

## Biographical Sketch

### Virgil Pendelton Gibney, MD, 1847–1927

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Published online: 17 November 2009  
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**Abstract** This biographical sketch on Virgil Pendelton Gibney corresponds to the historic text, *The Classic: Chapter XVIII. Operative Treatment in Chronic Articular Ostitis*, available at DOI [10.1007/s11999-009-1165-3](https://doi.org/10.1007/s11999-009-1165-3).

Dr. Virgil Pendleton Gibney was born in Jessamine County, Kentucky in 1847 [3]. Although born on a farm, Gibney's father, an immigrant from Northern Ireland, was a general practitioner and also owned part of a retail store to supplement the family income [11]. Gibney lost his ring and little finger in an accident at age 11, but this evidently did not stop him from pursuing surgery [11]. He obtained his undergraduate education at the University of Kentucky, from which he graduated in 1869. He then earned his MD degree from the Bellevue Hospital Medical School in New York City in 1871 [3]. (The Bellevue Hospital Medical College was the first medical college in New York connected to a hospital and in 1861 produced the first outpatient department associated with a hospital, the "Bureau of Medical and Surgical Relief for the Out of Door Poor" [1].) At age 24, in 1871, Gibney was appointed an Assistant Physician and Surgeon to the Hospital for the Ruptured and Crippled (the predecessor to the Hospital for Special Surgery) (Fig. 1). According to Levine, "This was a strange appointment as Gibney was a disciple of Lewis H. Sayre, M.D., who represented everything that Knight was not" [10]. (Knight, who served as the President of the Board of the hospital, "had the personality of a surgeon but

ironically was vehemently antisurgery" [10]. Sayre, on the other hand, was a cautious advocate of surgery in the new Listerian age.) According to Sherk, "Knight forced Gibney to renounce the idea of surgical treatment of musculo-skeletal deformity" whereupon Gibney resigned and toured European hospitals to more thoroughly study surgical treatment [6]. (The reader should recall Knight had trained and largely practiced in the days before anesthesia, anti-septic surgery, fluid management, and blood transfusions. Given the high mortality and complication rates of surgery, Knight's position was not so outrageous as it might otherwise seem.) However, Gibney evidently returned to the hospital because in the preface of his book in 1884 he stated, "For thirteen years I have resided in the Hospital for the Ruptured and Crippled, all of my time being devoted to daily service in both the in-door and the out-door departments" (it was not unusual for physicians to reside in the hospital) [5]. Undoubtedly, Gibney operated little in those days:

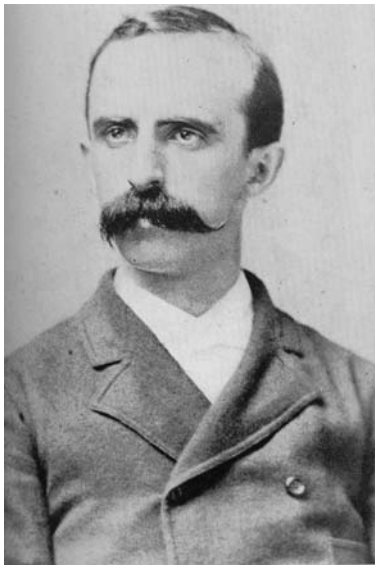
"The hospital is further known as an extremely conservative institution. Dr. Jas. Knight, its founder and surgeon in-chief, has been led by his extensive experience to adopt a plan of treatment which coincides, in many respects, with the definition I have elsewhere given the term expectant" [5].

After Knight's death, in 1887, the hospital board appointed Gibney as surgeon-in-chief [12], a position he held until 1925 when, owing to failing health, he stepped down. On assuming the position his stipulations were to be able to live outside the hospital and hold a private practice and operate outside the hospital. Gibney in fact had the first operating room installed in the hospital in 1889 [2]. He became the first Professor of Orthopaedic Surgery at Columbia Medical College.

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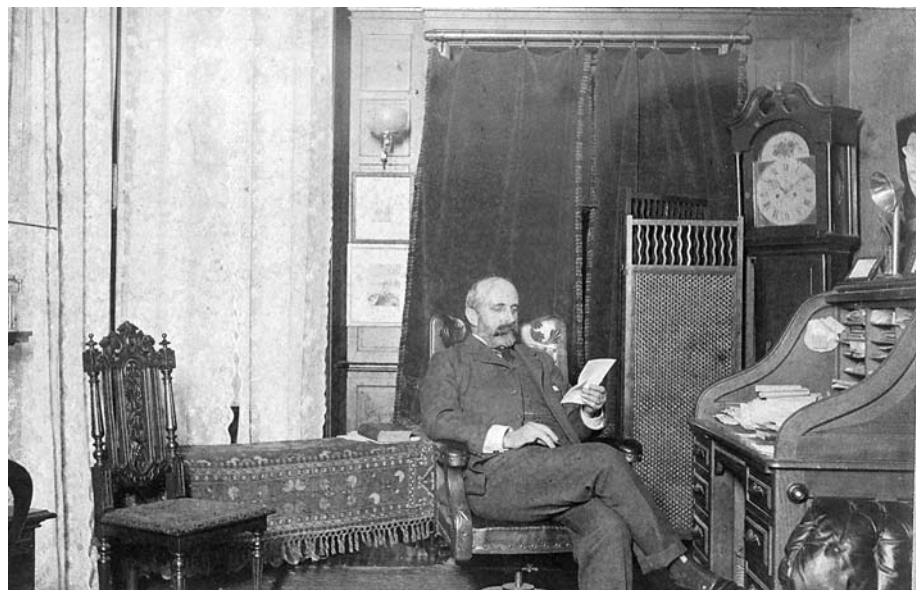
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Gibney was active in a number of organizations. He was a founding member of the American Orthopaedic Association in 1887, its first president, and the only individual to serve twice as president (again in 1912) [11]. He became a member of the New York Academy of Sciences in 1887, and was a fellow of the American Medical Association and the Pathological Society. He was a consultant surgeon for a number of regional hospitals. He found time to publish extensively: the collected papers occupy a volume over 5 inches in thickness (personal communication, Dr. David Levine, The Hospital for Special Surgery).



**Fig. 1** A photograph of Gibney at age 24. (Courtesy of Hospital for Special Surgery Archives.)

**Fig. 3** A photograph of Gibney in his office during his mid 40s. (Courtesy of Hospital for Special Surgery Archives.)



This month we reproduce an abridgement of Chapter 18 from his monograph, “The Hip and its Diseases” [5], published in 1884 (Fig. 2). By that time, Gibney was persuaded of the safety of surgery:

“The question of surgery no longer turns on the mortality of the operation. True, the danger in all

## THE HIP AND ITS DISEASES

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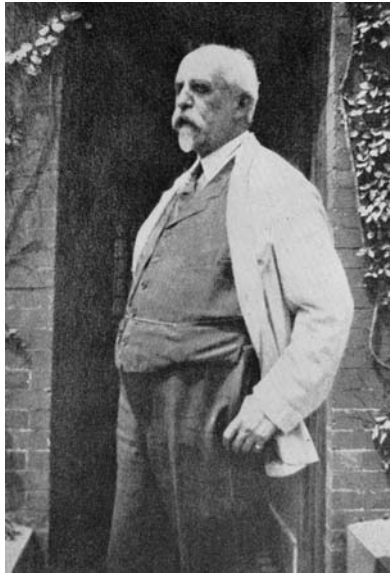
PROFESSOR OF ORTHOPAEDIC SURGERY IN THE NEW YORK POLYCLINIC; ASSISTANT SURGEON TO THE HOSPITAL FOR THE RUPTURED AND CRIPPLED; FELLOW OF THE NEW YORK ACADEMY OF MEDICINE; FELLOW OF THE AMERICAN ACADEMY OF MEDICINE; MEMBER OF THE NEW YORK PATHOLOGICAL SOCIETY, OF THE MEDICAL SOCIETY OF THE COUNTY OF NEW YORK, OF THE NEW YORK CLINICAL SOCIETY, OF THE PRACTITIONERS' SOCIETY OF NEW YORK; MEMBER OF THE AMERICAN MEDICAL ASSOCIATION, OF THE AMERICAN NEUROLOGICAL ASSOCIATION, ETC., ETC.



BERMINGHAM & COMPANY,

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NEW YORK. | LONDON.  
1884.

**Fig. 2** The frontispiece of Gibney’s monograph, *The Hip and its Diseases*.



**Fig. 4** A photograph of Gibney at age 77. (Courtesy of Hospital for Special Surgery Archives.)

surgical procedures is to be considered, yet antiseptic surgery has contributed largely toward removing this element. When I say antiseptic surgery has done this, I mean that it has done so directly and indirectly. Those surgeons who oppose Listerism have, in order to maintain their position, grown more cleanly in their operations, more careful, and more discreet. It is seldom now that a patient dies of shock from an operation...”

Clearly, the dangers of surgery had been very real in Knight’s day, but the advances associated with “Listerism” and anesthesia had, by 1884, made surgery less risky and more practical.

The concepts about and terminology of arthritis have evolved over the centuries, but by the late 1800s they were quite primitive by our current standards [4]. Even seemingly clearcut distinctions such as septic from nonseptic, and rheumatoid arthritis from degenerative arthritis were not clearly made. Of course, the science of microbiology had just emerged and we must recognize doctors simply did not have the tools to make the distinctions. Gibney’s Chapter 5, “Rheumatism of the Hip,” distinguishes rheumatism of the hip in the child and in the adult (“chronic rheumatic arthritis or malum coxae senile”). The descriptions of the cases, however, do not entirely conform to our current understanding, and so in the former case there are likely patients with acute or chronic juvenile rheumatoid arthritis, tuberculosis, Legg-Calve-Perthes disease, late sequelae of septic arthritis (when they survived), among others. He also uses the term, “peri-arthritis” to describe conditions limited to the soft tissues, undoubtedly of a

septic sort since he mentions acute cellulitis and abscesses: “Its (peri-arthritis) early recognition is also important, in view of advantage to be gained by early incision of purulent areas. These abscesses in children not suffering from any malnutrition are harmless...” However, he distinguishes peri-arthritis from “similar conditions occurring in connection with the second stage of a chronic articular osteitis very insidious in its approach.”

Today septic arthritis in children is typically diagnosed early in industrialized countries, and we rarely see any indolent forms. Gibney does not describe what happened to those children with acute septic arthritis but I suspect many died of sepsis in those days (childhood mortality was quite high) and perhaps the diagnosis was not even made since joint symptoms might have been overwhelmed by the systemic symptoms. What percentage of these patients may have survived and developed the indolent form seen by Gibney is unknown, but clearly there were a substantial number of patients with the problem. Gibney evidently preferred an excision described by Sayre, one with a small incision and with simple excision of the head and neck depending on the amount of diseased tissue. This operation differed markedly from the radical operations described later by Girdlestone for treating tuberculous and pyogenic arthritis [7–9]. Gibney described followup only in a few patients in the chapter we reproduce (those sections abridged), and they did well. We may presume, however, from Girdlestone’s procedures a fair number of patients did not respond to simple excision and rather required more radical procedures involving débridement of the hip capsule and muscle. Gibney’s descriptions do indicate how surgeons managed patients with septic arthritis in the days before the discovery of methods to identify bacteria and well before antibiotic treatment.

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