A Scheme for the Establishment of an Association of New Zealand Surgeons

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Every year during the last four years I have had something to say about the formation of a Fellowship, or Brotherhood, or Association of New Zealand surgeons. The deficiencies in surgical service, both in public hospitals and private practice, have been borne in upon me as the result of a long and arduous experience of over 30 years, and I feel somehow that it is my duty, before my retirement from active surgical work, to draw pointed attention to these deficiencies, and to indicate a method by which I think such deficiencies can be made good.

I noticed recently, in the *British Medical Journal*, a report of the proceedings of the Royal Society of Medicine, dealing with Exophthalmic Goitre, its medical and surgical treatment, and reference was made to the fact that a similar discussion had taken place ten years previously, and that little to no progress in the direction of standardising methods of treatment had been made in that long interval. Physicians, radiologists and surgeons are still all in need of guidance in handling this grave malady, and only by the publication and study of careful records of cases with their end-results can we learn what to do, and what not to do, in the best interests of the patients. I read, also, a surgical discussion at the Glasgow meeting of the British Medical Association which centred itself on the question of removal *versus* drainage of the gall-bladder for cholecystitis, and which left this much-vexed problem still unsolved. Records, careful records, with end-results, can alone establish a standard operation for gallstones.

At the same meeting various distinguished surgeons enunciated their views on the treatment of visceroptosis, and intestinal stasis. For similar grades or results of these common, and often serious, troubles, one surgeon recommended an ileo-sigmoid anastomosis, or a total colectomy, whilst another would stop short at a semi-colon, and still another would fix the ascending colon against the posterior abdominal wall, and so on. Such discussions teach us what methods are available in the treatment of these maladies, but they leave us confused as to what the standard method should be. We must have careful and intimate records of end-results to guide us.

What is the best standard operation for the average case of hæmorrhoids? I am quite sure that at least half-a-dozen methods are in vogue in this Dominion—varying in degree from a Whitehead to a carbolic injection, but the surgeons who operate are too often content with the rapid recovery made by the patient from the operation, and remain in ignorance of the trials and tribulations endured later on. So it is with varicose veins, variocele and hernia operations. Recurrence of trouble is common in all these cases after operative treatment, as any surgeon of large experiences, or any general practitioner, can testify.

I have quoted only a few out of very many examples that could be brought forward to show that the procedure of the surgeons at the present time in New Zealand is not calculated to diffuse the knowledge born of experience. What chiefly is lacking, is the publication by trained surgeons of their hospital records, with end-results. In New Zealand we have, I consider, a country singularly favoured for the compilation of such records. It would not be difficult to keep in touch with all but a very few of our patients, and I feel confident that very valuable contributions to surgical progress and research could be made from this country. We New Zealand surgeons should take a more prominent place in the surgical world, and we should do better work for the country than we are doing at present. We ought to raise our standard of efficiency—our main hospitals should be re-organised and standardised. These should be at every one, a full stuff, not only of hon. surgeons, but of assistant-surgeons, all working on a definite plan calculated to increase individual efficiency, and to stimulate research and community effort. Greater opportunities should be afforded to those members of our profession who are anxious to fit themselves for surgical practice, and the Health Department should see to it that arrangements are made in all the larger hospitals to provide facilities for modern surgical work by a full stuff of earnest workers. When a

member of such a surgical staff has proved his competency, and has given to the community a due measure of public service, his efforts should be rewarded by admission to an Association of New Zealand Surgeons. Needless to say every encouragement should be given to the holding of regular meetings by such a hospital staff as I have indicated, for the discussion, particularly of anæsthetic and other fatalities, errors and failures, delays and disappointments, and for the concerting of measures for the improvement of surgical service.

I venture to believe that the hall-mark of a New Zealand surgical brotherhood would be a much coveted distinction. The service required for its attainment would be willingly given, and I am sure no one would grudge the payment of an adequate fee, say £20, for the privilege such a distinction would confer. In this way a fund could be established for the expenses of management, and also, perhaps, for the institution of research scholarships.

In America the progress of surgery during the last few years has been very remarkable. American surgeons, American hospitals, American journals, have all reached a very high standard of excellence, undoubtedly surpassing the surgical standard in most, if not all, other countries. In my opinion the greatest surgical advance ever made in any country was the establishment of the Fellowship of the American College of Surgeons, 10 years ago. You must all be more or less aware of the activities of this body, and how much it has done for the promotion of surgical efficiency in the United States and Canada and other parts of America. I wish to see an association of similar character established in New Zealand, and constituted in a way that would suit our particular conditions. We need not, for instance, use the term Fellowship in this connection, as done in America. There the fellowship is a purely clinical distinction, whereas with us a Fellowship of the Royal College of Surgeons of England, Edinburgh or Ireland indicates academical status. I shall, therefore, in the meantime at any rate, speak of membership and not fellowship of the Association of New Zealand surgeons, and I shall proceed now to repeat and elaborate the ideas I have formed in my own mind regarding the establishment of such an Association. The Association of Surgeons be a part and dependency of the New Zealand Branch of the British Medical Association. There is to be no disruption of the parent body, and the new offspring is designed to be a source of strength and not of weakness.

To begin with, a foundation body of members should be selected by The Divisions, and these foundation members should be only those about whose surgical efficiency and high professional and ethical standing there is no manner of doubt. They should be surgeons of wide experience in both hospital and private practice, and might include gynæcologists, ophthalmologists, and other specialists. Such a foundation body might number 25 or 30 members, or more. The foundation body would then meet and draw up a constitution, and formulate regulations for the admission of other members, subject to confirmation by the Branch. Surgeons recognised by the profession generally as of wide experience and established reputation could be elected without further investigation or examination on the unanimous vote, or even a three-fifths majority vote, of the foundation body. I would recommend a very generous admission under this category. Provided a man had received a good surgical training and had a wide surgical experience, especially in hospital practice, and possessed the esteem and confidence of his colleagues, I would advocate his admission to the Association of New Zealand Surgeons.

Other candidates who had not reached this high surgical status, but who were desirous of obtaining the hall-mark of surgical efficiency connoted by membership of the Association of New Zealand Surgeons, would be admitted on a majority vote, preferably a three-fifths majority, provided that the credentials submitted were reported as satisfactory by a specially-selected examination committee. Candidates coming under this category should be practitioners of at least eight years' standing, and should produce evidence of having been on the staff of an approved hospital (note the term *approved*) as house surgeon, assistant surgeon, or full surgeon, for at least five years in all. They should be required to hand in careful and detailed records of fifty major operations performed personally, and of fifty others in which they took a prominent part. These records should include history, clinical features on which the diagnosis was made before operation, laboratory investigations, description of operation, post-operative history, and end-results.

An approved hospital must be staffed and equipped to the satisfaction of the Association of Surgeons. There should be on the staff both surgeons and assistant-surgeons, and a surgical registrar to look after the records, paying particular attention to end-results. Needless to say, there should be proper operation-room facilities, X-ray

department, and pathological laboratory. Regular meetings of the staff should be held for discussion of such things as sepsis, failures, mistakes in diagnosis, death, and so on. The Inspector-General of Hospitals would, I am sure, co-operate in classifying our hospitals, and in trying to raise the standard of those not conforming to the regulations and requirements of the Association of Surgeons. The knowledge that ordinary candidates for membership must serve for a number of years in a recognised hospital would soon bring about a radical alteration for the better in our hospitals. At present, with very few exceptions, the honorary staffs in such New Zealand hospitals as have them, attend in perfunctory fashion, and the great bulk of the work is done by the medical superintendent and his paid staff. That means a very fine experience for these officers, but it is an experience that should be shared by all those aspiring to a surgical practice. If there were a large number of honorary appointments, junior as well as senior, open to those surgically inclined, and if it were understood that, after a faithful and successful term of service in a properly-run hospital, the holders of such appointments would have their service and surgical fitness recognised by the hall-mark of membership of the Association of New Zealand Surgeons, then, I claim, that an immense and enduring stimulus would be given to surgical progress in this country. A criterion of surgical efficiency and worthiness would be established. Those practitioners who, by special study, painstaking effort, and long hospital service, have qualified themselves as efficient surgeons should possess a hall-mark of some kind to raise them in status above practitioners who practise major surgery, but who have not gone through a full course of instruction and hospital service to equip themselves adequately for a position of such importance and responsibility.

If a practitioner holds one of the higher qualifications, such as Master of Surgery, or Fellowship of one of the Royal Colleges, so much the better; that is an indication of special intensive and successful study on his part, and entitles him to a higher status than those who have not such a qualification, but it is not essential for membership of the Association of New Zealand Surgeons.

The Association of Surgeons should meet at least once a year, probably about the time of the annual Branch meeting. Surgical matters in general and the affairs of the new Association would be discussed, clinical demonstrations provided, research encouraged, and efforts made to improve by all possible means the standard of surgery in this Dominion. New Zealand surgeons should not be content with mediocrity, they should set a high standard and try to keep at any rate near the van of progress.

The foregoing paper was read at a largely-attended meeting of the New Zealand Branch on 22nd February, 1923, and at its conclusion a free discussion took place on the merits and demerits of the proposed scheme. It was speedily seen that the paper published by myself in the NEW ZEALAND MEDICAL JOURNAL of April, 1922, and which had been submitted to the Divisions prior to this annual meeting, had been misunderstood in several respects, and some delegates to the Council had been instructed to vote against the scheme, largely owing to these misunderstandings. Two or three of the delegates, after hearing the address as published above, expressed their conversion from hostility to the support of the scheme, and although the first voting in the Council resulted unfavourably to my proposal, the final decision of the New Zealand Branch was that the question should again be submitted to the Divisions for further consideration, in the light of the additional explanations I was in a position to give.

I beg, therefore, to ask the members of the Divisions, before voting again on this important matter, to read carefully the address published above, and in answer to the various questions and criticisms made by speakers at the annual meeting just concluded, I wish to emphasise the following points:—

1. In my opinion the time *is* ripe for the establishment of an Association of New Zealand Surgeons on the lines laid down in my paper. I cannot see why the obvious advantages should be indefinitely delayed, and, on the other hand, the disadvantages alleged by those hostile to the proposal will not be lessened by the waiting.
2. There is no suggestion in the scheme that members of the proposed Association of Surgeons should practise surgery only. General practitioners who have by study and experience, and especially by hospital service proved their surgical efficiency, would be welcomed in the ranks of the Association, and would be, of course, permitted to do such general practice as they desired.
3. Some of the larger hospitals—for example, Invercargill, Timaru and several others—are at present carried on without the

services of an honorary staff, and therefore no opportunity is afforded to the private practitioners of the district to obtain hospital surgical experience. These practitioners feel that they would be penalised in their desire to obtain membership in the Surgical Association. In answer to this I would say that one of the planks of the proposed Association is the standardisation of hospitals, so as to ensure that they shall be staffed and equipped in the best interests, not only of surgeons, but of the community generally. Public opinion would be enlightened on the recognised deficiencies of hospitals that do not come up to the standard, and public opinion once aroused as to the backwardness and inefficiency of such hospitals, would force upon the authorities the necessity of a change to the recognised establishment of an honorary visiting staff.

4. It is necessary to start the scheme by the election of a body of foundation members, who will meet together to draft a constitution, and submit rules and regulations for the approval or otherwise of the New Zealand Branch of the British Medical Association. In my opinion this Association of Surgeons should be a dependency of our Medical Association and, therefore, the selection of the foundation of members should be made by the Medical Association, and all rules and regulations, and subsequent additions in membership, should be submitted for approval or otherwise to the parent body. My idea is, that each Division should be asked to send in the names of such surgeons as it selects for the foundation body, and this first selection should include only the names of those men, including specialists, of course, who have proved themselves by experience and hospital service, and high ideals to be good surgeons in the best sense of the term. I would make it an essential condition for foundation membership that each man selected should have had at least ten years of hospital service. It is difficult for me to be more explicit in this matter of selecting foundation members, but a better understanding of my own particular views on this point might be gleaned if I stated that, personally, I would like to see appointed as foundation members from the Otago District the following:—Dr. H. Lindo Ferguson, Dr. L. E. Barnett, Dr. F. R. Riley, Dr. F. S. Batchelor, Dr. E. O'Neill, Dr. A. J. Hall and Dr. W. Newlands.
5. Subsequent to the election of foundation members, a large addition to the Association would be made by invitation or application. I, personally, would welcome to membership any practitioner, desirous of joining, who was held in high surgical and ethical repute amongst his colleagues, and who had served at least eight years on the surgical staff of an approved hospital, part of which time might have been spent as a house surgeon or resident medical officer. Candidates under this category should require a three-fifths majority for their election by the foundation body, and their names should go before the Council or the whole Association for approval.
6. Those who have not yet won their surgeon's spurs, but who by training and hospital experience wish to equip themselves adequately for surgical practice, will be required to submit evidence of fitness and worthiness for investigation by an examination committee as explained in my address. One of the important and obvious advantages of the scheme is that it would encourage the younger members of the profession to take the right path for acquiring surgical proficiency, and would provide for the granting of a hall mark of the surgical status earned by hard work and devotion to duty.
7. It need hardly be said that no interference whatever is contemplated with the right of those members of the profession who do not become members of the Surgical Association, to practise surgery. Those amongst them who have already obtained the confidence of their patients will still maintain their surgical practice. But I admit that, of two younger practitioners seeking to establish a surgical reputation, the man who possesses the hall-mark of the Association of Surgeons would have, and should have, a very decided advantage over his colleague who has not taken the time and trouble to educate himself adequately for the important responsibilities involved in operative surgery.

In conclusion I plead for the thoughtful consideration of the scheme by the Divisions. Sooner or later some such surgical reform as I have described is bound to come. I can see no valid reason for delay, and I should dearly like to see the scheme launched at our next annual meeting, when Dr. W. J. Mayo, one of the founders of the American College of Surgeons, is to honour us with his presence. The establishment of an Association of Surgeons would be of no particular benefit to me, as I shall very soon be retiring from active surgical practice, nor would it, from a business point of view, be of any particular benefit to the surgeons who have already won a high reputation in this country, but it would confer a very real and deserved advantage on the younger generation of efficiently-trained men who are desirous of practising surgery; it would raise the standard of surgery throughout the Dominion, both in hospital and private practice, and the whole community would thereby reap the benefit of a vastly improved surgical service.