This Time Is a Good Time

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THAT THE YEAR 1965 falls exactly 100 years after Lord Lister enjoyed his first success with antiseptic surgery is to me rather exciting. His patient was an 11-year-old boy with a compound fracture. He was treated on August 12, 1865. The second success occurred the following month. These patients were treated in Glasgow before Lister's return to Edinburgh. Written in neat longhand, the reports are brief, complete and made up of simple direct words that by comparison with our "slanguage" of today shame us.

The key figures at the first Clinical Congress in 1913 were Lister's nephew, Sir Rickman Godlee, and John M. T. Finney, our first president. Godlee was then president of the Royal College of Surgeons of England, and at the Convocation the two walked in arm and arm.

The Congress has always had many impressive features, but as an educational effort it has come a long way in recent years. The first one that I attended, as a member of what is now called the Candidate Group, found the wet clinics still in full flower, with strenuous competition for tickets of admission to the impressive operating sessions of the fastest and busiest surgeons of the day. For the remarkable five days of which the Congress now consists we are most grateful to various standing committees of the College, to the nine advisory councils for the specialties, and to the staff. The amount of effort involved is indeed great, and each year finds the Congress improved as a magnet bringing together many thousands of surgeons of all ages and interests.

The President. Addressing himself "especially" to the surgeons just received into Fellowship and assembled before him at the Convocation on October 17, 1965, during the Clinical Congress in Atlantic City, Howard A. Patterson as incoming president shared with them "some thoughts" as recorded herewith on "the influence on surgery of the whirlwinds of change." The forty-sixth president is clinical professor of surgery, Columbia University College of Physicians and Surgeons, and chief surgeon, Roosevelt Hospital. The title of his address connoting the president's pleasure in and his concern for the present stems from Ralph Waldo Emerson's "The American Scholar."

In 1906, Charles Eliot of Harvard dedicated the new buildings of the medical school with these words: "I devote these buildings, and their successors in coming time, to the teaching of the medical and surgical arts which combat disease and death, alleviate injuries, and defend and assure private and public health; and to the pursuit of the biological and medical sciences, on which depends all progress in the medical and surgical arts and in preventive medicine." This was a splendid statement, and President Nathan Pusey, in May, 1965 and nearly 60 years later, very appropriately used the identical words to dedicate the great new Countway Library. There has been no change in the aims of good medical schools, and there has been no change in the aims of the American College of Surgeons.

When the College was founded in 1913, there was no control over a surgeon's privilege, except his conscience, and his ability to persuade patients to allow him to operate. The first organization in America to establish qualifications for surgeons, the College has gradually but persistently raised its requirements for Fellowship. Its membership now consists of one half general surgeons, and one half specialists. Specialization adds to scientific knowledge and solves clinical problems; but it does tend to isolate us from one another, and to make us lose some of our common heritage as surgeons. It is extremely important to maintain this College as the home of all able surgeons regardless of the special fields in which they work.

The Regents are hard at work on the future position of the College in the changing world of medical practice. We can not remain aloof at a time when the tough problems of the day seem at times to be tackled with more abandon than wisdom. We must, however, be very sure that our criticism is at all times constructive.

The problems are not really new. George Berry lists them well: "How to marshal more rapidly, for the benefit of mankind, the results of new knowledge; how to provide better care, more equitably distributed; how to create a more fruitful environment for teaching and research; how to utilize in the national interest the vast resources of government and yet safeguard essential independence."

We must keep open ears, a clear head, a desire

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to be helpful, and a determination to guide legislative and other trends toward what is in the best interest of the surgical patient. The enormous flood of money now available for fellowships, training grants, and research grants—about two thirds of which comes one way or another from federal sources—continues to produce problems as well as great benefits. Each of us must make a real effort toward seeing that the money is well spent, and that those attracted by the prestige attending research are really qualified by training, ability, opportunity and singleness of purpose to pursue it. We must not let the quality of teaching in our medical schools suffer at the hands of candidates for various and sundry degrees, nor should we forget that a goodly proportion of our doctors are needed in the care of patients.

What About the Present?

One often hears a recounting of the amazing strides made by surgery in the past 50 years, together with forecasts of the unbelievable changes that the next 50 years will bring. In general, it seems to me, the pessimists tend to look backward, and to disapprove of many trends. They complain that the patient's chart now tends to weigh as much as the patient, that unnecessary tests have lifted costs out of sight, and that the five-day week has affected hospitals to such an extent that nothing much gets done on weekends. They loudly complain that the research tail is wagging the clinical dog. They also talk nostalgically of the days when nurses and doctors seemed to work together more effectively in helping patients.

The optimists look gaily to the future, and tell us that a series of laboratory findings will be fed to a computer and that diagnosis and indicated treatment will appear forthwith. Not much is said about an old-fashioned physical examination. And there seems to be a childlike faith that money and government will somehow solve all problems and that illness and death will be no more. The dreamers keep reminding us that one pound of plutonium, in size a little smaller than a golf ball, has the energy equivalent of three million pounds of coal, a most fortunate arrangement for we will soon use up all the coal, gas, and petroleum on this planet. Moving to other planets is then discussed in spite of the fact that the nearest star outside of our own solar system is so far away as to make the recent trip of our Mariner to the neighborhood of the planet Mars seem like a jaunt just around the corner; and we do not even know that Alpha Centauri has planets about it. It is a comfort to recall the old saying that the world needs two types of people, the poets to write about the glories of autumn, and the rest of us to rake them up.

I am well aware of the fact that we must plan for the future. What worries me, however, is that few seem to be sufficiently concerned with the present. To the man on Ward Four with a colonic tumor, or the lady on Ward Three with gallstones, today and tomorrow are very important, indeed. This brings me to my text, "this time is a good time." It is quoted from Ralph Waldo Emerson's "American Scholar." Emerson felt sure that the present day, as any other day, is an excellent time to do a good job, with all the knowledge and resources presently at our command.

The French proverb, "the more things change, the more they remain the same," applies well to the world of surgery. As many wonderful new things appear on the horizon, we must keep in mind the fact that many things have not changed.

The guiding determination of this College will not change. It is quite unnecessary for me to recount the College's ideals and aims, its sole purpose being the advancement of the welfare and safety of the surgical patient.

Young Surgeons Are Stimulating

Secondly, we must remember that it is largely from the young surgeons that stimulation comes. The finest activity of the College during the past 24 years, I firmly believe, has been the Forum on Fundamental Surgical Problems. Launched in 1941 by Owen Wangensteen, with the strong backing of Evarts Graham, this splendid activity has been led successively by Wangensteen, Ravdin, Longmire, Shumacker, Muller, and now William Scott. Now more than 800 excellent papers are submitted annually by our young surgeons, and about one third of these are selected for presentation at the Forum sessions during the Congress. Every field of surgical endeavor is covered. More than 6,000 copies of *Surgical Forum*, the book in which the reports are collected, are distributed annually.

The third truth that should never change is that anatomy should be taught and learned. The surgeon should be proud to be an excellent anatomist. He should enjoy it and should teach it. Some 30 years ago, before the American Surgical Association, the late David Cheever pointed out the sorry state of this fundamental field. He quoted a Sixteenth Century observer, who said that to turn loose a surgeon who doesn't know anatomy is like

hiring a man who doesn't know the good vines from the bad to trim in a vineyard. There was a time when great surgeons, men like Maurice Richardson, Cheever and Robert Green, also taught anatomy. Perhaps we may see this again some day. Or an excellent clinician might teach physiology. Anatomy has now been backed into a very small corner. Unless they do a bit of experimental endocrinology on the side, whether they do it well or poorly, those who teach anatomy, even though they teach it well and try to make it highly interesting, are likely to be looked down on by their colleagues.

Has Research Displaced the Patient?

As far back as 1934 Harvey Cushing expressed regret that many teachers in the first two years of medical school are not really much interested in patients. He observed that "more and more the preclinical chairs in most of our schools have come to be occupied by men whose scientific interests may be quite unrelated to anything that obviously has to do with medicine, some of whom, indeed, confess to a feeling that by engaging in problems that have an evident bearing on the healing art they lose caste among their fellows." This may well add to the tendency to produce nine-to-five doctors, for it is with these men who lack interest in patients that the students are most closely associated.

The fourth truth that should never change is that hospitals exist primarily for the benefit of the patient, not primarily for the benefit of trustees, doctors, nurses, administrators or researchers. We all realize that no hospital will be a fine hospital without a good teaching program, or without an appropriate adequate research laboratory. It is the matter of emphasis that is disturbing. When one looks at a huge addition built beside a hospital that has a four-month waiting list for elective operations and is told that not a single bed for patients has been added, one is sad, or should be sad.

Is Space for Computer or Stricken?

The same reaction should follow when the admissions policies become too selective, and the surgical ward bed is held for more romantic problems while the victim of an extremely painful fissure waits and prays for admission. The hospital administrator should be a bit less interested in finding space for the computers and in the year 2000, and more interested in the immediate welfare of every patient within the walls of the hospital. So should the doctors.

The problem is especially difficult in a large medical school hospital. I have often thought, in recent years, that the senior professor of surgery has an impossible task and that it might be well to have one professor of surgery for sick people and another to guide the important work in the surgical laboratories.

A fifth unchanging truth is that people are important. It is sad to see generous and dedicated citizens work to produce a fine community hospital building, and furnish it with the latest equipment, but give little or no thought as to how they will properly staff it. It is far harder to get money for adequate salaries than for memorial wings and rooms.

The President *and Mrs. Howard A. Patterson are flanked at October 19, 1965, reception in their honor by* (left) *Adrian Lambert, New York, and José R. Gonzalez Giusti, Santurce. The reception was given by William H. Cassebaum and other staff members at Roosevelt Hospital, New York, where Dr. Patterson is chief surgeon.*

Surgical patients still sorely need good surgical nurses, at the bedside, in the operating room, the recovery room and the special care unit. The shortage of operating room nurses has become very serious, so serious that the College feels it necessary to help hospitals establish training programs for surgical technicians such as those who assisted many of us so well during World War II. They would not displace any nurses from our operating rooms but would give them greater opportunity to participate as invaluable members of the operating team. Most pupil nurses these days spend little or no time in the operating room and have no chance to find out if the work there might appeal to them. Hope is slight. In a recent issue of a leading nursing journal, these two sentences appear in sequence. You won't believe this, but it's true.

"In her conventional role, the nurse typically focuses much attention upon routine proceduralism and on a multiplicity of clerical and managerial tasks which remove her both physically and psychologically from the patient's bedside. In recent years, however, and in conjunction with the several versions of the patient-centered care concept, a nurse role has been defined which is fundamentally therapeutic in nature."

How on earth could any nursing "care concept" ever be anything but patient centered?

Swap Administrators etc. for Good Nurses

In the late 1930's, when Harvard's football fortunes were at a low ebb, a popular sportswriter said that he had heard that Harvard was willing to trade any ten deans for a good tailback. Hospitals, nowadays, should be willing to swap a great deal, perhaps a few surgeons, a few trustees and a whole platoon of administrators, for a dozen excellent dedicated nurses who like to nurse. Perhaps the most able nurses should be paid more than those doing less arduous tasks. Perhaps the week-end problem in our vital special care units could be solved by having skilled nurses work a seven-day week for two weeks, then have a full week off with pay, their pay to be about double that of those who act largely as clerks.

The rewards of surgical practice and of surgical teaching are still great. They are no less great today than they were decades ago but are rather out of fashion. Sir Arthur Conan Doyle is said to have replied to a question as to why he gave up practice by observing that he didn't abandon his practice—his practice abandoned him! Whatever the reasons, many of our ablest surgeons are rarely found in the operating room these days, and seem to have far less contact with their interns, residents and students than was the case not long ago. This is a pity for it is a great privilege to guide an intern through his first operation for the repair of a hernia, or to help a senior resident in handling a difficult problem involving a stricture of the common bile duct; and the fourth year students can still ask very stimulating questions. Perhaps this shortage of time for teaching and practice is engendered by too many administrative chores and meetings.

Practice and Teaching Are Rewarding

The hospital administrator may not know his way about the hospital; the head of nursing service may know all the jargon of those who have top degrees in nursing education, but may know little about the patients, who, after all, are the reason the hospital exists; and the professor of surgery may not know his interns and residents and their problems as well as he would wish.

There are, fortunately, many notable exceptions, and the wonderful influence of some who are no longer with us is carried on by young teachers who stepped on the professor's shoulders to reach even higher, while holding fast to the love of teaching that they inherited from "the chief." I hope that a great many of our new Fellows will enjoy the very real pleasures of teaching.

In the last act of Shakespeare's fantasy *A Midsummer Night's Dream*, in a play within a play, Pyramus makes quite a speech before stabbing himself. After more talk he announces, "Now am I dead." Theseus looks over the situation and decides that "with the help of a surgeon he might yet recover."

Just what sort of surgeon did Pyramus need? He must surely be promptly available. He must be a member of an able team with the best of modern anesthesia. He must be an excellent craftsman, with an old-fashioned knowledge of anatomy.

Speaking of a craftsman, ten years ago when Prince Philip was made an honorary fellow of the Royal College of Surgeons of Edinburgh, he proposed a toast to "the Craft of Surgery," and expressed the hope that no surgeon would be insulted by being referred to as a craftsman. In closing, the prince emphasized these two sentences: "I only hope that those people who, quite rightly, believe that surgery is more than a craft will forgive me but I look at it, still, from the point of view of the patient. If anyone is going to tinker about with my insides, I would rather he were an accomplished craftsman."

Pyramus needed a surgeon who was equally at home in the abdomen or the chest. Those of us who are interested in the training of young surgeons do not worry about too much specialization, but we do worry a lot about too early specialization. No surgeon can achieve top skills in all fields of surgery, but he will be far abler and far more valuable to his patients if he has a broad and excellent basic surgical training before entering his specialty.

I am well aware of the years and expense involved in such training, but I applaud the wisdom of the thoracic surgeons in requiring that a doctor have a full general surgical training before he is accepted for training in thoracic surgery. It seems to me that producing general surgeons with no gynecologic training, or gynecologic surgeons with little or no general surgical training, is rather like training one group to work in the upper part of the thorax and another group to work in the lower part.

Thorough training also tends to save us from tiresome arguments as to which specialty inherits a given surgical problem. The thyroid normally inhabits the neck but nodular goiters often wander into the chest. The stomach should stay in the abdomen but sometimes much or all of it lies in the chest. Small children swallow or inhale all sorts of foreign bodies, and great skill may be required in retrieving them. Who should do this?

I firmly believe that the available person who is most skilled at such manipulations should. Just which specialist operates on patients with head and neck cancer seems to me far less important than the requirement that the operation be properly selected and skillfully done in a reasonable time.

I have no intention of suggesting exactly how much basic training the various boards should require—perhaps we should emphasize more the content of the training period, rather than the months and years—but the training must be adequate. Dr. Finney advised, in 1913, that "there is no royal road to surgery. There is no such thing as surgery made easy . . . or a ten-lesson course." It is interesting to observe the versatility of those surgeons who are frequently asked to do major operations on members of doctors' immediate families. Furthermore, from the patient's standpoint there is no such thing as a "minor" operation. The surgeon must be ready for any problem that appears, no matter how unexpected. The late Edward Gallie, one of the esteemed Canadian presidents of this College, expressed this all nearly twenty years ago in his address to the American Surgical Association about surgical training.

Pyramus's surgeon should have had extensive training and experience in the field of trauma, including the evaluation and practical management of shock.

Here is one last attribute of Pyramus's surgeon: He must be attentive and kind to the patient and to the family. When they approach "the valley of the shadow," as all must, it is not the cynical brilliant Arrowsmiths but the Weelum MacLures* that men and women will seek to ease their burdens.

This time is a good time, and I envy this splendid group of new Fellows.** Having already reached important milestones in your careers, you still have many years ahead of you in which to practice the finest of professions, and to enjoy the great satisfaction of helping surgical patients along the road, an exciting and brightening road.

Please remember, always, that there is no substitute for excellence.

*Hero of Ian MacLaren's *A Doctor of the Old School*, one of several stories collected under the title *Beside the Bonnie Briar Bush* (New York, 1895: Dodd, Mead & Co.).

**EDITOR'S NOTE: Listed geographically and alphabetically in the *1966 Supplement to the 1965 Directory* distributed to the Fellows and accredited hospitals in Canada and the United States in early January.