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a numbers game. Until the sciences of psychology, sociology, theology, and others give us a more definitive picture of the normal family for optimal rearing of children as mature human beings it seems we should be wary of simply arithmetical solutions.

8. Finally, and this is a note that applies to the moral order, it seems superficial to think that the issue between liberal and orthodox moralists is only a matter of means: artificial birth control (contraception) vs. periodic abstinence (rhythm). Surely the whole question of ends and purposes, motivation and intention, and values, is involved in the determination of the circumstances, which make it wise or unwise to effect birth reduction in individual families or groups of families. The history of mankind records how frequently we suffer when we pit our dated knowledge and thinking against nature's tried and tested wisdom or against God's providential order. When we have deviated from nature's norms, we have experienced nature's capacity to strike back. It is, therefore, most incumbent upon us first to obtain and utilize adequate knowledge of nature, including man's nature, as a prelude to a wise approach to population in those areas where population explosion is actually occurring.

The foregoing is an abstract of a public talk given by Dr. Ratner under auspices of the Newman Club, University of Missouri, last December. He is the full-time director of the Oak Park, Illinois Department of Public Health. Since 1947, Dr. Ratner has served in the Department of Public Health and Preventive Medicine of Loyola University School of Medicine and now holds the rank of associate clinical professor. He is on the faculty of the St. Albert Magnus Lyceum and the National Sciences of the Dominican House of Studies, River Forest, Illinois. Dr. Ratner is a well-known lecturer in biology, medicine, and marriage; he is also a medical adviser to the Cuna Conference of the Archdiocese of Chicago.

WHO SHOULD GET SURGICAL PRIVILEGES IN HOSPITALS?

C. Rollins Hanlon, M.D.

This important and difficult question is answered in a number of ways by various segments of the medical profession. For example, the American Academy of General Practice holds that the family doctor should be entitled to surgical privileges, while the American College of Surgeons maintains that the practice of surgery in hospitals should be limited to qualified surgeons. What is the background of these conflicting views? The controversial issues may be indicated by four propositions. There are a number of important side issues, but let us examine these four propositions:

1. Surgical problems can be divided into "major," "minor," and "intermediate."

This appears at first to be a reasonable statement of fact, supported by logic as well as by long tradition. Excision of moles or warts is performed by many physicians who would not dream of attempting a gastrectomy; they act on the obvious presumption that gastrectomy is a larger and more difficult operation than removal of a mole, and associated with a greater morbidity and mortality. Equally true, but much less evident is the possibility of fatal complications from an inadequately treated mole that turns out to be a malignant melanoma. Such an instance illustrates forcibly the danger and artificiality of dividing surgery into "major" and "minor." We must still have textbooks of "minor surgery," but the authors generally stress in the preface the virtual impossibility of establishing a division from "major" surgery.

With this in mind, it is apparent that "intermediate" surgical operations defy analysis: indeed, the whole idea of such categories is based on the false premise that the only significant factor in the surgical experience is the operation itself. This is not to deny the importance of the operative procedure; it done badly, the patient may die despite masterful pre-

A single free copy of an informal critique on modern medicine by Herriot Ratner, M.D., as interviewed by Donald MacDonald for the American Character Series of the Center for the Study of Democratic Institutions, Fund for Republican, may be obtained by directing a request for The Interview on Medicine to the Center for the Study of Democratic Institutions, Box 4068, Santa Barbara, California.
operative care. On the other hand, the most deftly performed operation will fail to benefit the patient if it is unnecessary, incorrectly chosen, poorly timed, or associated with inadequate preoperative and postoperative management. In the interest of the patient, the only conclusion to be drawn is that all surgery is of major significance and that the categories of "intermediate" and "minor" surgery should be abandoned. From such considerations we come to the second proposition.

Physicians can be divided according to their capacity to undertake operations of increasing magnitude.

This proposition is advanced as a substitute for residency training in surgery, despite wide agreement that the best way to educate surgeons is by an accredited surgical residency program which schools the candidate in fundamentals of surgical diagnosis, pathology and therapy in an integrated fashion with the gradual assumption of increasing responsibility under supervision. The improvement in the general level of surgical care since this plan has been widely adopted is apparent. Why then do some advocate a loose form of preceptorship training? Simply stated, the standard surgical residency is "unduly burdensome and time consuming." Moreover, in the case of a general practitioner, it "would place disproportionate emphasis on surgery"; in effect, he would be overtrained in one aspect of his diversified practice.

Qualified surgeons would agree that a four-year residency training period in surgery would tend to convert a general practitioner into a surgeon, so that he would give "disproportionate emphasis" to the surgical aspects of his practice. The same surgeons would state that a man should not be half-trained or quarter-trained in surgery because a half or a quarter of his practice calls for surgical management. There is involved here the same basic misconception previously noted, that surgery consists of learning a number of technical procedures, to be applied to patients in the same way one prescribes a drug or a hot water bottle.

It is true that surgical training is "burdensome and time consuming," but these burdens rest equally heavily on all surgical trainees, be they fresh from their
privileges must complete 100 major applicant may be granted addi­
tions to "advanced" surgical hospital surgical committee, the
procedures arising from his own
After suitable assessment by the
privileges." After completing 25
"minor surgical privileges" and
plan by which general practition­
cal outlays so that he is increas­
ingly involved in debt. But such
an argument about degrees of in­
convenience is irrelevant to the central issue, that one cannot edu­
cate surgeons well on a painless, casual, learn-as-you-earn basis. A surgical residency is a full-time enterprise, and those who expect to achieve the same result by in­
hospital preceptorships are closing their eyes to the necessary qualifi­
cations of a modern surgeon.

Let us examine what is offered as one substitute for residency training. The article previously cited describes an "active, working plan by which general practitioners are gaining increased surgical privileges. After completing 25
minor operations under supervi­
the candidate may be granted
"minor surgical privileges" and
may then "proceed to higher cate­
gories" without interrupting his practice.

The further progress of the plan will be outlined only briefly. The aspirant to "advanced" surgical privileges must complete 100 major procedures arising from his own practice; the first 50 as assistant to a supervising surgeon and the rest with their roles reversed. After suitable assessment by the hospital surgical committee, the applicant may be granted addi­

This preceptorship type of train­ing falls far short of providing the kind of surgical competence which can cope with any situation that arises. Consequently, if the best treatment for patients is our cri­

tion, it is hard to justify two standards of surgery in hospitals where qualified surgeons are avai­
ble. Recognizing that the "ap­
prenticeship" or "in-training type of surgical education is inferior, the American College of Surgeons forbids its fellows to train nonsurgeons by this method.

Restriction of surgical privileges may be satisfied in large urban hospitals but is unrealistic in smaller community hospitals.

Some have said that in rural areas with excellent hospital facili­ties, the family doctor is the only available surgeon. "It is futile to discuss surgical residency, Board certification, pathologic skills and hospital surgical privileges under such circumstances. If the patient needs surgery, the family doctor operates. There is no practicable alternative." 1

As convincing as this may seem at first, one cannot withhold the hard question: "Why can't the patient be sent to a nearby hospital with qualified surgeons in attend­ance?" Modern transportation puts the most advanced surgical care within easy reach, generally in less than an hour. 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 physi­
cian? In urgent emergencies, the
initial operation may have to be
done locally, but this does not pre­
vent subsequent transfer for the
specialized care that may be even
more important than the operative
procedure.

Keeping the patient in an instit­
tion close to home has been
invoked to justify another perni­
cious practice — that of itinerant surgery. The patient is operated on by a visiting surgeon whose sole activities may be the operative procedure and the collection of the fee. Even if he furnishes consulta­tion and examination before operation, he fails to provide care and advice in the critical period after operation. All too often the
doctor is opened to ghost surgery.

It is true that there are at present not enough "Board qualified"
surgeons to staff every hospital in
the country. In some of these hos­
pitals there are physicians who by
(long years of surgical practice or
preceptorship and self-educ­
ation have made themselves into
competent surgeons. These men were formed in another era, before the widespread adoption of the residency system of training. There is no desire to legislate against such men or to quarrel with the statement that some ex­
cellent surgeons have been pro­
duced by the apprenticeship sys­
tem. Today that system is not only unfeasible, it is manifestly inferior to residency training. Its continued advocacy as a means of changing general practitioners into surgical practitioners by a painless, learn­as-you-go mechanism is a backward step in improving the surgical care of patients.

Who should get surgical privi­
leges in hospitals today? Clearly it should be the qualified surgeon, as recognized by eligibility for, or membership in the American College of Surgeons.

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