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Address

THE ETHICS OF SURGERY.*

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The evolution of surgery during the past century has kept pace with the development of science along other lines, wonderful as this has been, and we have reason for just pride in the contributions made by the surgeons of our own land during this period. If, however, none other had been made than the discovery of the use of ether in producing anesthesia, America would still be entitled to the highest mark of honor. No other discovery yet made in surgery has been so great a boon to suffering humanity. Every young physician should avail himself of the opportunity, when in Boston, to visit the Massachusetts General Hospital and ask to be conducted to the little amphitheater at the top of the old building where the first operation was performed under ether administered by Morton. This room has been left practically unchanged, and there may be seen the original apparatus used in its administration. To me this seems a sacred place.

The advent of antiseptic and aseptic measures marked an era but little less important than that of the introduction of anesthesia. Those of us who began our professional studies a quarter of a century ago, look back on some interesting events. How little, indeed, does the graduate of to-day know of the uncertain and often direful results of the surgery of preantiseptic days. The result of a given operation was unknown and unknowable. Whether to expect healing with the formation of so-called laudable pus, or whether erysipelas, pyemia or gangrene would follow, could not be determined. All this is changed, and these terrible wound complications of former days are merely facts of historic interest. History bears out the oft repeated statement that there has been more progress in surgery in the twenty-five years following the advent of antiseptics than was made in the preceding twenty-five centuries.

With the establishment of a perfected aseptic technic, it seemed that the acme of surgical effort had been reached; and yet in the light of the discoveries coming to us daily, we can prophesy greater achievements for the future than are yet dreamed of. The border-line cases of yesterday become settled surgical problems to-day; and the border-line cases of to-day will, many of them, by modern aggressive methods, be settled in the same manner to-morrow. It would, indeed, be rash to attempt to place a limit to the future of surgery.

We have reason to be thankful that it was our fortune to come on the stage of activity in this age of wonderful progress. Our opportunities have been great,

but we should not be unmindful of the magnitude of our heritage. Individually, most of us can hope to do but little toward paying this great debt; collectively, as organized surgical associations like this, it seems to me we may do much by helping to mold the surgeon of the future. We can lend our aid toward the elevation of the standard of the surgeon's qualifications.

The ambitious medical student does not usually get far into his college work before he aspires to become a surgeon. He sees in the surgical clinics more definite and striking results than are discernible in other branches. Without being able to judge of his own relative fitness or whether he possesses the special aptitude so essential to success, he decides to become a surgeon. There will always be room for the young surgeon, who, fitted by nature for the work, takes the time and opportunity to properly prepare himself. There is more good surgery being done to-day than ever before, and there are more good surgeons being educated to do the work. If, however, the surgeon of the future is to hold the high and honorable position our leaders have held in the past, there must be some standard of qualification established that shall protect the people against incompetency and dishonesty in surgeons.

That there is much that passes under the name of surgery being done by ill trained, incompetent men, will not be denied. What standard, then, should be established, and what requirement should be made before one should be permitted to do surgery? In his address as chairman of the Section on Surgery and Anatomy of the American Medical Association at the Portland (1905) meeting, Dr. Maurice H. Richardson deals with this subject in such a forceful, clear-cut way, that I take the liberty to quote him¹ at some length:

The burden of the following remarks is that those only should practice surgery who by education in the laboratory, in the dissecting room, by the bedside, and at the operating table, are qualified, first, to make reasonably correct deductions from subjective and objective signs; secondly, to give sound advice for or against operations; thirdly, to perform operations skilfully and quickly, and, fourthly, to conduct wisely the after-treatment.

The task before me is a serious criticism of what is going on in every community. I do not single out any community or any man. There is in my mind no doubt whatever that surgery is being practiced by those who are incompetent to practice it—by those whose education is imperfect, who lack natural aptitude, whose environment is such that they never can gain that personal experience which alone will really fit them for what surgery means to-day. They are unable to make correct deductions from histories; to predict probable events; to perform operations skilfully, or to manage after-treatment.

All surgeons are liable to error, not only in diagnosis, but in the performance of operations based on the diagnosis. Such errors must always be expected and included in the contingencies of the practice of medicine and surgery. Doubtless many of my hearers can recall cases of their own in which

* President's Address, delivered before the Western Surgical and Gynecological Association, St. Louis, Dec. 30, 1907.

1. THE JOURNAL A. M. A., Oct. 7, 1905.

useless—or worse than useless—operations have been performed. If, however, serious operations are in the hands of men of large experience, such errors will be reduced to a minimum.

Many physicians send patients for diagnosis and opinion as to the advisability of operation without telling the consultant that they themselves are to perform the operation. The diagnosis is made and the operation perhaps recommended, when it appears that the operation is to be in incompetent hands. His advice should be conditional that it be carried out only by the competent. Many operations, like the removal of the vermiform appendix in the period of health, the removal of fibroids which are not seriously offending, the removal of gallstones that are not causing symptoms, are operations of choice rather than of necessity; they are operations which should never be advised unless they are to be performed by men of the greatest skill. Furthermore, many emergency operations, such as the removal of an inflamed appendix and other operations for lesions which are not necessarily fatal—should be forbidden and the patient left to the chances of spontaneous recovery, if the operation proposed is to be performed by an incompetent.

And is not the surgeon, appreciating his own unfitness in spite of years of devotion, in the position to condemn those who lightly take up such burdens without preparation and too often without conscience?

In view of these facts, who should perform surgery? How shall the surgeon be best fitted for these grave duties? As a matter of right and wrong, who shall, in the opinion of the medical profession, advise and perform these responsible acts and who shall not? Surgical operations should be performed only by those who are educated for that special purpose.

I have no hesitation in saying that the proper fitting of a man for surgical practice requires a much longer experience as a student and assistant than the most exacting schools demand. A man should serve four, five or six years as assistant to an active surgeon. During this period of preparation, as it were, as much time as possible should be given to observing the work of the masters of surgery throughout the world.

While Dr. Richardson's ideal may seem almost utopian, there being so wide a difference between the standard he would erect and the one generally established, we must all agree that however impossible of attainment under present conditions, such an ideal is none too high and its future realization not too much to hope for.

While there is being done enough poor surgery that is honest and well intended, there is much being done that is useless, conscienceless and done for purely commercial ends. This is truly a disagreeable and painful topic and one that I would gladly pass by, did I not feel that its importance demands some word of condemnation coming through such representative surgical organizations as this.

The spirit of graft that has pervaded our ranks, especially here in the West, is doing much to lower the standard and undermine the morals and ethics of the profession. When fee-splitting and the paying of commissions for surgical work began to be heard of something like a decade ago, it seemed so palpably dishonest and wrong that it was believed that it would soon die out or be at least confined to the few in whom the inherited commercial instinct was so strong that they could not get away from it. But it did not die; on the other hand, it has grown and flourished.

In looking for an explanation for the existence of this evil, I think several factors must be taken into account, among them being certain changes in our social and economic conditions. This is an age of commercialism. We are known to the world as a nation of "dollar chasers," where nearly everything that should contribute to right living is sacrificed to the Moloch of

money. The mad rush for wealth which has characterized the business world, has, in a way, induced some medical men, whether rightfully or wrongfully, to adopt the same measures in self-protection. The patient or his friends too often insist on measuring the value of our services with a commercial yard-stick, the fee to be paid being the chief consideration. In this way the public must come in for its share of responsibility for existing conditions. So long as there are people who care so little who operates on them, just so long will there be cheap surgeons, cheap in every respect, to supply the demand. The demand for better physicians and surgeons must come in part from those who employ their services.

Another source of the graft evil is the existence of low grade, irregular and stock-company medical schools. In many of these schools the entrance requirements are not in evidence outside of their catalogues. With no standard of character or ethics, these schools turn out men who have gotten the little learning they possess in the very atmosphere of graft. The existence of these schools seems less excusable when we consider that our leading medical colleges rank with the best in the world and are ample for the needs of all who should enter the profession. Their constant aim is to still further elevate the standard and to admit as students, only those who give unmistakable evidence of being morally and intellectually fit to become members of the profession.

Enough men of character, however, are entering the field through these better schools to insure the upholding of those lofty ideals that have characterized the profession in the past and which are essential to our continued progress. I think, therefore, we may take a hopeful view of the future. The demand for better prepared physicians will eventually close many of the avenues that are now open to students, greatly to the benefit of all. With the curtailing of the number of students and a less fierce competition which this will bring, there will be less temptation, less necessity, if you will, on the part of the general practitioner to ask for a division of fees. He will come to see that honest dealing on his part with the patient requiring special skill, will, in the long run, be the best policy. He will make a just, open charge for the services he has rendered and not attempt to collect a surreptitious fee through a dishonest surgeon for services he has not rendered and could not render. Then, too, there will be less inducement and less opportunity for incompetent and conscienceless men to disgrace the art of surgery.

The public mind is becoming especially active just at this time in combating graft in all forms, and is ready to aid in its destruction. The intelligent portion of the laity is becoming alive to the patent medicine evil. It is only a question of time when the people will demand that the secular papers which go into our homes shall not contain the vile, disgusting and suggestive quack advertisements that are found to-day. A campaign of reform is being instituted against dishonest politicians, financiers, railroad and insurance magnates, showing that their methods will be no longer tolerated. The moral standards set for professional men and men in public life are going to be higher in the future, and with the lime light of public opinion turned on the medical and surgical grafter, the evil will cease to exist. Hand in hand with this reform, let us hope that there will come to be established a legal and moral standard of qualification for those who assume to do surgery.

I feel sure that it is the wish of every member of this association to do everything possible to hasten the coming of this day and to aid in the uplifting of the art of surgery. Our individual effort in this direction must lie largely through the influence we exert over those who seek our advice before beginning the study of medicine, and over those who, having entered the work, are to follow in our immediate footsteps. To the young man who seeks our counsel as to the advisability of commencing the study of medicine, it is our duty to make a plain statement of what would be expected of him, of the cost in time and money and an estimate of what he might reasonably expect as a reward for a life devoted to ceaseless study, toil and responsibility. If, from our knowledge of the character, attainments and qualifications of the young man we feel that at best he could make but a modicum of success in the work, we should endeavor to divert his ambition into some other channel.

We should advise the "expectant surgeon" in his preparation to follow as nearly as possible the line of study suggested by Richardson. Then I would add the advice of Senn, viz.: "To do general practice for several years, return to laboratory work and surgical anatomy, attend the clinics of different operators and never cease to be a physician. If this advice is followed there will be less unnecessary operating done in the future, than has been the case in the past." The young man who enters special work without having had experience as a general practitioner, is seriously handicapped. In this age, when we have so frequently to deal with the so-called border-line cases, it is especially well to never cease being a physician.

We would next have the young man assure himself that he is the possessor of a well developed, healthy, working "surgical conscience." No matter how well qualified he may be, his enthusiasm, in the earlier years of his work, will lead him to do operations that he would refrain from in later life. This will be especially true of malignant disease. He knows that early and thorough radical measures alone hold out hope, and only by repeated unsuccessful efforts will he learn to temper his ambition by the judgment that comes of experience. Pirogoff, the noted surgeon, suffered from a malignant growth. Billroth refused to operate or advise operation. In writing of the case to another surgeon friend, he said: "I am not the bold operator whom you knew years ago in Zurich. Before deciding on the necessity of an operation, I always propose to myself this question: Would you permit such an operation as you intend performing on your patient, to be done on yourself? Years and experience bring in their train a certain degree of hesitancy." This coming from one, who, in his day was the most brilliant operator in the world, should be remembered by every surgeon, young and old.

The surgeon should be thoroughly trained in his aseptic technic early in his career so that it may become with him automatic. It is painful to see a man of forty or over attempt to clean up to assist at a surgical operation, unless his training began long years before. When such an emergency arrives, it is safest to relegate him to the retractors and keep him there, however much in the way.

This association has just reason to be proud of what it has accomplished. Its influence for good can not but be helpful and elevating. No better surgery is done in the world than in the geographical area from which the membership of this association is drawn. The history of surgery could not be written without enrolling the

names of some of our honored members. Let us exercise due care in extending fellowship and lend our every effort to elevate the standard of our cherished art.

Original Articles

THE TREATMENT OF IRITIS.*

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It would seem that very little remains to be said concerning the treatment of a disease so long recognized and so frequently encountered as iritis, but for those reasons the discussion should be sufficiently interesting and profitable to justify our Chairman in providing such a paper.

The varieties of iritis can be dismissed in a few words. The most useful classification is that based on the cause, which will be duly considered in this paper. As regards the local clinical manifestations, we may regard all iritis, from the point of view of treatment, as forms of plastic iritis, differing only in degree.

The object of the treatment of iritis may be stated, in the words of Brailey and Stevenson, as threefold:

1, To dilate the pupil; 2, to relieve pain; 3, treat any constitutional condition that may be present as a cause, as well as to attend to the patient's general bodily welfare and secretions.

I. DILATION OF THE PUPIL.

The object of this procedure is, as we all know, (a) to prevent the formation of adhesions, which may so lessen the size of the pupil as to interfere with vision, or to interfere with the circulation of the aqueous between the anterior and posterior chambers; (b) to diminish the volume of the iris, and thus to squeeze out the blood from it; (c) the drug which paralyzes the iris muscle affects the ciliary muscle similarly and puts both at rest; (d) it also acts as a local sedative.

To dilate the pupil we must use a mydriatic drug. We must then consider (1) what drug, (2) in what strength, and (3) how and how often should it be applied.

There are not many drugs from which to choose, and if we omit cocain and homatropin as being of too feeble mydriatic power to be considered in this connection we have three left, namely: (a) Atropin, (b) scopolamin and hyoscin (which are possibly identical), and (c) hyoscyamin, daturin and duboisin (which are identical).

Without going at all into a discussion of things so often discussed, it suffices to say that of these drugs we unanimously choose atropin as the most efficient. Nor is it necessary to review the well-known questions of the chemistry of the mydriatic drugs, so fully elucidated long ago by Risley and others.

What strength solution shall we employ? The standard solution of four grains to the ounce may require modification either way. In patients presenting themselves for treatment with adhesions already formed, it may be necessary to increase the strength to eight grains to the ounce for a few instillations in order forcibly to break up the adhesions. On the other hand, in children, and in those susceptible to the drug, a weaker solution may be expedient. Under some circumstances a small solid crystal of atropin may be introduced into the eye, as will be mentioned later.

*Read in the Section on Ophthalmology of the American Medical Association at the Fifty-eighth Annual Session, held at Atlantic City, June, 1907.