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From the Editor's Desk ...

Catholic Physicians' Guilds

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In May of last year, THE LINACRE QUARTERLY *carried an article entitled, "Who Should Get Surgical Privileges in Hospitals?" by C. Rollins Hanlon, M.D. of St. Louis. Several lengthy responses were received and we have permission to publish the two appearing below.*

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I am writing in protest to an article that appeared in the May issue of LINACRE written by C. Rollins Hanlon, M.D. and entitled "Who Should Get Surgical Privileges in Hospitals?"

I do not believe that the LINACRE should engage in the political side of medicine. This article mentioned little or nothing of the ethics involved in this question. Since it was written and printed, I would like to offer a rebuttal. As you have probably already assumed, I am a general practitioner in my ninth year of practice.

Dr. Hanlon spoke of the inadequately treated mole and its fatal complications. I do not believe anyone with any education today "inadequately" treats a malignant melanoma. If he does, then he has committed a moral wrong—whether he is a G.P. or a "super" surgeon. Yes, I will excise a mole for pathologic microscopic examination and will do a good job of it. *No,* I will not do a gastrectomy because I would do a poor job of it.

He also mentioned "The most deftly performed operation will fail to benefit the patient if it is unnecessary . . ." I am afraid that I bristle at that word after all of the poor publicity the medical profession has recently received. Any operation that is "unnecessary" is morally wrong. This is the crux of the matter and it is wrong whether performed by G.P. or surgeon.

Dr. Hanlon—it would be interesting to know what you would do in the hypothetical case you proposed of the acute appendix that proved wrong. Would you terminate the case and prepare the patient for a bowel resection at a later date or would you go ahead and do the resection on an unprepared bowel? It appears that a number of details were omitted. You also mentioned "That the patient takes all the risks in such a misadventure by the operating surgeon." Now, who takes the "risks" regardless of who the operating surgeon is?

The G.P. of today probably does re-admit more post-operative bleeding tonsils. In most areas he is probably being extra cautious because he knows he is being watched. Regardless of his reasons, he is offering good medical care for this uncommon (34 per thousand) complication. Is he to be condemned for this practice?

The remainder of Dr. Hanlon's article is spent in condemning the Hospital Preceptorship Program and exalting the merits of the Hospital Residency Program. He admits that "There are physicians who by long years of surgical practice or by preceptorships and self-education have made themselves into competent surgeons." I maintain that these plans are only as good as the men who are being taught

and as good as the men who are teaching them. The Preceptor Program with a good teacher and a competent student is a step ahead of a residency program with poor students or teachers.

The reference to "ghost surgery" is well taken. I can see why your article would not discuss the financial implications of these improper practices but it could have perhaps delved into the moral aspects of such improper practices.

Now, Dr. Hanlon, I would like to take a statement out of your article and ask you a question. You stated under proposition number 4 that "If the best surgical management is our goal, are we going to sacrifice this to the convenience of the patient, the relatives, or the attending physician? Modern transportation puts the most advanced surgical care within easy reach generally in less than an hour." In our area (Denver, Colorado) we have neuro-surgeons, eye surgeons, ear surgeons, throat surgeons and surgeons specializing in thoracic surgery—heart, abdominal, gynecologic, orthopedic, urologic, rectal, maxillofacial as well as plastic surgery. Yes, we even have pediatric and hand surgeons. My question, Dr. Hanlon, is just where does the so-called "general" surgeon fit or is he soon to be categorized with the general practitioner as being unqualified to do even "minor" surgery?

Who should get surgical privileges in hospitals today? Clearly it should be the qualified surgeon as recognized by his moral and ethical background — his judgment. And he should be given privileges according to his ability. Eligibility for or membership in the American College of Surgeons should *not* be the *only* determining factor.

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Concerning Dr. Hanlon's article in the current Quarterly, this is written more in sorrow than in anger. During my senior year at St. Louis, I spent 12 weeks under Dr. Hanlon, six as a student clerk and another six as a student "intern." He is a man whose dedication would be hard to match.

Let us study this article paragraph by paragraph. Is all surgery major, to be done only by those board qualified? My observation, after nine years "on the firing line" (to use a phrase popular on So. Grand Ave. in my day) is that this depends on the day of the week and time of day. Cases to be done on weekends or at night become "minor" and capable of being handled by the general practitioner where the same case on week-days and during working hours is a different situation entirely and much more complicated.

The case of the unexpected cancer of the cecum is certainly harrowing. During the past nine years that I have been practicing in this county I have never heard of anyone facing this problem. If it occurs, I shall not hesitate to close up the patient and operate another day. If Dr. Hanlon, as he would have us believe, prepares all of his appendectomies for possible bowel surgery and resection of the cecum, then he is unique, not only in St. Louis, but in the entire United States.

Let us discuss tonsillectomies. Because of the nine doctors in our medical community only two of us (and now three since I have an associate) do tonsillectomies; I have done a disproportionate number. In nine years I have had two post-operative bleeders. As a Junior in St. Louis, I worked as an extern in one of St. Louis' best hospitals, drawing its staff from both medical schools. All tonsillectomies were done by board men. I became an expert in the control of post-operative hemorrhage. Indeed, still fresh in my memory are the two twins, one of whom exsanguinated following a T and A by a board certified man.

I should like to compare my post-operative morbidity rate with that prevalent at your hospitals. Do your herniorrhaphies go home in three days and your acute appendices without perforation or peritonitis in the same time? Do your hysterectomies, whether vaginal or abdominal, go home in five days, and in as few as three days?

Now I speak from experience as chief of staff of a small hospital, from observation as a member of a tissue committee and from conversations with other doctors from all over the state of California. Most of the difficulty with poorly performed surgery or ill-advised surgery has been with newly certified board men. This is particularly true of gynecologists. I'll be glad to defend this paragraph in debate any place.

Let me add this observation. The possession of four years graduate training or a board certificate does not by any means guarantee that a man is a good surgeon. I would be pleased to take Dr. Hanlon by the hand and show him, within fifty miles of my office, surgery being done by board surgeons who are incompetent both as to operative technique and as to surgical judgment. I could also show him general practitioners doing surgery of a quality equal to that done in his own hospital.

A final word: there is a good deal more poor general practice being done by general surgeons than there is poor surgery being done by general practitioners.

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