a clot can break off and go up to the brain. So there were a lot of people that needed carotid endarterectomy in this city. So I was called upon to do the operation pretty often. When you clamp off the artery to take that obstruction out, about 80 percent of people have enough blood going up the other side. It gets to the brain and it goes everywhere. But about 20 percent of the people, when you clamp off the carotid artery on one side to open and clean it out, the blood doesn't get enough blood on the other side and they'll have a stroke while you're working on them. For that reason, we commonly use a shunt, a plastic tube that we put in to carry the blood around the area that you're working on. Then after you get the thing cleaned out, then you take that shunt out and sew the artery up. There were about five shunts on the market that had been invented by different people, different surgeons to try to help with that. I tried all of them. But no matter what I did, I was having about a 4.5 percent to 5 percent stroke rate during the operation.

B: Would those ordinarily be fatalities?

P: No. A lot of them recovered. But about 2 percent of them would die. I wasn't happy with it. I thought it could be done with no mortality if we did it right. I tried everything I knew and I was still hanging in there. Then one night I was doing a carotid endarterectomy and suddenly a plaque came through my shunt and got up here to the upper end, it went about two-thirds of the way up and then stopped. It was still sitting there and it occluded the shunt completely, no blood could go through.

B: You could watch all this happening?

P: Right. I said, well damn, this shunt is stirring up something down there. I think this shunt may have grugged up some stuff that got in it here and that might be one of the things that's causing some of these strokes, the shunt itself might be causing them. These shunts might be causing as many strokes as they're preventing. So I sat down and designed a shunt that I thought would be less traumatic and safer. I had a friend that was a pacemaker salesperson. He was a very and smart energetic guy and I called him over and I said, Bill, I've got this idea that I need you to get it made for me somewhere. If anything comes of it I'll give you half of the company. He said, well, I'll get it made. So he applied to the FDA for permission to get a shunt made to my specifications and to use it on one hundred people under local anesthesia with an EEG going all the time too, so we could tell what was happening. Sure enough, it worked really good. One person out of that hundred, the EEG showed it needed to have a little more blood going through it, so we had to modify it and make it bigger so it would carry more blood. It had several main features. The main feature was that instead of holding it into the artery with tapes or clamps, like the other five shunts that were on the market, this one had a balloon on both ends. When you put it in, you'd blow up this little balloon and the pressure of the balloon against the inside of the artery would hold it in place, and that didn't damage the artery like these clamps and tapes. Another thing, it was smaller than the other shunts, so when you put it in, the shunt wasn't scraping the wall of the inside of the artery. Another thing, it had a side port, so if there were any particles, you could bleed them out through this side port before you let the blood start going to the brain. Then it turned out that the clamps and tapes that we had been using to hold that shunt in place, that was keeping you from being able to see up in the artery. It was pinching the artery against the shunt, keeping you from seeing. But this balloon was holding the artery open so you could see it better and make sure you could get all of the particles out.

So it turned out it was highly successful and reduced the stroke rate quite a bit. So I applied for a patent and it turned out that there was a guy, a vascular surgeon out in Oregon who had a patent on any hollow tube with a balloon on both ends used for any reason in any artery. He had had the patent for about

eight years. Actually he didn't get the patent, he had bought it from somebody else. Nobody could ever figure out anything to do with the patent. So it never had been made or used, but there was such a patent. So my patent attorney said, well, there's another patent that's not exactly like what you're doing, but it's close and you probably ought to contact him and work something out with him. So we contacted him, he was Dr. Inahara, who was a Japanese-American surgeon in Oregon. It turned out he was a very highly respected surgeon who later was president of the Society for Clinical Vascular Surgery. The Board of Vascular Surgery had only three surgeons in the country where they let doctors go and not go through a residency program to get to be a vascular surgeon, but just work with a surgeon and get to be one. And his was one of those programs. He was a very high-class guy. We didn't really want him in the company, but he insisted on being part of the company, so we ended up giving him a third interest in the company and Bill McPherson a third interest and me a third interest so that we didn't delay and we could get this thing going. So we started manufacturing it. Then I was using it, and the word got out that I had invented this shunt and I was interested in these carotids and they started coming from everywhere, and I was just swamped under with carotid endarterectomies to do.

B: Did referrals for this come from out of the area?

P: Oh yes, they were coming from all over the country.

B: What was the name of this device?

P: The Pruitt-Inahara Carotid Shunt. And it's used all over the world now. It's a very successful shunt. I sold it after I had my heart transplant. I sold it to CryoLife and they sold it to LeMaitre Vascular. So LeMaitre Vascular now owns it. It's very popular.

B: Do you still get any residuals from that?

P: No. I did for a while, but I don't now. I'm still interested in [it]. It's definitely the safest shunt in the world, and I'm interested in more and more people using it because it can save a lot of lives.

B: What year was it that you devised this, the shunt?

P: About twenty years ago.

B: Okay, about 1985 or so?

P: Right.

B: So you'd been doing these carotid procedures for some time?

P: Yes. I'd been using all those other five shunts and having a 4.5 percent to 5 percent stroke rate. But I published on this and by the time I published on this, even adding in all those other cases that I had done up to that point, my stroke rate for the entire period was less than 2 percent. I had all those early ones at 4.5 percent to add into it, so it's . . . .

B: When you say stroke rate, you don't necessarily mean mortality rate?

P: No.

B: Mortality is quite a bit less than that?

P: Right.

B: Was it likely that people could recovery from a stroke experience done under the conditions you're talking about during surgery?

P: Yes. Most got gradually quite a bit better. Sometimes they would still have a limp, or a little weakness in a hand or loss of coordination. But using this shunt it was at least twice as safe. But there are a lot of people still out there using all those other shunts, and I'm not happy about that. I won't be happy until they're all using this one. But there's still some people using the other shunt. So we started a company making this shunt. Then ultimately, when we had the company there, so we had the employees and the engineers and everything, it was easy for me to invent all kinds of surgical things that I had wanted to use that weren't available to me. So I invented a stack of stuff.

B: Can you name some other examples?

P: Well, the simple little thing called a Pruitt Occlusion Catheter. It's just a tiny little catheter with a tubing that's about the size of this electric cord with a balloon on the end here and a syringe back here. So any artery that you're working on, instead of putting a clamp on it, which if there's calcium inside of it, it crushes it like an eggshell.

B: Breaks it loose.

P: Makes it easy to clot off. I could run this little Pruitt Occlusion Catheter and blow the balloon up and do the same thing. It required a lot less dissection. You didn't have to put clamps on both sides of the artery. You'd have to dissect out that much of the artery that you could see. But to put a balloon in it, you'd need about this much. Then you'd work inside the balloon and then sew up this

little hole. I mean, it saved a great deal of time if you could use occlusion catheters instead of clamps. Turned out that was very popular and we would use it in many different sites. So we had occlusion catheters, all different sizes for all different arteries.

One of the things that saved the most lives is an aortic occlusion catheter. The aorta's the biggest artery in the body and one of the causes of sudden death is rupture of an abdominal aortic aneurism. And when an aortic aneurism starts leaking, if you can get in there, you can often times save those people. But when you get into the abdomen, sometimes there's three pints of blood and all this stuff is behind the tissues, nothing looks like it's supposed to. It's hard to see it, to tell what's what, what the pancreas looks like. To get a clamp above the leak, so you can resect the aneurism and put in a new artificial artery, sometimes you would tear a lot of stuff getting, quickly getting in there and getting control of that artery. But you could put a needle into the aneurism, which is, the leak will be up here, but the aneurism will be down here. You could see the aneurism very easily. Well, I could put a big needle into the aneurism and thread this big occlusion catheter through the needle and up above the leak and blow up the balloon and stop the leak without ever having to put a clamp on that thing. Every hospital in the world needs those things in every operating room and also in every emergency room.

B: What's the name of that device?

P: Pruitt Aortic Balloon Occlusion Catheter.

B: All right.

P: They sell a lot of those. Then Dr. Fogerty is a famous surgeon who invented a simple device called a Fogerty Catheter, which is a lot like a Pruitt Occlusion Catheter, it's just as long as your leg. You put a syringe on this end and it's got a balloon on the other end. And let's say your iliac artery here, up in the abdomen, just below the bellybutton is occluded with a clot, either a clot that came from the heart and lodged there, or a clot that formed there. Up until Dr. Fogerty invented this catheter, we used to have to open the abdomen and open that artery to get the clot out. But after Dr. Fogerty invented this catheter we would, under local anesthesia, make a little incision in the groin, thread this thing in the femoral artery, and go up above the clot, blow up the balloon and pull down on it and then the clot would come and would come out through the femoral artery. We'd sew the femoral artery up and we'd never have to go in the abdomen. It's a great device. Only thing was, those clots, in about twelve hours, they grow to the wall of the artery, they stick so fast to the artery, that you pull the balloon through and the clot doesn't come, it stays there.

So I invented a Pruitt Embolectomy Catheter that has two lumens. One's for

flushing, so you'd thread it up above the clot, blow up the balloon and then you had another syringe that you'd start flushing with and the hole was behind the balloon. So you'd start pushing the saline in and it would flush the clot off the wall, rather than depend on the balloon pulling it out. So you would flush at the same time you're pulling it down and we could get clots out that were in there three days instead of twelve hours.

B: You've got some complicated gifts. You're on the one hand a surgeon with a penchant for sort of this artistic engagement with all the different infinite variations of the way somebody's condition can present to you. Once you open them up you don't know what you're going to see until you get them open I guess, right?

P: That's right.

B: And hardly any two people are exactly alike. But on the other hand, you're a man of some mechanical ingenuity who has devised some things that work according to some pretty practical applications of hydro mechanics and machinery.

P: Well, I had a good time doing all of that. The people here at Bayfront helped me quite a bit with it. For example, in trying to develop that shunt. Before the FDA would give us approval to build that, we had to prove that those balloons weren't going to hurt the artery. And the common carotid was a very strong artery, wasn't much danger of it hurting that one. But the internal carotid is a very fragile artery. So we started trying to prove to that to the FDA's satisfaction. So we tried [it] on dogs but the dog's carotid artery was biologically different in too many ways. And we tried sheep and the amount of elastic tissue was different. Goats it was different, cows it was different, pigs it was different. We spent a lot of time going through all these animals and finding out that the anatomy was just such that it was not comparable to a human carotid artery. So then we needed to do it on a human after death. We knew from cadavers that things don't change the first two hours. We needed to do it preferably within four hours after death for it to be comparable. Then we couldn't get the pathologist to do the autopsy within four hours after people died. They usually don't do it until a couple of days later and stuff, then they fiddle around. So ultimately we started paying the pathologist \$200, when they had an autopsy request, to get on in here and do it so I could get these studies done during that four hour time frame. We did that out at St. Pete General. But we took the specimens and brought them here to Bayfront and they did all these special stains for us. So we were able to get beautiful pictures and determine at how many pounds-per-square inch the balloons started hurting the artery. Then we could put a safety balloon on that thing to fix it so that if a surgeon tried to blow the balloon in the internal carotid artery up with too much pressure, it wouldn't let it

do it. It would valve off into another balloon. So after we did that, we never had a problem with injuring anybody's arteries.

B: Were you always an inventive personality? As a child?

P: My dad was an inventor. I fiddled around with stuff, but I never succeeded with inventing anything until that shunt.

B: Are you good at other things, for example, I guess I'm wondering if you have hobbies or avocations that stimulate you. Woodworking, any kind of other gifts or hobbies?

P: I don't think so. My hobby is farming. I have cattle ranches and I grow things.

B: By the way, I've been to the Pruitt trail head at the Cross-Florida Greenway.

P: Good. That's a cattle ranch.

B: It's a beautiful piece of property and I salute you for making that donation to the state. That property. That's really made a nice addition to that whole facility.

P: Thank you. Thank you. Did you see my son's memorial?

B: Yes, sure did.

P: Boy that really killed me. We never got over that. I think that's really what caused my divorce.

B: Well, it's got to be one of the hardest things in a person's life to lose a child because they're not supposed to predecease you.

P: I know. He was a great child. He graduated from the University of Florida Law School with honors. He had been in practice for six months when that happened.

B: Well, I'm sure sorry. That's a nice memorial you created.

P: Well, he liked animals. He loved it up there. He used to work up there in the summertime. He planted some of the hayfields up there.

B: If surgery is an art, are you a perfectionist? Is every good surgeon a perfectionist?

P: I think probably so.

B: Are there particular personal gifts that every good surgeon has? Do you think there's any common denominator for people who become particularly good at doing what you do?

P: Paying close attention to detail and listening to the patient.

B: Physical dexterity?

P: That's important.

B: Is that one of the things that anybody who's really good at it needs to have?

P: Yes. And you need to have a strong foundation in the anatomy of what you're operating on. If you see a surgeon who's taking too long, it's usually he doesn't understand the anatomy. He's having to go real slow because he's not sure about where he is. A surgeon that totally understands the anatomy can do it by feel almost.

B: Even if you can't see very clearly what it is you're working with?

P: Right.

B: Who do you think influenced your training as a surgeon? Anybody stick out as particularly influential to you?

P: Well, there were a lot of people. There were two surgeons in Anderson, South Carolina, when I was a surgical extern that were influential. Then at Bowman Gray there were many. It was a great place for a residency. They had an enormous number of patients there that came out of those mountains that were semi-indigent and come always to that hospital. So the surgical residents are just operating constantly, trying to keep up with the load of people that really require surgery.

B: Is that where you really first experienced a high-volume, high-paced . . . ?

P: Yes. Dr. Bradshaw, who was chief of the department, he said, I want all my residents to have to operate so much while they're a resident that they will never do any unnecessary surgery. But we had some surgeons that transferred there from places like the Mayo Clinic, where they have so many residents that the resident often times would be three or four down the line here watching what was going on, but not really himself doing very much. When they would get down to

Bowman Gray, they couldn't believe what they would suddenly had to do, as far as volume of surgery.

B: Pushed onto the front line.

P: Right. So that was good for me when I came into practice because I had already had a lot more experience than people from most places.

B: Well, you've trained people in performing surgery as well. You've been an associate professor of medicine at the USF medical school, and I guess you've supervised a lot of residents in your career.

P: Yes.

B: What does it take to train somebody to do what you do, do you think?

P: You just talk to them and watch them. If they're doing a good job, you leave them alone. If you see something that you could do easier or better, you show them and then let them do it.

B: Are most of the people that you've trained at the resident stage in their careers when they come to you?

P: No. Actually, the Bayfront residency program usually was just first and second year residents in surgery that we had that were rotating through here. They weren't later in their training. So they were early on, we couldn't let them do anything big.

B: Have you seen people come into the residency program that you were training in surgery that you felt maybe were, had made a doubtful choice about their avocation, or do people generally have what it takes?

P: I think they generally have what it takes. It just takes some of them longer. Some of them never speed up. Fortunately, our anesthesiologists are good enough these days that it doesn't hurt the patient too much if the operation takes a long time.

B: When surgeons don't speed up and they tend to work more slowly, is that a function of a weakness in some particular aspect of their ability, or do you find that it maybe rises out of just a more deliberate kind of a nature about doing things?

P: Sometimes it's a simple thing. I got as far along as my third year of surgery when Dr. Bradshaw, the chief of surgery there at Bowman Gray, didn't usually

operate with the first two year people, you had to be in the third or fourth year before he'd start operating with you some. I remember the first time he operated with me, we were doing a chest operation, and Dr. Bradshaw said, damn, Crayton, quit tying off all those little bleeders. And he said, you're tying off capillaries in here! It's going to take you two and half days to do this operation. He said, 99 percent of those things are going to stop bleeding before you finish operating. So, unless it's a big bleeder, don't fool with it. Just put a lap-pad on top of it to cover it up so you can't see it and keep on operating. Then at the end of the operation, take all of your lap-pads out and wash it out good, and look at it, and anything that's still bleeding, then you tie that off. But, don't tie off these thousands of tiny little things. You'll never finish this operation. Then I tied off a couple of more them and he said, if you tie off one more of those things, I'm not going to help you any more. Well, I tripled my speed overnight. Nobody had ever told me that before. I'd had thirty or forty surgeons assist me on operations and nobody had every told me before.

B: Did that become part of your litany of teaching to surgeons that you were supervising and training?

P: Right.

B: You try to train people to go for speed when they can, if there's an opportunity to concentrate on the most essential part of the procedure, get in there and get it done and get back out again.

P: Very important.

B: And it sounds like the devices you've invented were sort of directed at that sort of thing too, maybe a little bit?

P: That is true. But in general, it's best to do them, if you can do them well, it's best to do them faster.

B: What particular gifts do you think you've had that make you good at what you do? I've heard it said that you have the gift of pretty adept, dexterous hands?

P: Yes, I did have good dexterity, and I knew the anatomy well for all of the things that I was operating on. And then, pretty soon, it became true that I had done each operation I was doing so many times, that it was second nature. Experience does count.

B: When would you say you were at the very peak of your skills?

P: I think, well I went into practice about 1963, by 1983 I was probably at my

peak.

B: And at that point you would have been in your, let's see, 1930s, 1980s, early fifties, I guess? Possessed of all of your physical dexterity, but at the same time, so much experience that you don't have to think very hard about what you're doing each time. As you see it again.

P: Right.

B: You became an attending surgeon, or a consulting surgeon at, I guess, virtually every other hospital in St. Petersburg. Is that customary for surgeons?

P: Well, surgeons have to go where the referring doctors put their patients.

B: They can't refer them to the hospital where you're on staff necessarily?

P: No, the patient wants to be where his family doctor is, too.

B: Okay.

P: So if one of my referring doctor's is at Palms, I had to go to Palms. I didn't really choose where to put all those people.

B: So most people who do surgery, a fair volume of surgery, would wind up attending or consulting at the hospitals throughout their region?

P: Right. One surprising thing happened to me though in surgery. When I went into surgery, I thought a patient would be referred to me for surgery, and I'd operate on him and do his case and then I probably never would see him again. By 1985, everybody I operated on, I had previously operated on that person or somebody in his family. Almost 100 percent. From 1983 to 1995, when I had my heart transplant, everybody was already a friend when they came in my door. Any referring doctor that tried to send them to somebody else, there was no way. They would leave their referring doctor. If a surgeon has operated on them before, they're going to go back to that surgeon, even if they have to change referring doctors.

B: Don't mess with success.

P: Yes. They won't do it. So, it became easier. When you see people for the first time, they don't know they can trust you completely or not, but the second go around, there's no problem with that.

B: Well, having practiced or performed surgeries at all of the hospitals in St. Petersburg, I guess not in Clearwater so much, mainly just in St. Pete?

P: Not in Clearwater. Nowhere except in St. Petersburg.

B: Okay. I wonder if you can identify any of the particular strengths of Bayfront Medical Center, Mound Park, which eventually became Bayfront Medical Center in 1970, I guess. What makes Bayfront Medical Center a distinctive place, compared to the rest?

P: Well, Bayfront has a great reputation for having excellent equipment. Always the latest thing. And well-trained specialists in every field. More cooperative as far as getting your indigent patients admitted. That's a problem that people don't really realize that surgeons have to waste a lot of time on is, even though the surgeon is willing to do the operation free, we have to send the bill, but tell the patient don't pay it, it's all right, I know you don't have any money. But I have to bill you because Medicare requires me to. But getting them in the hospital. The hospital is going to want up-front money from these people. Bayfront gets, it's noted as the indigent hospital for the town, so they get more assistance than the other hospitals, but federal law doesn't allow dumping.

B: Patient dumping?

P: Patient dumping. That puts the surgeon in a bad position because we'll have a patient that will go to the emergency room at St. Pete General and they'll say, well, you look like you've got a hernia, but it's not incarcerated so you don't have to be admitted tonight. This is the surgeon that's on call here. You can go to see him tomorrow. They'll make an appointment for you to come and see him. So the next day he goes to the surgeon and the surgeon says, yes, you do have a hernia and it needs to be fixed. And the patient says, but I don't have any insurance and I don't have Medicare and I don't have Medicaid. So the surgeon says, well, if you go back to St. Pete General now, they don't get as much help from the state and from the city, so they're going to be wanting a big up-front deposit here and they'll be hard on you about getting in. They can't really say no, but they're going to be tough on you. And if we send you to Bayfront, Bayfront's going to say St. Petersburg General dumped that patient on us.

A friend of mine, Bill Blackshear, got a letter from . . . that very thing happened to him recently, where a patient went to the emergency room at St. Pete General, but they were indigent and they came to him the next day and he said, well, I think Bayfront will be more likely and able to help you with this because you're indigent. And Bayfront turned him in to the regulation to the state and he got a letter from them and had to go through all kind of red tape explaining to them about it. They were accusing him of dumping, but he was just trying to help the patient. Ten hours he spent on that problem. Bayfront shouldn't have done that. They ought to understand that they get more money

than these other hospitals for taking care of indigent people.

B: Where does that money come from, to Bayfront?

P: Mostly from the county and the city. But the state and the federal government gives them tax advantages because they're noted as the primary indigent hospital.

B: I didn't realize the city of St. Petersburg still chips in. I know they used to subsidize Mound Park Hospital pretty heavily, and I guess that was one of the reasons for spinning Mound Park off into Bayfront.

P: Well, I really don't know much about the finances of it, but I do know that they hold themselves out to be the number one indigent hospital in the community.

B: Oh, yeah.

P: I know that there are some advantages of doing that. But I know that when you try to put a patient there, there's red tape for the surgeon.

B: You were here when Mound Park became Bayfront Medical Center. Do you remember that transition?

P: Yes, I do.

B: And what do you recall as being the significant changes that resulted?

P: Well, the hospital felt--it was a city hospital, and they thought that the city was not giving them the freedom that they needed and the support that they needed to be a first-class hospital. They wanted to borrow more money and buy new facilities faster than the city would provide them. Lenny Freed had come back and opened a hospital out there that was air conditioned with a telephone in every room and carpets everywhere, and Bayfront was still sitting here still no telephones in the room and not air conditioned, and they were having trouble competing.

B: Let me ask you, just to clarify the point. When you say that they were wanting the city to make these investments and help advance the hospital, was the push for that coming from the hospital administration or from the medical staff, the practitioners who worked here?

P: Both.

B: Okay. And some of what that was driving this was competitive pressure?

P: Competitive pressure, definitely.

B: Okay.

P: Actually, the first competitive pressure, I think, came from Palms. There was nursing home out at Pasadena that turned itself into a small little hospital. Then shortly after that Lenny Freed built St. Pete General. Then not long after that, they started talking about Ed White, then Sun Bay Hospital, then Northside Hospital. These hospitals started sprouting up and they were all state-of-the-art stuff, you know? Bayfront had to either close its doors or modernize.

B: Did the transition to Bayfront, was that a success as far as you're concerned?

P: It was, but Bayfront got behind on the curve. There were two years when most of the practitioners were going to other hospitals. I personally did at least 70 percent of all the surgery at Bayfront Hospital for at least two years.

B: Why did you stay around when other disappeared?

P: My office is across the street.

B: Physical proximity?

P: Yes. But the neighborhood got bad too. I got mugged in my own parking lot.

B: No kidding?

P: Yes. And there were some rapes. Nurses leaving and patients leaving.

B: When did that happen?

P: About that time.

B: Which would have been around the early 1970s?

P: Right.

B: Were you injured in that attack?

P: They knocked me down and stole my wallet. That's it. I got up and went and operated.

B: Man. Did that make you have second thoughts about continuing to keep your

office down here?

P: Well, there were some people that thought I should move. There were some patients that didn't want to come down here. For a while it was difficult to talk people into coming to Bayfront.

B: What measures did the hospital have to take, or did they, to respond?

P: They had to hire security guards and make them prominent. They ultimately bought up a lot of the little houses around here where bad people lived and tore them down.

B: Expanded the campus?

P: Yes.

B: Of course in a place like your office that's private property and the hospital really can't take much responsibility for what goes on there?

P: Yes, but they owned a lot of little houses around through the neighborhood. They ultimately tore them down.

B: Okay. So that expanded the sweep and sort of maybe created a more secure environment?

P: Yes. Then they put in the interstate over here that blocked them from coming in that end. Then the city started making the police stay down here more.

B: Did the proximity of All Children's help with any of this?

P: Yes, I think so.

B: What would you say the relationship between All Children's and Bayfront has done? I mean, has that been a good thing for both institutions?

P: I think so. They've had some little spats from time to time, but in general it's been a symbiotic relationship. It was sometimes sort of inconvenient for the doctors. I can remember times when I would see a patient in the emergency room late at night here at Bayfront, the patient would be like twelve years old, and they wanted everybody up to fourteen to go to All Children's. I'd come to Bayfront and see them and I wanted to send them right upstairs and operate on them, and they would make me send them to All Children's and I'd have to go over there and do another history and physical over there and fill out more papers and operate over there. Minor aggravations, but in general it was okay.

B: Other hospitals were opening around St. Petersburg. What I understand was that there was the beginning, if not on the uptake, of this trend toward an increasing number of specialties within the medical field? In other words, people concentrating more and more on a pretty narrow field. Would you say that was true?

P: Yes. I think that's true. But overall, the competition, I think was good because neither Bayfront nor St. Anthony's had air conditioning or tried to improve its physical plant for years until the competition came.

B: Just didn't have to?

P: Just didn't have to.

B: Where's anybody else going to go?

P: Yes.

B: Were you identified as a specialist? I mean, other than being a surgeon who does thoracic and other surgeries, what was the gift or the particular area of strength or expertise that people would say that . . . ?

P: Well, by the time I retired, about 75 percent of what I did was vascular and a higher percentage of it was carotid endarterectomies. But I operated on everything. I did lungs and pacemakers and stomachs and esophoguses and gall bladders and intestinal resections and hernias, hemorrhoids, varicose veins, bypass, graphs, I did all of that.

B: You know your way around the human anatomy.

P: That was part of the fun of it. But the things that were being referred to me were primarily vascular.

B: Other than this increasing tendency toward specialization in medicine, what would you say are the big changes that you've seen unfold in the time that you've been practicing as a surgeon in health care?

P: Well, I think anesthesia has gotten a lot better. They have a lot better drugs, a lot better monitoring, it's safer. Good anesthesia makes it easy for the surgeons. If the patient is straining while you're trying to operate on them, it's difficult. You're trying to sew the abdomen up and they're pushing the intestines out against you, it's horrible. And complications occur from that kind of thing too. Ventral hernias, people who get ventral hernias after having abdominal operations, it oftentimes is because the anesthesiologist let them get too light

and they were straining against the incision while the surgeon was trying to sew them up. But anesthesia has gotten a lot better. And management of the heart rhythms has gotten so much better.

I was so wrong, one of the most wrong things that I've even been had to do with pacemakers. Pacemakers came out when I was doing my surgical residency, I would be putting in a pacemaker and I'd sometimes have a problem and I'd sometimes have a problem and I'd drop out and call the guy that invented pacemakers and talk to him on the phone while I was operating. I mean it's that new. I remember the first six months that I was here in town some stock broker came to me and said, Dr. Pruitt, I just want to get your idea of what the volume of people there are out there that might need pacemakers. For a city the size of St. Petersburg, 300,000, how many people do you think might need a pacemaker in a year? And I said, maybe five. It was more like 1,000. I was so wrong in those early days about that. But we just kept on finding more and more things that were wrong with people that we had no idea that it was their heart rhythm that was the cause of it. Then they invented this thing called a Halter Monitor, which would, say you'd do an EKG on somebody and their EKG would be alright. They'd be complaining of dizzy spells or syncope but then when you'd check them everything was fine. But then when they got this device that let you do an EKG constantly for twenty-four hours, you would find that during that twenty-four hour period, there were sometimes when the heart just stopped for ten seconds, didn't beat at all. Then the patient would get dizzy or faint and fall and break a leg or hit their head, all kinds of things were happening. But before anybody could get to them, their heart would start back up again and it'd be normal again.

B: And nobody knew what happened?

P: Nobody knew what happened. But all those people needed pacemakers. It turned out that there were a tremendous number of people that needed pacemakers. Then they started coming out with all these different kinds of pacemakers. Some were for preventing ventricular fibrillation, rate responsive ones and all kinds of different pacemakers. So I was just way off the beat on that thing. Before 1980, sometimes I put in five in a day.

B: Well, that's a technological change that's taken root and made a huge difference in a lot of people's lives and in the work of a lot surgeons and cardiologists. What other technological changes do you think have really made the biggest splash?

P: Well, the open heart surgery has become much safer. The risk of coronary bypass is less than 1 percent in most places. The heart transplant's an amazing thing. In 1995, I thought I was the healthiest guy in St. Petersburg. I had been to Guatemala, to a wedding that weekend, dancing in the mountains and no

chest pain, never had any problem. Chased cows all the time, all kinds of active stuff, no problem. I got back from Guatemala on Sunday, on Monday I did eight big operations, went to bed Monday night feeling good. I got up Tuesday morning, no pain, but I stood up and then I was dizzy, almost fainted. I laid back down, waited about ten minutes, stood up again and almost fainted again. This went on two or three times and I finally called my PA over to my condo to help me get dressed and get to the hospital. I thought I had caught something in Guatemala or something. I had no idea I'd had a silent heart attack during the night. But, it turned out I had a pretty big heart attack during the middle of the night. I had no pain. So they did an EKG in the emergency and said, you've had a heart attack and we need to do a coronary arteriogram. They did that and they said, well, we need to do a coronary bypass to try to help limit the damage to your heart. So they did that and I thought I was doing fine. Two days after surgery I was in the coronary care unit, but I was sitting up in a chair watching TV and thought I was doing good. They had taken my tube out of my lung. Suddenly the buzzer went off and I had gone into v-fib, and that's not compatible with life, so they had [to] run over there and shock me to get me out of v-fib.

B: Were you aware of this going on?

P: Oh yes. I knew it. My son's a heart surgeon, so he came over. They put my endotracheal tube back in, and about every hour . . . .

B: Did he do your bypass, by the way?

P: No. One of his partners did. At any rate, about every hour I went back into v-fib and they had all these rhythm specialists over there giving all kinds of medicines to control the rhythm and they couldn't control it. This was Sunday afternoon. So by 2 a.m. on, I guess this was Saturday afternoon actually, now at 2 a.m. on Sunday, I had been shocked eight times. They said, we can't control it, you're going to have to have a heart transplant. I said, oh, God. I had never had a patient that had a heart transplant. This was 1995. My son had done some heart transplants in his residency and he was the one who decided I should have one. So the cardiologists agreed that they weren't going to be able to help this heart that I had. So there are three transplant centers in Florida. One is at the University of Florida, one is Tampa and one is in Miami. My son and the cardiologists had decided that both my left and right ventricles were not functioning properly. I needed what they call a biventricular assist device. So my son called all three places, and Tampa didn't have a biventricular assist device. They had a left ventricular assist device, but not a biventricular one. Miami had both and Florida, University of Florida had both, but Shands was ready to operate as soon as I got there.

B: Did they have a heart?

P: Nobody had a heart, but they had the assist device to put in.

B: Okay.

P: So they flew me by helicopter from here to Shands.

B: Was that Bayflight?

P: Yes. I got there about 4 a.m. They were ready to operate at Shands when I got there. They went in and attached this huge pneumatic assist pump on my heart, it sat on my bed there. It was about the size of a washing machine. I still would go into abnormal rhythm every day, once or twice, but that thing would pump enough blood so that they could page somebody to come and they'd give me a pain reliever before they shocked me. Those first eight were cold turkey. Now they had time, with this assist device, they could give me something to relieve the pain before they shocked me. Then it took them ten days to find the heart. So they did the operation to do the coronary bypass and then they did that again to put in the biventricular assist device and then ten days later they opened it up again to put in the transplanted heart, and I started getting better the next day and it's been ten years.

B: But all of that unfolded within thirty days of you going to bed one night thinking you're healthy as a horse?

P: Right.

B: And then into this maelstrom of surgery upon surgery upon surgery from there on out?

P: Big surgery. Yes.

B: That's an amazing experience. Particularly for somebody who is in the business.

P: The University of Florida did a fantastic job. Everybody, Bayfront did a good job too, everybody did a good job or I wouldn't be here.

B: You're walking, talking proof of all of that.

P: Yes. Everybody did a good job. I would not be here.

B: What do you think about that as you look back on the experience of somebody who's knowledgeable about medicine, particularly about vascular matters, and a

surgeon at the top of his craft, having something sneak up on him like that?

P: Yes, that's what everybody says. Dr. Pruitt you're a vascular surgeon, how did you let your own heart get so bad that it couldn't even be fixed, they had to put a new one in? And I said, you know that's an amazing thing to me as well. I had three exercise stress tests within a year-and-a-half of that episode, because I took out a five million dollar life insurance policy and they made me have three exercise stress tests. I passed all of them. Got the insurance. So I called the American Heart Association and I said, what could I have done to have prevented this? They said, well we'd need to get back with you. They called me about a month later and they said, you know, cardiologists are all over the wall on this. Some think you should have done this or that or this or that, but nobody, there's not a set rule for it. If I had an exercise stress test with Thallium, it would have probably shown it. But they don't do that. That's a radioactive material that they inject and it might have shown an area of the heart that was not getting enough blood. But doctors don't ordinarily order that on asymptomatic people who have a normal exercise stress test. But that's the only test that would have shown it.

B: But if there's nothing to indicate it, nobody will start down that road?

P: Well, the insurance companies won't let a doctor if you're asymptomatic. They won't pay for it. Nobody likes to order tests on asymptomatic people.

B: Sure.

P: So they still don't have that settled as of today.

B: So the diagnostic capability that we have for conditions like this is maybe one of the weaknesses in the chain of treatment?

P: Well, it's also maybe our system. Our entire system is set up on treating symptomatic people. But most diseases start long before they become symptomatic. At what point do you want the government to pay for tests on asymptomatic people? Right now we don't at all. So the only thing that people can do really, to protect themselves, is pay for their own screening tests. There are screening tests out there and it's not against the law for you to have one. I mean, for carotid stenosis, for example, if you're not having any transient blindness or weakness or loss of coordination or any signs or symptoms of a stroke and you don't have any noise when they listen with the stethoscope, your doctor's not going to order an ultrasound of your carotid. But we've got thousands of people walking around there with a 95 percent blockage in that carotid artery waiting to have a stroke tomorrow.

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B: Could you hear that if you knew what to listen for, I mean you know what to listen for, but . . . ?

P: Yes, but there are about 25 percent of the people with the blockage that don't have any noise.

B: So even if Pruitt was listening, knowing what he knows . . . .

P: The only thing you can do to protect yourself, is after age 50 get an ultrasound of the carotid artery every two or three years. Now screening people can do that for you for about \$50 of your own money. If you had that test done in a hospital, where a doctor orders it, your insurance will pay for it and the hospital charges \$350. But you can get a screening test done just because you want it, without your doctor's prescription for \$50, and that's what you need to do. For hearts, you probably ought to get an exercise stress test with Thallium.

B: But a doctor is restrained from doing that just . . . .

P: He's not going to order it. You're going to have to pay for it. At least the Thallium part. Or you can have a coronary arteriogram that will show it. But that's invasive and they don't really want to do that. But otherwise, there's no way to pick it up. My trouble came before they came out with Lipitor. So I did have a high cholesterol. I knew I had a high cholesterol. But my mother was 89 and my dad had lived to be 74. He smoked, and I had never smoked, so I was thinking, well his mother is 89 and he was 74, and I don't smoke, he was also diabetic, I'm not diabetic, so I ought to watch my diet, but probably it's a genetic thing that's not going to be all that important. But it was important. Then I tried everything to get my cholesterol down. I tried Zocor, Pravachol, there was about fifteen of them. They didn't budge it. But then Lipitor came out and it dropped it, not all the way to normal, but to about 250. Then there was two or three more years before Zetia came out, and by taking Lipitor and Zetia, my cholesterol is 180, but it takes both of them.

B: Pharmaceuticals have made a big impact on the way we take care of ourselves.

P: Right.

B: In the last twenty, thirty years?

P: Right.

B: Is that where the next big changes are coming from in medicine, do you think, and healthcare?

P: I think that's a very important part of it. I think that's going to help a lot with our vascular disease, now that these, Lipitor and Zetia, and medicines like that. Everybody should get their cholesterol back to normal. I feel sure that that's why I had my problem. We need to do some screening tests on [the] heart, we need better ones. Rapid CT of the heart is, some people think, a good screening test. It costs about \$300 though, even if it's a screening test, it's pretty expensive.

B: What does CT stand for there?

P: It's a computerized test that does rapid X-rays of the heart with a computer and it can see calcium in your heart vessels.

B: Okay.

P: It gives you an index, a number, and if you've got more than a certain number calcium index, then you ought to have an arteriogram of your coronary vessels to look at. But that's a non-invasive test. Knowing what I know, if you've got a strong family history of trouble or high cholesterol that you haven't been able to get down, you probably ought to do some screening tests.

B: Other than pharmaceuticals and maybe, I guess we've heard you say a more effective approach to screening people for incipient diseases or conditions, where else would you say the next changes, big changes are coming from in medicine?

P: Genetics. Genetics is going to be the biggest thing probably. But screening can't be overemphasized because you read on TV and on the billboards all about prevention of stroke and they say, get your blood pressure down and get your cholesterol down and exercise more to prevent stroke. Well, it's true that those things will help prevent a stroke twenty years from now. But if you're walking around here with a 95 percent blockage in your carotid artery, you need to know tomorrow.

B: Yes.

P: And stopping at getting your blood pressure down and getting your cholesterol down and exercising more is not going to help you. You need a screening test.

B: You're making me want to run right out and get one done now.

P: Well, I don't think the general public is aware of this. And that's what that book's about.

B: What are the changes that you think that are going to occur to a big public hospital, like Bayfront Medical Center, in the future?

P: Well, I think Bayfront's keeping up with the times very well. St. Petersburg is very lucky to have Bayfront Medical Center. I think it needs to be clarified a little bit more in the community and even with the doctors about under what circumstances who can you send here and not have to spend a lot of time and effort. How's your best way of helping the hospital and the patient? Let us have a chart to see, for each kind of patient, who we can send here. I think it's still muddy in my own mind.

B: Is that a change that rises out of the policies and behavior of individual institutions like Bayfront or St. Pete General or Northside or . . . ?

P: Well part of it's, you know, federal law of no dumping and part of it's hospitals all don't have enough money. But see, there's another problem out there that makes this worse is that Medicare and Medicaid and all of the insurance companies, Aetna, Banker's Life, all of them have negotiated terms with the hospital to get good deals for all of their enrollees. But indigent patients, medically indigent patients, nobody has negotiated a price for them, so they get charged more than anybody, for the same procedure. I mean, if a person is medically indigent, if he knew when he came to the hospital he was going to get charged the same thing as Medicare Allowable, for example, no more than Medicare Allowable, that would take a tremendous load off of his shoulders. But they get charged more and they don't have any idea what it's going to cost him. And then the bill, you can't read it. Patients bring me these bills and . . .

B: Oh, I know.

P: A CPA can't understand those things.

B: I know something about what you're talking about there.

P: But I think it ought to be clarified in the newspapers, on the front door of the hospital, everywhere, who, if they're not insured, what kind of patients is Bayfront going to take without an argument, without reporting the doctor to Department of Professional Regulation, and assuring the patient that he is not going to be charged more than Medicare Allowable.

B: Well, I'm getting the high sign from our people out there that I need to bring this in for a landing, so I'm going to approach the end by just asking you Dr. Pruitt, is there anything else you would say that you need to add to this commentary or interview before we close?

P: No. I'd just like to say that I think Bayfront's performing a great service for the

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community, and I know Bayfront by itself can't solve all these problems. But I think that they've got good leadership and they've got good doctors, and I would personally feel comfortable coming here with anything.

B: That's no small endorsement coming from you. I thank you, Doctor, for your time.

P: You're welcome.

[End of Interview.]