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But Above All, A Good Doctor

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Address of the President

THE ADDRESS OF THE PRESIDENT was presented at the Convocation of Fellows, Clinical Congress, American College of Surgeons, San Francisco, California, October 12, 1956, when Dr. Elkin took office. Now living at Lancaster, Kentucky, Dr. Elkin was formerly Joseph Brown Whitehead professor of surgery at Emory University School of Medicine, Georgia, and chief of surgery at Emory University Hospital.

I GREET YOU, Fellows of the American College of Surgeons, from what I believe is a unique position for a president of the College. I do not use unique in the comparative sense in which it is often employed. I mean really one of a kind. So far as I can determine, I am the only surgeon ever chosen for this high office who had retired from practice. That should permit me to survey the surgical scene with Olympian detachment. I must warn you to the contrary. Now that I am looking in from the outside, I find myself taking more positive positions—I hope on things that really matter—than I did when I was actively practicing.

If you have come here, like St. Luke's Athenians, to "hear some new things," I shall disappoint you. I am rather old-fashioned, given to plain speaking, and I shall expose you to the repetition of a number of old-fashioned ideas. Like Laënnec, I do not fear to repeat what has already been said; I share his conviction, which others have shared, that repetition may quite as well indicate intensity of belief as paucity of thought.

I shall take the liberty, which I hope I shall not permit to degenerate into license, of emulating "Omer," at the time he "smote his bloomin' lyre."

If you remember, he just "went and took" "what 'e thought he might require." And so shall I, sometimes without even using dear Charles Lamb's "inverted commas."

Now that I have concluded these introductory peregrinations, let me pass on to what a lord chief justice used to call "my series of carefully prepared impromptus." I have no particular subject. I was tempted by the theme that tempted Barrie when he was rector of St. Andrews: "The mess the speaker had made of his own life." I have passed that by, to address you on a variety of subjects, some connected with the College, some rather far afield. You who are newly inducted into this Fellowship must stay with me. You are a captive audience. Your academic garb would give you away if you tried to leave. I shall remind the rest of you that the exits are well marked—walk slowly, please—though in this lovely city of San Francisco fire is a never-mentioned word.

I did not walk hand in hand with the founding fathers of this College, but I knew many of them. I admired and respected them. Franklin H. Martin, the man who conceived the American College of Surgeons and who directed it for the first 22 years of its existence, has never ceased to influence it, not only in its activities, but also in the splendid journal *Surgery, Gynecology & Obstetrics* which he founded and which he and his wife bequeathed to the College.

He builded better than he knew. He set the face of American surgery toward its present goals. He raised its standards far above the level of earlier standards, or, more correctly, he set up standards where none existed.

I wonder whether you realize how far flung these activities are. Let me list a few of them.

There is the Clinical Congress, with 1,000 registrants at the first session in 1913 and 10,000 at the 1955 session. Sectional Meetings are held in the United States, Canada, South America and Europe. Many other scientific sessions are sponsored by the College's local Chapters.

There are postgraduate educational activities, including scientific exhibits at the Congresses and the Forum on Fundamental Surgical Problems.

There is the College library, of some 40,000 volumes, and the associated Department of Literary Research.

There is the cancer program, under which this year [1956] 713 hospitals are listed* as approved either as cancer hospitals, cancer consultation services, or consultation and treatment services.

There is the program on trauma, now in its thirty-seventh year, and now chiefly directed toward the fields of trauma and the management of mass casualties.

There is the pioneer work of the College in hospital standardization. Now, properly, the responsibility of the Joint Commission on Accreditation of Hospitals, which represents not only the American College of Surgeons but the American College of Physicians, the American Hospital Association, and the American and Canadian Medical Associations. In 1918, when the first survey was made, only 13 per cent of 700 hospitals met the minimum standard. In 1952, just before the College turned the program over to the Joint Commission, 3,000 hospitals were fully approved and another 400 were provisionally approved. The standards were never lowered.

The College has been responsible for the establishment of standards of graduate training in surgery. In 1939, there were only 200 hospitals approved for residence training; now there are 700.*

HELP THEM TO KEEP THEIR DREAMS

If you want to know the details of the long fight which the College has waged against the unwholy practice of fee-splitting, I recommend that you read, with care, the "Vignette of Medical History" on the rise and fall of this phase of surgery in the November-December, 1955 issue of the College's BULLETIN. It has been a long, uphill fight.

The older Fellows of this organization have a par-

*EDITOR'S NOTE: This list was published in the September-October, 1956 BULLETIN.

responsibility in this matter. Younger men might perhaps be less tempted to depart from their pledge if they were helped along the way. Fee-splitting would never be a temptation if young men entering the practice of surgery could be convinced that a living could be made honestly and honorably without it. Men who are older in the profession could make their beginnings easier for these younger men. The patient is not a prize to be striven for. Jealousy, hatred, the desire to get ahead at all costs, should have no place in a profession such as ours. Stephen Paget once said that practice is the breaking of dreams. I would remind all of you present at this Convocation that it need not be.

In this year of 1956, 43 years after its founding, the American College of Surgeons' chief objective is exactly what it was stated to be in the bylaws formulated in 1913: "To elevate the standards of surgery and to establish a standard of competency and of character for practitioners of surgery."

Those of you who have been inducted at this Convocation into the Fellowship of this College have fulfilled those requirements. Your admission to this Fellowship implies the training you have undergone, the work you have accomplished, and the competency you have attained. You have not reached the end of the road. True, the training which gives you the right to be here has removed you from the category of which Osler spoke when he said that there were no more dangerous members of the profession than those born into it, so to speak, as specialists. You have served your apprenticeship, even if not in the older—and, I hasten to add, entirely honorable—sense, and I hope that during it you acquired that "relish of knowledge" which will keep you students all your days.

DEXTERITY IS NOT ENOUGH

You do not need me to remind you that surgery is considerably more than the ability to use one's hands dexterously. You understand what Harvey Cushing, a former president of this College and a surgeon who was as percipient as he was brilliant, meant when he said that he would like, some day, to see some medical school appoint as its professor of surgery a physician who had no hands. You know that the surgeon who does not possess something more than technical competency is not only an unsuccessful surgeon, however brilliantly he may operate, but is a highly dangerous man.

One of the wisest things that was done during World War II was to put that principle into practice. Another former president of this College, the

The Presidents

Dr. Daniel C. Elkin (right) and Dr. William L. Estes, Jr. are seen here at the Convocation when the former was installed as president of the American College of Surgeons. Dr. Estes is president elect.



late Dr. Fred Rankin, chief surgical consultant of the Army, had much to do with it. I am afraid that with all of their excellent technical training, many of our medical officers might, in their enthusiasm, have done unwise and foolish things except for the maturer judgment of the consultants who guided and directed them and who frequently said them nay. The Army consultants had no more important function than to provide for these men that "certain degree of hesitancy" which "years and experience bring in their train."

The College of Surgeons has established surgical standards. Let us be certain that we do not use the term lightly, that when we prate about standards we know whereof we speak. Many years ago Sir Astley Cooper, addressing a group of candidates seeking admission to the Royal College of Surgeons, said that their success in the noble and difficult profession they were about to enter depended upon their knowledge, their industry, and the preservation of their moral character.

DEGRADATION OF OPPORTUNITY

I think we may take your knowledge of your specialty more or less for granted, but this question of industry cannot be dismissed so readily. Several years ago, in an excellent editorial in *Surgery, Gynecology & Obstetrics*, Jonas had some bitter things to say about the present attitude in the profession toward hard work. He was speaking particularly of residents, but what he said could well be required reading for many older men. The forty-hour week not yet come to medicine. To insist upon it,

with as many nights and weekends off as possible, means only degradation of opportunity. The most interesting cases and the most troubling complications occur just as the whistle blows or in the middle of the night. Continuity of observation is essential to good patient care. The term "resident" means living in the hospital, close to the patient. Osler, Jonas concluded, brought the student to the patient's bedside and the residency system should keep him there.

I want to reach Sir Astley's thoughts upon the moral character of the surgeon by a somewhat devious route. I envisage the day when the physician will once again stand for something in the community over and beyond medicine. Today he seldom does. Perhaps the swift pace of modern life is the explanation. More likely it is the passing of the family doctor.

EACH ACCORDING TO HIS TRAINING

I would myself prefer to keep that honored term. I doubt that the recrudescence family doctor will be a better physician, or will be more readily accepted by his patients, if he is called by the proposed new term "generalist." Whatever he may be called, I am glad to see that his status is beginning to improve. The specialist, surgical or otherwise, would do well to pay more attention to what the family doctor knows about his patients and what he says about them. The religious fervor of Sir Thomas Browne may ring strangely in modern ears, but all of us would agree with him that the physician's first task is to deal with the whole man. The methods of the

family doctor as he once existed were often astonishingly successful in treating the whole man, a matter at which some of us who call ourselves specialists are sometimes not so efficient.

What should the family doctor be permitted to do in the way of diagnosis and treatment? There is no reason, as I see it, why he should not undertake whatever his training qualifies him to undertake—a restriction, incidentally, which applies to all of us, whether we be Fellows of this College or diplomates of the various certifying boards. The privilege to practice within special fields is not solely a matter of licensure and credentials. The possession of these documents gives the medical graduate the legal right to operate on anybody ignorant enough or foolish enough to permit him to do so. I should not have to remind you that that fact carries with it certain moral implications for those who practice surgery. When we speak of the performance of surgery by those who have no right to do it, we must direct our attention to our own household also.

A TRUE VOCATION FOR MEDICINE

And so we come back to the preservation of the surgeon's moral character. The Candidates' Program of the College is based upon the surgeon's recognition of his responsibility. That is always emphasized in the resident's training, and it should be. But we should carry this recognition even farther back. The medical student cannot learn too early in his professional education what the ideals of this College are. He cannot be taught too soon the responsibility and solemnity—I use the word advisedly—of the practice of surgery, that it is a matter of the heart and soul and mind as well as of the hands. I doubt that we are teaching our students—or even our interns and residents—that, as Faure said, surgery is an act without appeal. It depends upon the point of view whether a surgeon regards his mortality rate as a triumph or a disaster. Said Benjamin Brodie, speaking to the students of Bart's over a hundred years ago:

"Let me exhort you never to slur over a single case, nor proceed to the smallest operation without having well considered that accidents may happen, what evil may follow, what degree of danger may ensue."

But does the medical school take us far enough back in the matter of the physician's fundamental integrity? In selecting our medical students are we

as careful as we should be to take character into account, to be sure that the candidate for admission has a true vocation for medicine? We are too engrossed with academic credits. Are we as careful as we should be to emphasize these qualities throughout the student and the intern and the resident years? The old system of apprenticeship often produced results that were better than the system. There were great physicians even when there were only poor schools. The apprentice absorbed the whole philosophy, morals and manners of the man under whom he worked. His preceptor carried a heavy responsibility. We must reassume that responsibility under our modern system of training. I would ask you to remember that, you men who have just become Fellows of this College. No matter where you work, I beg you to remember that the character and future conduct of the students you teach, the younger men with whom you work, will be molded by your conduct and example even more than by your professional ability.

I should also like to talk to you about certain aspects of research, and to begin by reminding you that a good deal still remains to be done. Said Sir Thomas Browne, 300 years ago, "I am not only ashamed but heartily sorry that besides death there are diseases incurable." There still are, still a thousand gates that lead to death, and mankind cries out for light and still more light.

OF RESEARCHERS WITHOUT LABORATORIES

That light can be shed by men who do not have elaborate laboratory facilities at their command. When Mackenzie began the research that ultimately made him the greatest heart specialist of his time, it was because a young woman with a cardiac condition had died in childbirth. He had not expected her to die. Like Hippocrates, Jenner, Bright, Addison, the Hunters, Colles, and a host of others, he had no x-rays, no pathologic laboratories, and not much in the way of diagnostic facilities except what he created himself. He was, he said, "under the prevalent belief that medical research could only be undertaken in a laboratory, or, at least, in a hospital with all the appurtenances." So, when he began, he "merely sought to find out something about the nature of patients' complaints."

That same road is still open. Do not be like Browning's grammarian. Do not, as Wakeley said, take a small aspect of surgery and beat it until it is dead. It was Wakeley who also said that research does not consist in sending one's resident to the

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NEW ORLEANS SECTIONAL MEETING—Continued

NURSES' PROGRAM—Continued

Thursday, February 7—Continued

Immediate Postoperative Care, *Symposium*
 BETTA A. HINCKER, New Orleans, *Chairman*

Management of Patient during Postanesthesia Recovery.....JOHN B. PARMLEY, New Orleans
 Surgical Management of Patient in Immediate Postoperative Period.....ISAAC W. KAPLAN, New Orleans
 Nursing Care in the Immediate Postoperative Period.....THELMA LAIRD, New York

2:00-3:30 p.m., Jung Hotel

Problem Clinic on Recovery Rooms
 SISTER ADELAIDE, New Orleans, *Chairman*

Anesthesiologist.....JOHN ADRIANI, New Orleans
 Supervisor of Operating Room and Recovery Room.....AUDREY BELL, Dallas
 Director of Nursing Service.....THELMA LAIRD, New York
 Surgeon.....ALTON OCHSNER, New Orleans
 Consultant on Recovery Rooms.....EDNA A. PRICKETT, New York
 Hospital Administrator.....RAYMOND C. WILSON, New Orleans

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record room to study a series of cases or in arranging for a series of tests to be performed by somebody else.

Let me warn you of the pitfalls of statistics, about which a good many in the profession and out of it have gone overboard today. The statistician can be a very useful member of the team, but, as Hill says—and as an old horse player myself I could not agree with him more—he must not be permitted to play the role of a super bookmaker and to calculate the odds for and against some clinical event, the pros and cons of which he is largely ignorant.

We should, of course, control our research studies, but, if they are clinical studies, we should provide controls only when the patient would suffer no harm and lose no benefit thereby. We might have emerged from the war with a good deal more precise information about the indications and limitations of penicillin in military surgery if we could have administered it to some casualties and withheld it from others. Similarly, we might have emerged from the war with a more precise knowledge about the use of whole blood, of which we wasted a good deal by over-generous and even unnecessary transfusions. But such a course would have been unthinkable. In my own field of vascular surgery, we

might have learned more if we had set up special schemes of frankly experimental treatment, but that would have been unthinkable.

This leads, of course, to another aspect of research. Those of you who have read Ivy's penetrating discussion of what might be termed the Nazis' "infamous conduct in a professional respect" will remember that he pointed out that all of these crimes involved the search for answers to entirely worthy medical questions. The experiments became crimes only because they were conducted on human subjects without their consent and because, in many instances, these unfortunate men and women received less consideration than if they had been experimental animals. Honest results cannot arise from a dishonest situation. Consequences follow causes. Legitimate medical investigations continued while these unholy deeds were being done. The majority of German physicians remained ethical; their sin was that they did not speak out.

No president of the American College of Surgeons, or, indeed, the head of any other responsible medical organization, will have done his full duty today if he does not speak out soberly, advisedly, and with due consideration on another subject, the role and obligations of all physicians in a world at

peace. In the event of thermonuclear warfare and an attack upon the industrial cities of the country which make up the target areas, there will be a flood of casualties over this land such as no battle in the history of the world ever before produced. The surviving casualty load will far exceed the immediately available medical resources. The immediate problems, mechanical trauma and thermal burns, are surgical problems, but it will require the services not only of surviving surgeons—all of us who survive—but of others also to cope with the situation.

FELLOWS AND MILITARY SERVICE

The succession of thermonuclear blasts recently set off by the Soviet Union and announced by the President emphasizes again that the surgical profession has a heavy responsibility in planning, training and indoctrination against that day of disaster. Preparations may be puny but they may turn the scale for or against national survival or destruction. If any of us is to survive, it will be because in this time of specious peace, all of us have set our hands to the task while still there is time.

I think that we err greatly and are derelict in our duties, those of us who stand in the kind of office in which by your graciousness I find myself, if we do not, firmly and unequivocally, take the position that the young man who now goes into medical practice must face and accept the inescapable fact that before he is free to follow his own desires, there is every chance that he may be called upon to give his time and service to the armed forces of our country.

This is the situation: Every 18-year-old must register for military service. The prospective physician can request deferment while he finishes high school, while he completes his premedical work, while he is in medical school, while he serves his internship, and, perhaps, while he serves a year or more of residency. He will be granted these successive deferments without question if his performance warrants it. But, after he has been deferred for these nine years or more, there will come the inevitable day when he must enter some branch of service. I grant you that the situation is unfair and discriminatory. If the student desires to fulfill his military obligations when he is 18, and fulfills them then, it will profit him nothing when he has become a doctor of medicine. For all practical purposes he is in double jeopardy. He must still do service for two years as a medical officer.

Unfair? Yes. Wastage and inefficiency in the use of medical officers? Yes, there is undoubtedly some basis for this charge. The act of Congress by which

physicians must serve in the armed forces will expire in June 1957, but it will remain the obligation of the government to maintain a medical service with a balanced structure. The men in the service must be cared for in peacetime as well as in war. The surgeons general of the Army, the Navy and the Air Force are charged with these responsibilities. We of this College will be derelict in our own duties if we do not hold up their hands.

TO SERVE OUR COUNTRY IS OUR PRIVILEGE

How best can we fulfill the obligations of the College in this regard? In two ways. First, we must take the position, automatically and without cavil, that as a matter of course every medical student must look forward to two years of service in the armed forces. Second, we must take our stand firmly against the cynical notion that these two years are a waste of time, a backward step in one's medical career. It is never a waste of time to serve one's country. I should like to see every instructor in every medical school devoting some of his teaching effort to refuting this notion and to emphasizing the concept that if these years are a waste of time, it is a reflection on the individual medical officer and on those who failed to prepare him for his military obligations rather than a reflection on the services. Medical schools must take cognizance of the state of the world. This is a fundamental problem of indoctrination and orientation, and it is one to which I should like to see the College make a constructive contribution.

We made a serious mistake in World War II in that we failed to use the surgical lessons of World War I. It is sadly true that the lesson of history is that the lesson of history is never learned.

There is a great deal in the story of surgery in World War II that is applicable to peacetime practice. Furthermore, given the chance, medical students show a surprising interest in that story. I have myself devoted a good deal of time to recording my own surgical experiences in it and to hounding my confrères into reporting theirs. Some of these surgical histories are already available. You will find them interesting and profitable reading, whether or not you went to the wars, and, if you will permit me the "plug," the Government Printing Office will be glad to sell them to you at a remarkably reasonable price.

One of my most old-fashioned notions is that all is not well with medical education today, and that

by no means all of the trouble is on the professional side. In 1956 we are still where we were when, a number of years ago, LeBaron Briggs remarked that a bachelor of science degree does not imply a knowledge of science, it merely guarantees an ignorance of Latin—and, I fear, of a great deal else besides.

Today there is a great deal of emphasis on meeting the technical requirements for admission to a medical school and far too little on the student's ability to speak, read and write his mother tongue correctly. As for the classics, they are all but forgotten. Bagehot remarked that if a man did not know Latin and Greek, he should at least have a firm conviction that both of those languages once existed. Yet the classical languages, aside from the loveliness of their literature, teach lucidity of thought and expression, which is no small matter. As Lord Moynihan well put it, words may come after thought, but surely they do not come far after.

President Kirk, of Columbia University, has expressed his concern over the risk we are now running of losing the proper balance between breadth in education and the ever-increasing demands of professional specialization. A committee appointed to study this subject had commented on the modern tendency to emphasize factual data and to de-emphasize the intellectual disciplines in the pre-professional years, although the intellectual disciplines alone can enable the student to continue his education and enlarge his knowledge in the rapidly expanding medical field. The endeavor to teach a man all the known facts will certainly fail. If, however, he is trained to develop his intellectual capacities and to use them in a disciplined manner, he will be given abilities which he can utilize all his life to acquire knowledge and search for truth in his own

way. Professional schools, says President Kirk, are increasingly alarmed over the inadequate preparation of the students they are now receiving, even from the better colleges. These candidates know little history, they are unable to use the English language with the precision and accuracy which could once have been taken for granted, and, withal, they have had faulty and inadequate instruction in the basic sciences for which, presumably, they have sacrificed these other things.

Let me close this rambling talk with a few words on what the late Dr. C. Jeff Miller said in his inaugural address as president of this College the year in which I became a Fellow. The medical profession, he feared, was in danger of forgetting what he called the humanities of medicine, and so he talked about them, reminding us of something Stephen Paget had once written, "to be wanted by men and women, to come natural to them in time of trouble . . . may fairly be called a career." Later that week, Dr. Miller ended his Convocation address, which dealt with the doctors of fiction, with a re-telling of Ian MacLaren's lovely story of William MacLure, the family doctor who, when he came in the door, could put fresh courage into sinking hearts, who served the people of the Glen for more than 40 years "with a devotion that knew no reserve, with a kindness that never faltered."

This was a humble village doctor who never forgot the humanities of medicine. I find it rather touching that the distinguished biographer of my mentor Harvey Cushing, John Fulton, himself an eminent man of science, wrote of this pioneer of neurosurgery:

"By valor and divine aid [Cushing] had more than fulfilled the promise and ambition of his youth: scientist, pathfinder, artist, writer, and bibliophile—yes, but above all, 'a good doctor.'"

A good doctor—could any of us ask to be more?