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A profession held in trust

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This is the Presidential Address delivered by Dr. Baker after his inauguration as fiftieth president of the American College of Surgeons during Convocation ceremonies in San Francisco on October 9, 1969.

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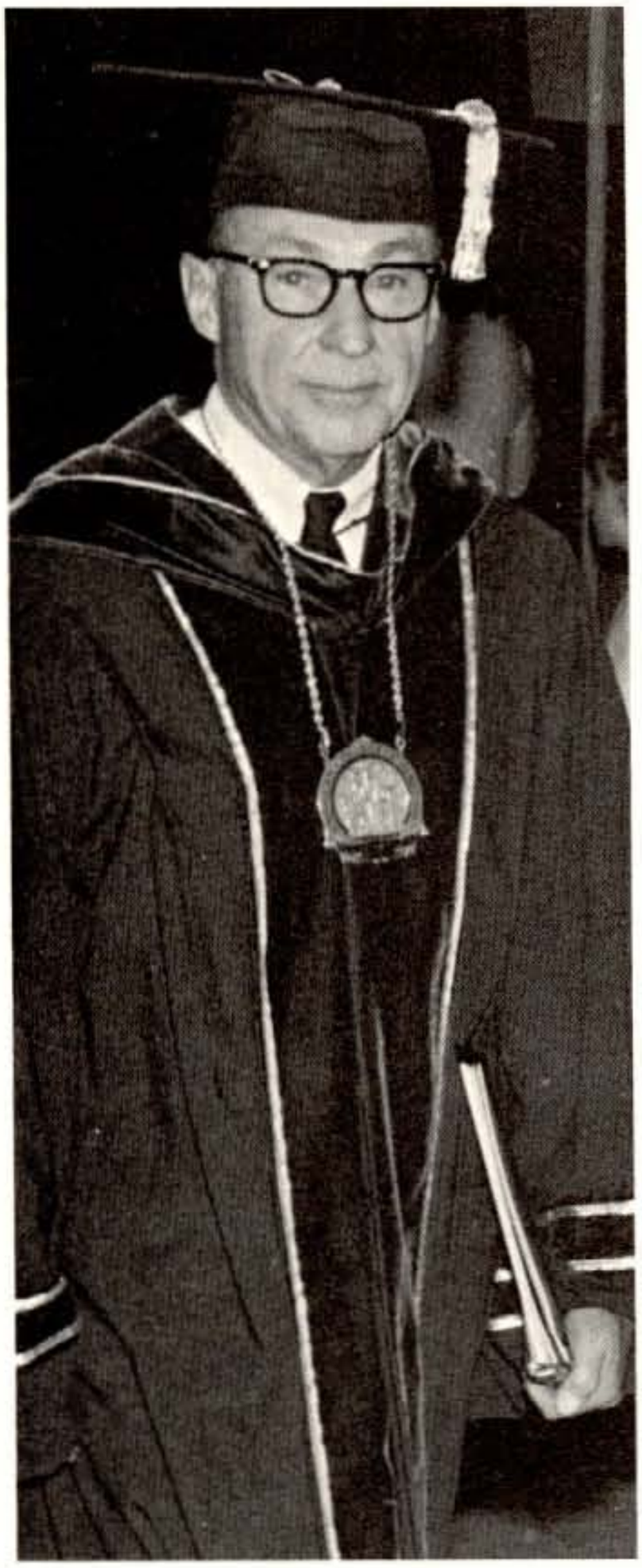

PRESIDENT BAKER

TO HAVE BEEN PRESENTED by a valued friend and distinguished surgeon, Francis McKeever, and to receive from the hands of another esteemed friend, Preston Wade, the medallion of office—and to have his immediate example as a guide in that office—are privileges for which I am grateful.

I trust our guests will understand when I address my thoughts in the main to you who are new members. You, and I, this evening each have pledged support to a common purpose, simply stated by the founders of this College to be the improved care of the surgical patient. We on this podium salute you as Fellows. We share this moment with your families and friends here present to honor you —we congratulate you on the years of endeavor, discipline and dedication by which you have conformed to the high standards for which this College has labored and for which it now recognizes you. Certainly you, your wives and families have every right to the pride which is yours tonight.

By your attainment you are recognized as a trustee of our profession—a trust to which I have chosen to address my remarks this evening. The profession we hold in trust has a heritage which includes a fine image built by our forefathers upon selfless service to patients, the scientific care of disease to the best of available knowledge, and the interested concern for the whole patient and his family—rich and poor alike. To maintain untarnished this ideal is not easy in today's world.

As Initiates you have reached, I am informed, an average age of 37-years. This thought gives one pause—to take inventory now, not later, of one's goals, and in the demanding tempo of our time to assign priorities. You have 25 or more years of surgical trusteeship in which to enjoy and contribute to these privileges before tendering them, hopefully undepreciated, to your successors—to men and women, incidentally, whom you must train.

Thirty-four years ago I sat where you now sit, coincidentally in this same beautiful city. At that time I felt fortunate, indeed as I do now, for the privilege of being a surgeon. In the years since, however, the responsibility of such privilege possibly weighs more consciously than it did then. In our professional

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stewardship, we share a common problem today with both concerned youth and puzzled elders. We all seek means to accommodate a sense of personal futility with tangible accomplishment, an approach by which we can in conscience weather these troubled times and hopefully improve them.

The frustrating confrontations which we as citizens must share with our elected government are constantly in the headlines, one following upon another. Now, achievements in space already promise interplanetary problems, even while on earth international relations and socio-economic problems remain as hazardous as the split atom on the one hand and the world's unequally split advantages for its people on the other. These disturbances of our time weigh heavily on all—on the old as well as the young, on the affluent as well as the poor.

We cannot be good doctors if we are not concerned citizens. But, as physicians our background qualifies us to help most in problems pertaining to health—and these indeed are urgent and must be our first, although not our only concern. It is to these professional matters I would direct our thoughts—to the problems of our trusteeship.

Problems of our trusteeship

Medical science has not lagged in either achievement or in the often unusual consequences of that achievement. It has evolved, peak by peak, with advances too numerous to catalog—advances which in molecular biology threaten even to create life itself. And certainly our surgical advances are impressive—witness, for example, the transplantation of one organ followed rapidly by another. Although such transplantations are yet limited by both tissue rejection and donor availability, they open a new horizon, even as they introduce new moral, spiritual and ethical problems. It is unfortunate that at times medical explorations as well as triumphs arrive prematurely in the lay press, to the confusion if not the disenchantment of the public. The need for protective guidelines and some professional discipline is evident. Equally obvious, I believe, is the precaution that these regulatory measures must be established by professional peers, rather than by government legislation, if both high principle and continued progress are to be insured.

Of still greater moment, may I direct your attention to what I believe is our consuming problem. It is likewise a consequence of vast scientific achievement, and one in which government has taken a high priority interest. I refer to the critical concern for the widening gap between the veritable explosion of medical knowledge on the one hand and its fruitful application at the bedside on the other. This picture is charged with still greater opportunity—and challenge—by the humanitarian concept, adopted by government, that every citizen is by right entitled to this most advanced medical care. In our expanding and shifting population this ideal presents lay as well as professional problems.

Thus at a time when each of us already is concerned with his personal inadequacy to stay abreast of scientific developments even in his own specialty, our profession is confronted with a critical shortage in the number of physicians as well.

In the correction of this rapidly acquired discrepancy between the supply and demand for physicians, the consumer public and its government have a right, and an obligation, to play a helpful and implementing role. However, throughout this search for solutions to the shortage, the protection of standards in patient care on the one hand as well as the discipline of our members against taking financial advantage of the shortage on the other is a responsibility that rests on our shoulders—is a part of our stewardship. In this latter regard the image of the many may be tarnished by the brush of a few. We cannot, and I am glad to see organized medicine has not, defaulted in these matters. As Dr. Dunphy succinctly reminded us in his presidential address a few years ago, in a democracy authority stems from the proper discharge of responsibility. Should we neglect responsibility in these matters, and should we not answer society's demands boldly with imagination

uninhibited by tradition, we will lose our influence to shape their correction—and parties less qualified, and I believe less dedicated in their motivation, will inherit the job.

These, our humanitarian tasks, acquire a sense of urgency in the present world—a world recently described so aptly by Rabbi Fellner in an invocation before graduating students at the University of Alaska. After referring to their years of study he said: "But years of learning are not enough. For alas we can reach the stars—but we still cannot reach each other; we have learned to transplant the hearts of men—but we still remain heartless; we have learned to compute, to measure with incredible precision—but we have not learned to make our days and hours count. The accumulated knowledge of the past brings only a measure of understanding to the difficult problems of the present, while the projected knowledge of the future can only cast a blinding glare upon our present inadequacies."

An organizational approach

It is easy to define the problems—but difficult to offer an approach toward resolving them. May I suggest that to exert an influence in these vital professional matters, we, as concerned individuals, will accomplish most through collective action by established responsible organizations. Tonight you have become a Fellow of an organization dedicated 56 years ago to the patient's welfare. Because through the years the decisions of the American College of Surgeons have been predicated on this basic and unselfish principle, its image with the public and the press is good. This influence will continue to depend, in the long term, not only upon what we do and for what we stand, but also the manner in which our actions are interpreted by the total community. We must again and again reinforce diligent work with public explanation of our goals. Each of us can best fulfill professional citizenship, I am convinced, by active and interested support of our College, and similar dedicated societies.

A successful attack on the professional manpower shortage will require united action and co-operative planning between the universities, the American Association of Medical Colleges, the American Medical Association and specialty organizations, and government. For we realize that the problem is not only a lack in the number of physicians, but equally their continuing education, and the more efficient use of their time by the training, certification and appropriate use of technicians and other ancillary personnel. Short of this goal, it is evident that the right of all citizens to benefit to the full from present knowledge and technology cannot be realized.

The university

As a trustee of our profession we can ill afford to neglect the university. We as a group have enjoyed more formal education than most. I suspect each of us has counted his blessings in this regard. We have had the encouragement of family, and the stimulation of teachers along the way. In our university years we may not have appreciated the fact that our education required monetary subsidy well beyond the tuition we paid. The responsibilities twin to these privileges hardly require mention. Our alma maters have continuing troubles, both financial and in direction. We should not stand by idly on either count. In our productive years we have the opportunity to repay in part our debt of gratitude—to create a real impact, if such support were broadly practiced and sustained.

We can use our influence to cement town and gown, whichever we imagine we represent, into a unified front for the betterment of patient care and greater influence in matters pertaining to health. Our Fellowship represents equally both segments, and it is time for each to realize that learning does not stop with graduation, nor does patient care begin there. At the present rate of scientific discovery, the potential for improved clinical results can best be realized when the pathways to research and to clinical competence are merged, when those in each career travel in company. A better understanding on each side to bridge this traditional gulf is now in order. Postgraduate and continuing education require it. Regional Medical Programs assist it. The widening gap between medical knowledge and its clinical application can be reversed in no other way. Hopefully neither town nor gown will any longer "go it alone." Actually the loss of the indigent patient need not impair either

teaching or a responsible role in surgery for the trainee, but rather it may reinforce the responsibility of teaching by example and by closer supervision, and the example of integrity by the teacher and trainee on behalf of the patient.

The Flexner report in 1910 gave needed impetus to the expansion of medical science and technology. The greater need now is to make wider use of this knowledge. The rigid standards, so needed then, have inadvertently served in later years to stilt curricula and to delay flexibility which might yield a greater supply of physicians more appropriately trained, and possibly in shorter time. Emphasis now must be on better methods of delivering health care, less on diverting uninterested students into research; a priority on educating a greater number of physicians; hopefully also the training of physicians from minority groups; and, the better use of all physicians through ancillary assistance. There must, I believe, be closer interties of community physicians and community hospitals with the university for the purpose of postgraduate and continuing education, and above all for the improved care of all people. Such is the responsibility entrusted to our medical profession.

As an individual

While we must act through organized channels to be more effective, in turn such organizations are only as strong as their constituent members. As an individual, one can be neither a good citizen nor a support to his professional society without being first a good doctor—a responsible trustee of the physician-patient relationship. In this, two ingredients are involved: one related to conscience and ethical conduct, the other to continued self-education.

Love of learning is sustained by motivation. It cannot be legislated. The President's Health Manpower Commission, in the public interest, has recommended exploration of compulsory re-examination for relicensure of physicians. But the increasingly diversified pursuit of special skills and knowledge I believe make impractical the formulation of examinations that would be meaningful. Further, as Plato observed, "knowledge acquired under compulsion has no hold on the mind." Our conscience, and the patient's trust in us, are our reminders. The present vast store of knowledge is the exciting advantage we hold over our predecessors.

Granted the desire for self-improvement, what is the way? Donald Williams, in an excellent treatise on continuing education, says it can be accomplished best in four ways: by the scholarly habit of planned daily reading and study in the sanctuary of a home library; likewise, by the day-to-day colleague and peer association in patient care in the community and teaching hospital, in group practice, and by consultation; by the periodic return every three to five years for several months of more intensive study in the teaching hospital; and by the attendance at scientific sessions of learned professional societies.[1]

Probably the most important of these, and in the press of the day the easiest to neglect, is the budgeted daily use of a carefully selected library or other improving media of learning. Forming the habit of planning the time, either an hour a day, or half a day a week, is the first essential. It should be planned as carefully as our recreation. Certainly both are important. Dr. Zollinger, in his presidential address, suggested tithing our time for improving our education, our hospital and our College. One-tenth of our time wisely and faithfully spent in reading will scarcely neutralize the rate of obsolescence of previous teaching.

With a new medical article being published every 26 seconds, George Miller has aptly said: "The problem will never be solved by speed reading courses. What we really need are courses to teach people to write things that are worth reading slowly."[2] Short of this, the building of one's library will require discrimination. A practical suggestion in using library reference time is the observation that reading which pertains to the patient at hand is probably the most rewarding and best retained.

The other methods of continued learning require no comment, except to call to your attention that this College provides through its Clinical Congress one of the best of learning experiences, and this is augmented by sectional and chapter meetings, available audio-visual recordings for circulation, and the publication of *Surgery, Gynecology and Obstetrics*. Approximately 15,000 Fellows per year attend either

the Clinical Congress or Sectional Meetings. Such attendance would seem to make unnecessary the compulsory rules of minimal attendance exercised in some associations. However, today the quality of continued learning has become of public moment. What a physician does or does not do is increasingly in the white light of peer and public scrutiny.[3]

Beyond scholarliness we have yet another relationship with the patient: one of conscience and ethical conduct, and a concern for the patient as well as his disease. For the specialist, this implies a proper relationship with the family physician, a concern for the patient's adjustment to his family and to his occupation, and caution that we not thoughtlessly add unfairly to his financial burden. My chief, Dr. Tate Mason, was a busy surgeon, but he exemplified these qualities. He was accustomed to sitting while visiting in a patient's hospital room. While he stayed no longer than most, the patient derived more of a sense of unhurried mission accomplished. Dr. Mason's first year of practice in 1905 was in a small coal-mining community before medical insurance was available. He told me of watching the miner save his pennies through the year so that his wife might have special medical attention in the city. He worried lest the staff of the clinic he later built should neglect or overcharge these disadvantaged and trusting people. Sir Hedley Atkins quotes a teacher as saying, "There are only two things that a patient knows with certainty about his doctor: whether he is kind, and whether he has made a careful examination." Dr. Wade last year advised us that "science alone is not enough."

As to surgical conscience and ethical conduct, the pledge you have recited tonight leaves no room for confusion. I have sometimes wondered if our public relations would not benefit, and our self-discipline be reinforced, if this pledge, rather than our Fellowship certificate, were displayed in our offices.

Fellows of the College, I have reviewed some of the facets of a profession we hold in trust. And, I should confess, the few specific suggestions that have been made, in the main, are culled from 40 years, chiefly by neglect of these very items. You have yet the privilege of election—rather than the retrospective view of regret. If you care, and if you plan, you need not neglect your family, your profession nor your community.

Lest we think our times the most troubled and our difficulties greater than other generations have faced, I would close on a philosophical note with a poem which may place in perspective the problems of today, yesterday and tomorrow. It is by Edna Groh, and entitled *Good Timber:*

The tree that never had to fight
For sun and sky and air and light,
That stood out in the open plain
And always got its share of rain . . .
Never became a forest king,
But lived and died a scrubby thing.

The man who never had to toil,
Who never had to win his share
Of sun and sky and light and air . . .
Never became a manly man,
But lived and died as he began.

Good timber does not grow in ease:
The stronger wind, the stronger trees,
The farther sky, the greater length:
The more the storm, the more the strength:
By sun and cold, by rain and snows,
In tree or man, good timber grows.

Where thickest stands the forest growth
We find the patriarchs of both . . .
And they hold converse with the stars
Whose broken branches show the scars
Of many winds and much of strife . . .
This is the common law of life.

And so, as we of today stand upon the shoulders of the architects of medical history, we inherit a preferred vantage point and an enabling strength with which to fulfill our stewardship in a world replete with challenge—but also with opportunity. I thank you.

References

1. Williams, Donald H., A Taxonomy of Continuing Medical Education Endeavour. Canad. Med. Ass. J. (1967) 96: 1040-44.
2. Miller, George E., Continuing Education for What? J. Med. Educ. (1967) 42: 320-26.
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