

Our Destiny Is to Build

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The President: *One year ago I expressed my pride and pleasure in becoming president elect; and now I accept the presidency and will cherish this honor, not only in a personal way, but as an expression of the mutual respect and friendship which binds surgeons of many countries together in this great organization. The Fellows are generous in permitting a Canadian surgeon to be their presiding officer in 1967, Canada's centennial year.*

One of the most pleasant duties entrusted to the incoming president is the opportunity to speak to the incoming Fellows. May I, first of all, assure you who have just been received into Fellowship that we are assembled at the Convocation to pay you honor and to welcome you to the fellowship and friendship of a wonderful institution. But do not be too complacent about graduation. As Da Costa once said, "Each one of us, however old, is still an undergraduate in the school of experience. When a man thinks he has graduated, he becomes a public nuisance."

But I am not going to give you advice, as I am mindful of the admonition of the late Bob Edwards, editor of the Calgary Eye Opener, who said, "When people grow too old to set a bad example, they feel obliged to give good advice."

IN ANCIENT GREECE, at a time when education was available only to the very rich, a beloved and wise old teacher was visited by a number of noblemen. In view of the fact that their sons had finished their studies and it was time for them to go home, the fathers were anxious to honor them with a great feast, and on this occasion wanted the sons to be dressed in their finest garments.

The old teacher agreed that the sons would attend, appropriately dressed. The day of the feast arrived and the noblemen were dressed in their finery and jewels. The arrival of the beloved teacher and his students brought cries of dismay; the young men were dressed, not in their rich robes, but in simple sackcloth gowns, each carrying a mortarboard—a symbol of the common working man. The teacher held up his hands for silence, saying:

"Your sons are dressed in the clothing of the worker because their destiny is to build. Some will build cities, some will build better lives for their fellow man. All will be builders on the solid foundation of knowledge."

BETTER LIVES

This legend has made the mortarboard and gown a traditional part of graduation, symbolizing the fact that young men and women at this time of life are builders of their own future. In their case, the incoming Fellows will build better lives for their fellow men.

As they become part of the College may I remind them that the most important objective of this organization since its inception has been the "improvement of the care of the surgical patient." From this time forward they join this continuing endeavor. Upon the solid foundation of the knowledge available to us today and the new knowledge

which will be available to us tomorrow, our destiny is to build continual improvement in the care of the surgical patient.

In carrying out this task we must prepare three blueprints. The first is the provision of suitable manpower for our project. The second is concerned with what our workers must know. The third considers how our workmen are to be trained.

BY BETTER WORKMEN

Our first consideration, which concerns any builder, is manpower. It is essential that we do our part to attract the best of workmen. We must take part in the active recruitment of the best young men and women in medical schools to the discipline of surgery. Every surgeon's office, laboratory, clinic and operating room should be a recruiting center. You must convince these keen young people that every sacrifice you have made and every long hour of hard work have been worthwhile, when balanced with the satisfaction you have received from your work. They must be told that Longfellow's definition of success—"doing what you do well, and doing well whatever you do"—has a particular application in the field of surgery.

What type of people are we looking for? Apart from academic ability there are certain basic qualities of mind and body essential to the discipline of surgery.

A surgeon must have humanity, understanding, and love of people. These attributes must be balanced with toughness of fiber, inner composure and physical endurance. We must remember that, in the practice of medicine, "stability is but balance." At all times we are engaged in the masterful administration of the unforeseen. Osler's descrip-

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tion of the ideal doctor as having "coolness and presence of mind under all circumstances as will enable him to meet the exigencies of practice with firmness and courage, without, at the same time, hardening the human heart by which we live," is most applicable to the 'complete' surgeon.

Personal and professional integrity is a man-

At the 1966 Congress:

WALTER C. MACKENZIE, Edmonton, was inaugurated the 47th president of the American College of Surgeons on October 13, 1966, succeeding Howard A. Patterson. Fifth in a distinguished line of Canadians to head the College, Dr. MacKenzie's address directed especially to the incoming Fellows* assembled at the Convocation begins on foregoing page.

At the Convocation in San Francisco also, John C. Jones, Los Angeles, and Truman G. Blocker, Jr., Galveston, were inaugurated first and second vice presidents, respectively.

At the Fellows' annual meeting, Reed M. Nesbit, Ann Arbor, was named president elect; Joel W. Baker, Seattle, first vice president elect; and Eugene M. Bricker, St. Louis, second vice president elect. They will take office at the October 1967 Convocation in Chicago.

The 68 Fellows elected by the Fellows to a three-year term on the Board of Governors are named on page 55.

Fraser N. Gurd, Montreal, George R. Dunlop, Worcester, Massachusetts, and William F. Meacham, Nashville, were elected (page 53) to the Board of Regents.

Regents re-elected were Paul C. Samson, Oakland; Harold G. Scheie, Philadelphia; and Claude E. Welch, Boston.

John M. Beal, Chicago, was appointed chairman of the Committee on Motion Pictures (page 43), succeeding Hilger Perry Jenkins.

The 52nd Congress was a record breaker. Of the total registration of 15,876, doctors numbered 9,884. They included 5,002 Fellows; 833 Initiates (of a total of 1,356); 733 Candidates; 997 residents; and 2,319 other doctors of medicine. There were 4,118 doctors' wives; 1,275 industrial exhibitors; 55 members of the press; 142 staffers; and 402 others.

*Included in the 1967 *Supplement to the 1965 Directory* distributed (page 4) in December.

datory qualification. A surgeon must have this to resist participation in unethical practices. Fee-splitting and other forms of under-the-table compensation, ghost surgery and similar practices are absolutely contrary to the objectives and ideals of our College. As that wise old physician of Norwich, Sir Thomas Browne, said: "No one should approach the temple of science with the soul of a money changer."

We have to prepare blueprints of what our workman is to learn. The first part of the plan for his learning experience must be the development of a scientific way of thought along with the capable and dexterous practice of his surgical craft. Note I say "a scientific way of thought." Too many think of science as the application of what is called "the scientific method." But science is much more than that. It is concerned with much more than facts. Science is an adventure in the search for law, order, understanding and meaning in the infinite variety of nature.

A distinguished past president of this College, I. S. Ravdin, points out that in the 1900's surgical interests centered on the abnormalities of function resulting from a wide variety of surgical lesions. In the 1960's surgical interest is still concerned with abnormalities of function, but also with the contribution of the basic sciences to a more complete and fundamental understanding of disease processes in general, with particular emphasis on disease of surgical interest. Distinguished pioneers in our surgical craft realized that the young surgeon taught in an atmosphere of scientific inquiry derived tremendous educational and technical benefits from such an experience.

QUESTION AUTHORITIES' TEACHINGS

Our young men and women of tomorrow, in the spirit of Harvey, Hunter and Lister, must always be prepared to question the teachings of those in authority unless satisfied that the facts and evidence support them.

The rapid and ever increasing body of scientific medical knowledge has led to specialization, but we must make a plea for broad vision and a wide range of knowledge for those who practice, teach, and prosecute research in surgery. Specialism is inevitable. It is necessary. But disease is no specialist, and we must continue to counteract, in every way in our power, the limitations imposed by specialism upon the general corpus of medicine.

As Prince Philip, Duke of Edinburgh, puts it: "The educated man can be a specialist or need not be a specialist, but the important thing is that his specialization, whatever it may be, should in no

way prevent him from being, behaving and thinking as an educated man."

Surgeons must be well grounded and competent to apply general surgical principles in the restricted field of their discipline. Our surgical teachers must stress understanding built upon the sound foundation of knowledge in sciences basic to surgery and the application of these sciences to clinical problems.

Judgment comes with experience. Judgment and experience based on sound knowledge is conducive to the production of that rarest of human attributes—wisdom. Our ideal is to produce competent and wise surgeons.

Some of our surgical workers will study in depth one or more of the basic sciences and will aspire to a career in an academic setting. We urgently need an increase in the number of these clinical scientists who plan to pursue a career in teaching and research.

Others will not carry out research in exotic areas or study in depth esoteric fields, but rather will be trained in the basic sciences and surgical skills to such a degree that they are competent to offer high quality total surgical care. These workers will be the consultants in either the general or the restricted fields of surgical practice.

Lord Lister chose as the subject of his address to the British Association at Liverpool in 1896 "The

Presidents Elect and Incumbent



Read M. Nesbit (left), president elect, receives congratulations from President Walter G. MacKenzie at 1966 Convocation.

Interdependence of Science and the Healing Art." Sir Charles Illingworth in his Lister Oration before the Royal College of Surgeons of England, in 1964, took the same title, and he had this to say about it:

"The interdependence of science and the healing art epitomizes Lister's own achievement and must be the pattern for all future progress."

We would add considerably to our own blueprint of what we should teach if we included, "Our destiny is to build on the interdependence of science and the healing art."

The last blueprint we must consider is how we are going to train our workmen. At this time we are facing one of the most fundamental changes in the education of surgeons since the introduction of bedside hospital teaching. We have always had in teaching hospitals a supply of indigent patients to provide an adequate patient pool for undergraduate and graduate teaching programs in surgery. These patients receive and accept the excellent surgical care these educational programs provide.

The health and welfare legislation now being considered on this continent of North America will result in radical changes in the status of those receiving health care and services. All indigent citizens and many with low taxable incomes will possess medical insurance.

There is universal agreement that any program of surgical training must be characterized by increasing responsibility for the trainee as he progresses, culminating eventually in the acceptance of independent and individual responsibility for his patient. A surgeon, to be fully trained, must be given the opportunity to perform surgical operations. It is obvious, then, that this new legislation must take into account our training obligations.

ESTABLISH CLINICAL TEACHING UNITS

We must establish clinical teaching units. Such a unit is defined as "a clinical teaching unit, division, or service, which may be an entire hospital or a designated hospital area, is one providing undergraduate and graduate medical education, not limited to the intern year, under the auspices of a faculty of medicine. The medical staff of a teaching unit is to be jointly appointed by the university and the hospital. The medical care of the patient by a teaching unit is the function of the team of staff physicians, resident, intern, and clinical clerk, based on the principle of graded responsibility commensurate with competence and level of training. A strong program of medical research must be

developed in the teaching unit to reinforce the scientific background of the educational programs."

These units will take care of both ambulatory and bed patients in ward, semiprivate and private accommodations. Their physical facilities must be acceptable and the services excellent. The patient load will be related to the educational and training program requirements and will be restricted. Too large a patient load would impair the quality of the teaching program. Ideally, the number of patients seen in the ambulatory patient department and in wards should provide the optimal balance between the service load and educational responsibilities of the teaching staff.

The most important factor in attracting patients to this type of clinical teaching unit will be the exemplary care provided, *one high-standard care based on the quality of team performance, not on the type of hospital accommodation.* The level of care must be equal to or better than that available to the same patient elsewhere. Insured or private patients must not be discouraged from attending clinical teaching units because of poor accommodation, poor liaison with their personal physician, by misconceptions and prejudices about being used for teaching purposes, or by fear of being subjected to experimental studies or research. Most important of all, we must impress upon the patient

that the resident staff responsible for his care have had superlative training and broad experience.

We also must accept the principle of team care. The patient must be assured that each member of the team carries out that part of the care for which his training and experience make him most competent. It must also be emphasized that the supervision of the activities of the team is close, constant, and effective. In the management of patients, many of whom will be privileged to have their doctor of choice, it will be the attending surgeon who has the final surgical responsibility. He may, in some instances, be the operating surgeon, or he may have a definable role of direction in team care, including the operative procedure. Our educational programs must be adaptable enough to satisfy the requirements of the patient who, while realizing his private status, is happy to receive treatment under the staff man's direction, through his team of resident, intern and other assigned personnel.

It is our destiny to build this concept of surgical training into a reality, and to show both the profession and public that this method will not only produce superior surgical care now, but will at the same time replenish and augment the ranks of the surgical profession in the future.

In fulfilling our destiny we must remember Osler's words: "Much has been done, much remains to do, a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

Shock is on the mind of Lloyd D. MacLean, Montreal (left), moderator of the session on that topic at the 1966 Forum on Fundamental Surgical Problems. Listeners are (l-r) Robert C. Lim, Jr., San Francisco, who presented report on massive pulmonary microembolism in regional shock; Walter E. Zimmerman, Freiburg; and Ulrich P. Gruber, Davos, Switzerland.

