MITCHINER MEMORIAL LECTURE *

“ SOME MASTERS OF THE SURGICAL APHORISM ”

Sir RODNEY SMITH, K.B.E., P.R.C.S.

Commandant, Mrs. Mitchiner, Ladies and Gentlemen,

THIS is going to be a lecture about Surgery—and in particular about surgical teaching, for Philip Mitchiner loved surgery and above all he loved the clinical, bedside teaching of those just embarking upon a career in medicine. It is no misuse of the word to say that he was truly a “Great” teacher and if you listened to him with a sufficiently receptive mind you could abstract from what he would tell you far more than merely factual surgical knowledge. Wisdom, distilled from long experience was there and in the, at times, earthy phrases, it was not difficult to detect a penetrating insight into the eccentricities of human behaviour, for Mitch above all excelled in his analysis of the people to whom disease was attached rather than the disease itself. You should not, by the way, regard it as a sign of disrespect that I use this colloquial abbreviation of his name. Genuine affection does not diminish respect and to generations of pupils and those privileged to be his friends Mitch he was and Mitch he will always remain.

Now one valuable characteristic common to most great teachers is the ability to seize the attention of the mind of a listener and implant within it some important truth by the use of a single challenging phrase compressing, perhaps in one sentence, a basic principle that others, less gifted, would seek to establish through a page or more of closely argued prose.

The immense value of the well-turned and well-timed aphorism has been understood for centuries, even if not always referred to as such—but how else would you describe Paré’s famous “I dressed him and God healed him” or Avicenna’s “The cure of a disease must never be worse than the disease itself”?—each in its way a perfect example of a Medical aphorism.

The skilled aphorist does much more than merely provide entertainment. His sayings can be educationally beyond price and in a discourse upon a routine surgical topic, for instance, may add the seasoning without which the fare would be dull and unappetising.

I remember, to give an example, an occasion some years ago when the surgical section of the Royal Society of Medicine discussed the digestive troubles that may beset patients who have undergone the operation of partial gastrectomy. It was, frankly, a dull discussion and deteriorated into a series of mediocre contributions centred around the changes in the blood chemistry that might occur in such patients. When Sir Heneage Ogilvie made his way to the rostrum, many thought that this elder statesman would now analyse all that had been said and drawing the threads together, weave them into some comprehensible pattern which would be valuable for the future. Not a bit of it. His contribution consisted of one sentence only. “In general” he said “the bad results of Gastrectomy are the results of a bad Gastrectomy”.

An over-statement, of course, but hyperbole is sometimes necessary to achieve maximum effect and Sir Heneage was a past-master at the art of the proper usage of the

* Given at the Royal Army Medical College, Millbank, London S.W.1 on 23 November 1976.

surgical aphorism. He would produce it suddenly and unexpectedly in a way that said as clearly as possible "Now, wait a minute; aren't we in danger of overlooking an important principle". This particular aphorism did in fact originate with Ogilvie but it is so good that it has been copied and plagiarised by others, because it applies pretty well to the whole of surgery, the principle he was seeking to establish being a simple one, that when the result of an operation turns out to be unsatisfactory in some way, a surgeon, before blaming circumstances beyond his control, ought first to search his own conscience and ask himself the question "Are perhaps the patient's symptoms caused by technical imperfections in the way in which I performed the operation?"

The way in which an operation is performed is important. This fact should not be overlooked, though it should not be given exaggerated weight either. Fashions change and if one studies papers and editorials in surgical journals at different periods during just the last half century one cannot help being struck by the change in the importance attached to surgical technique between, say, the 1920's, the 1950's and the 1970's.

By and large, surgeons in the 1920's were, I think, concerned far too much with technique and surgical *prima donnas* with showy gimmickry of various kinds abounded. To them the operating "*Theatre*" was indeed a theatre, "*le mot juste*", and they enjoyed the opportunity to show off and exaggerate their skills, just as some of their blunter and more honest colleagues enjoyed debunking the pretentiousness of such displays. Mitch was by nature one of the latter and so was the famous Wilfred Trotter who, when invited once to comment upon the abilities of a colleague who was inordinately proud of being able to tie knots not only one-handed but with equal facility with either right or left hand, did so with his famous aphorism "Not all surgeons who can use either hand equally well are ambidexterous. Some are ambisinistrous".

It would be my belief that in the 50's the balance was about right. Technical excellence was still highly regarded, but not now as an end in itself. Will Mayo, for instance, put it very simply when he said "Many very skilful operators are not good surgeons". This was not an attempt to disparage the value of a good surgical technique but merely to emphasize that it should be regarded as an instrument through which surgical science could be applied with maximum advantage to the patient. Surgeons did still travel to Boston to watch that great master Dick Cattell operate, or to Manchester to watch Peter McEvedy for that matter, and if they could thereafter practise what they saw, were the better equipped for the experience.

Today, in the 1970's, superb technical skills are to be seen in a great many centres and operations performed which were not considered possible even twenty years ago. The younger generation of surgeons now growing up operate as well as or, in many instances, a good deal better than their predecessors, but not all of them, and it is difficult to understand how a fair proportion of publications today appear to assume that an operation performed by Mr. A is necessarily identical with the same operation performed by Mr. B. I read recently, for instance, a most detailed 50-page report upon wound sepsis in relation to a complex of three operating theatres and this report never once referred to operative technique and to the fact, which all surgeons know, that whatever the bacteriological background the accurate, tidy, gentle operator will always have a low postoperative sepsis rate and the reverse is the case with the rough surgeon who leaves devitalised tissue, dead spaces and haematomas.

Frank Glenn of New York, another great surgical teacher, insisted upon the development of an excellent, as opposed to a good, operating technique and never tired of repeating that all operations ought to look easy. As a final touch, to rub this in, outside the operating room where his residents would operate was a notice on the wall which read "if you find this operation difficult, you are not doing it properly", another aphorism worth remembering. This same Frank Glenn was also insistent that the patient who becomes ill after an operation is much more likely to have some major surgical complication than the coincidence of an unconnected medical catastrophe, and he rubbed this in by a second notice, this time on the wall of the room in which his residents would write up their notes. It read "No patient in this department, after biliary tract surgery, ever has a coronary thrombosis". Hyperbole again but familiarity with this aphorism can save the life of the patient whose sudden postoperative collapse is, let us say, due to a gram-negative septicaemia.

Operative technical skill, then, is important but it must be seen as the servant, not the master, of knowledge and judgement and, as the frontiers of surgical achievement are pushed back and we are physically able to do more and more for patients, intervening in the ills that afflict mankind in areas where surgery previously had no place, the problems of when to operate and how much to attempt become not less but much more difficult.

This is particularly the case when some new operation is developed, previously considered impracticable for reasons of technical difficulty, but whose place and relevance in the treatment of patients is as yet not established. Lord Cohen of Birkenhead at a meeting once, irritated by some recently developed procedure of this kind, which he personally did not consider to represent an advance, observed "The mere demonstration that an operation can be done is no clear indication that it should be done."

Few, I believe, would contest the validity of this statement, but all the same, on a lower plane, it is far from uncommon to come across a surgeon busily engaged in the surgical correction of some physical abnormality just because it is an abnormality, without asking himself whether the patient is in any way inconvenienced by it or in any danger on account of its presence. If you think that this is a rare thing to happen I wonder how many surgeons here today have removed an asymptomatic lipoma. Stanley Hoerr of Cleveland, Ohio, when he was the editor of the *Annals of Surgery* once wrote a whole editorial upon unnecessary operating, entitled "Hoerr's Law" and he began by saying that he would first state this law for those who might be unfamiliar with it—a reasonable preliminary as he had of course invented the title for the occasion. "Hoerr's Law" he stated "is this. If a patient has no complaints at all, you always find it difficult to make him feel better".

It is, in fact, easy to forget this law and to assume that every departure from the accepted standard of physical normality demands surgical correction, just as it is easy to make other fallacious assumptions in surgery. For instance, it is tempting to assume that for every ailment curable by surgical intervention one ought to be able to arrive at an optimum surgical technique, which one could then apply to all cases. The assumption is fallacious because although one case may closely resemble another, it is never identical with it and an operation which brings relief to one patient may prove disappointing to another. Then again, advanced age or infirmity may impose limitations upon the choice

of surgical technique. Contemporary with Mitch at St. Thomas's was Bernard Maybury, a small quiet, modest and immensely skilled man, for whose judgement his colleagues had particular regard and respect. He was not as great a teacher as Mitch but nobody has improved upon the way he expressed this particular truth.

"The best possible operation", he would say, "is not necessarily the best operation possible."

Good judgement is like style in a violinist, a skater or a tennis player—one can recognise it immediately but to define or explain it, that's less easy. To a surgeon, though, its importance is obvious, for it guides him and helps him to make the right decision when faced with such questions as "Should I advise this patient to have an operation?" "Which procedure has the best chance of giving maximum help to this particular patient?" or "How much should I attempt here? Ought I to perform a radical operation or should I be content with a palliative procedure?"

How is it acquired? Well firstly it required hard work. As Professor Saint of Cape Town once said, "Knowledge and Wisdom are acquired, not congenital". Knowledge and wisdom—the surgeon of good judgement must of course acquire both, though naturally it is likely that chronologically one will follow the other; but they are not identical, nor are they really facets of the same intellectual capacity. We could, I think, all cite examples of colleagues possessed of almost encyclopaedic knowledge whose results over the years are nevertheless deplorable through their inability to apply wisdom as well as knowledge, and they will often tell you as their patients die that they are dogged by a totally inexplicable run of bad luck. Conversely some surgeons acquire the enviable reputation of being blessed by more than their fair share of good fortune.

The late Peter McEvedy of Manchester, of whom I have spoken this evening already, once heard a friend refer to him as a lucky surgeon and, after commenting, not unreasonably, that if he personally had to have an operation he would be much comforted by the knowledge that his surgeon had a reputation for good fortune, added "I do admit that there have been times when I have felt myself lucky to obtain a good result in unfavourable circumstances and, you know, as I grow older and learn more about surgery I have noticed something very strange; I seem to be getting even luckier".

Note, by the way, how these three little words "a good result" occur so naturally in the context of this saying of McEvedy. Yet is it all too easy to overlook the fact that in surgery this is surely the sole objective of applying both knowledge and wisdom. Sir Heneave Ogilvie did not overlook it. Confronted at a meeting by a member of his audience claiming that success in surgery was hard to define, he said "Not at all; you can define success in surgery in one word—'results'"—and surely this is true. The surgeon to whom colleagues refer their patients who are in trouble, and he gets them better again—he is a success. But no man dogged by ill-fortune is a success and those who would include themselves in this group should perhaps look closely and analytically at their persistent ill-fortune and ask whether perhaps at least some of it is not home-made.

Let us return to knowledge and wisdom. The difference between the two is not easy to define, but perhaps wisdom is merely knowledge laced with a good measure of common sense; to which we might add Will Mayo's aphorism "Knowledge is static; Wisdom is active and moves knowledge, making it effective".

Whatever the catalyst that enables a surgeon to cross the dividing line between the two adjectives “knowledgeable” and “wise”, the essential preliminary acquisition of knowledge itself demands above all sheer hard work. Sir Gordon Gordon-Taylor, whose personal contributions to surgery, to surgical teaching, to literature, to every aspect of surgical life, were prodigious, knew very well how essential to a successful career was continuing application and hard work and also the evidence that might be visible to the discerning eye when a young disciple had perhaps not as yet appreciated this fact. Commenting years later, upon the early career at the Middlesex Hospital of a young surgical hopeful, he observed “A man of many admirable qualities, but not really one of the best House Surgeons I have had. Whilst he was with me, he put on weight”; not quite an aphorism, perhaps, but worth remembering all the same.

Hard work, then, is essential but since the day has only 24 hours, the time spent in working must be used sensibly and with intelligence. The young would-be surgeon who says to himself “Tonight I shall read and commit to memory chapters nine and ten in ‘Romanis and Mitchiner’ is not so much working as committing a self-inflicted injury upon his own intellect. The man, on the other hand, who says “That was an interesting case of a cystic swelling in the neck that Mitch demonstrated on the ward round today. Whilst it is fresh in my mind, I’ll see what the chapter in the book has to say upon the subject”—now he is using the time he allots to reading intelligently, usefully, and enjoyably. The difference is enormous, just as there is a big difference between sitting down to a nicely cooked meal at one’s favourite restaurant (or better still prepared at home by one’s wife) and the goose’s experiences in being fattened up for Christmas. I heard Mitch say many times “Don’t read all the time. Do a little thinking for yourselves”. Wise advice and one may perhaps pair it with Will Mayo’s “It is better to think and sometimes to think wrong than not to think at all”.

Let us move on a stage. In the transition from knowledge to wisdom, the observation of certain constantly repeated phenomena inevitably leads to the acceptance of certain guiding principles or, if you wish, certain convictions, around which matters of detail are constantly being arranged and re-arranged as more and more evidence becomes available. It is important to develop convictions, as points of stability—terra firma—from which to take a bearing and to set a course. But, and it is a big “but”, whilst it is right to have the courage of one’s convictions, it is equally right to have the courage to question and re-examine one’s own convictions from time to time. One can occasionally discover that a conviction is really that word’s younger, illegitimate brother—a prejudice. What is the difference? Well, though difficult to explain, I’ve often thought that the difference is that you can explain a conviction without getting angry about it.

The validity even of strongly held convictions, then, needs to be checked from time to time and it should be no reproach that a man may on occasion make a statement flatly contradicting something he himself has said a few years earlier. Sir Heneage Ogilvie, in a little book called “American Adventure”, once described how in a certain surgical centre of excellence the writings of that great surgical pioneer, Halsted, had acquired almost the status of the holy writ and how he had not been able to restrain himself from exclaiming “The trouble with you people here is that you appear to regard Halsted’s footprints in the sands of time as fox-holes to be defended to the death and re-excavated as they crumble—instead of merely evidence of the direction in which he was travelling”.

Then again, Sir Ralph Marnham, challenged at a meeting once, after giving a paper, in the following terms “ But, Sir Ralph, what you have just said is diametrically opposed to what you wrote in the British Journal of Surgery five years ago ” replied “ My dear sir, that is the nicest thing I’ve had said to me for years. I had no idea I still had such a flexible mind ”.

Surgery is both an Art and a Science. It does demand both knowledge and wisdom. It does demand thought, imagination, flexibility, ingenuity, above all application. If we can develop or are prepared to apply all these things, is that enough? or have we left something out? There is, in the argument so far, still a serious omission and Mitch would by now have spotted it without difficulty. “ You know what you’ve done?” I can hear him say, “ You’ve left out the patient ”; and he would have been right. Any list of qualities essential to the practice of surgery must include humanity. It is more than 45 years since I entered St. Thomas’s Hospital as a student and it was not long after that that I stood for the first time in “ Mr. Mitchiner’s operating theatre ” in a little group with others as junior as I and as apprehensive that the great man’s eye might fall upon us and that some question would lay bare for all to see our ignorance and lack of experience. Well, he did advance upon us and put a question and I remember it well. “ Who ” he said “ is the most important man in this operating theatre this morning?” Those were the days, remember, when a senior consultant surgeon was still regarded as deserving of considerable respect, or even awe, and we replied dutifully “ The Surgeon ” or “ You are, Sir ”. “ No, I’m not ” replied Mitch and turning round and pointing at the operating table onto which the patient was being transferred from a trolley, “ He is. He’s the *only* important person and don’t you ever forget it ”, and I never have. Others have expressed the same kind of philosophy but usually less well. Lord Moynihan when asked by a somewhat clumsy questioner “ My Lord, how do you treat duodenal ulcers?” is said to have replied disdainfully “ I have never treated a duodenal ulcer in my life, but I have treated many patients suffering from a duodenal ulcer ”. The sentiment is right, though to Moynihan’s rather autocratic answer I prefer Mitch’s more simple and more arresting gesture. But then Mitch was a much simpler man than Moynihan and displayed a good deal less self-regard too.

In the complexities of modern scientific surgery we are, if we are not careful, in danger of ignoring or at least not giving sufficient weight to factors concerned with the personality of the patient, his insight into and his individual reaction to his own illness, his personal wishes in regard to treatment. “ Never ”, Mitch used to say, “ compel a patient against his will to have an operation ”, and old St. Thomas’s students will remember certain capital letters that were sometimes to be seen in patients’ notes and their significance, for if Mitch advised an operation and the patient said he didn’t wish to have one, he would first make quite sure that the patient did understand the reasons why the advice had been given and the possible implications of refusal to accept it and then, if he still remained obdurate, Mitch would dismiss him, telling him to return if he changed his mind, writing in the notes “ Operation advised but refused. To return C.I.H. ” and those letters stood for “ Cap in Hand ”. What a wealth of experience, learnt the hard way, in these three letters; C.I.H.—the time to operate was when the patient re-appeared, took off his cap and said “ Please, Mr. Mitchiner, may I have the operation ”. I think we can all recognise the reverse of this coin, the patient who says “ I don’t want the operation but I will have it if you insist ”, and then blames whatever

complication, major or minor that may occur upon his surgeon with the words "You made me have this operation. I didn't want it in the first place".

Another way in which the patient gets left out of the calculations is when too great a regard is paid to figures and statistics. I listened to a paper only a short time ago which examined the indication for a certain line of treatment in a certain variety of cancer, itself acknowledged to be invariably fatal within a relatively short time if untreated. "On the average" (note these words) "On the average" the lecturer said "the period of survival in patients treated in this way is only a little better than without any treatment at all, so that its advocacy is questionable". What basic inhumanity underlies such a statement. "Only a little better" may well mean (as in this case) that many patients disappointingly fail to respond to treatment and that only occasionally do we hit the jack-pot and have a triumphant success, returning a patient we thought doomed to his family and friends for perhaps several more years. But by what right, because it is an exception, should we refuse to give the chance of this happy result to every patient in such a position? Is it not better to offer a patient the possibility of something rather than the certainty of nothing? The fault goes back of course to the exaggerated respect for statistics behind this phrase "On the average". If I were asked to leave with you this evening a single personal aphorism I think it would be "No man is an average" and no doctor should, I believe, try to treat more than one patient at a time.

The aphorism can be applied with great effect in so many areas of surgery and indeed of Medicine in general that any discourse upon it may get out of hand and, straying unintentionally into territories which belong more truly to philosophy or even morality may lose the focus and concentration which is the essence of the aphorism itself. If I have allowed this to happen, I apologise and will come back to earth with a final thought. What does the aphorism tell us about the man or woman who wields it? We have directed our thoughts, this evening, to Mitch, of course, and to Trotter, to Moynihan, to Will Mayo, and to Gordon-Taylor, to Ogilvie, Frank Glenn and others. Much that is essential to a career in surgery is to be learnt from their sayings and writings but what, in addition, can be learnt about them personally.

Well, since I suppose it is true to say that a successful aphorism usually contains not only an element of surprise but often an element of humour as well, or at any rate wit, it is not irrelevant to comment that the use of wit or humour is itself an intensely personal matter. Some use it almost exclusively to wound, and as one reads the aphorisms of Wilfred Trotter one cannot help but notice that although he was undoubtedly a very great man with a giant intellect amounting, some would say, to genius, his wit had often such a cutting edge to it that the occasions upon which he drew blood from a colleague were frequent.

The wit of others is invariably kindly. Dr. James Colyer of St. George's Hospital, in his day the foremost neurologist in the country, was one of these. On one occasion a new House Physician, introducing himself on his first day with this very eminent chief, rather apprehensively volunteered "I'm afraid I don't know much neurology, sir" and received the courteous reply "Never mind, my boy. I dare say I know enough for us both".

Then again, some have used wit to show off, for personal aggrandisement, and Moynihan could not altogether escape criticism on this score. Others whilst using the

weapon of humour effectively and logically have shown unmistakeable signs of writing the epigram first and then scouting around to find an occasion upon which to hang it. This could certainly at times be said of Ogilvie.

What of Mitch? Was he a man of humour? Oh, yes indeed. And did he use the weapon of humour skillfully? I would say, incomparably, for the type of humour would always be so perfectly suited to the occasion. For the pompous and self-opinionated there would be ridicule, but not unkindly and with a twinkle in the eye to take away at least some of the sting. Mitch on these occasions would strike not to kill but to deflate. He was slow to anger and sarcasm with a biting edge to it, meant to hurt, emerged only as a response to injustice as when, for instance, he saw one of "his boys" being unfairly oppressed in some way.

As a teacher of students his use of humour has never been equalled and anecdotes illustrating this abound, none of which am I going to recount today. You see, Mitch knew a lot about patients, but perhaps even more about the workings of the minds of medical students. During a mere few years a great mass of knowledge had to be absorbed. This could only be done through hard work, there was no evading this, but how to persuade students to work, this is where the presence of a gifted teacher as a catalyst was beyond price.

"Students have got to be interested, not bored" Mitch would say and he might have added "and made to laugh" as well, for one could seldom come away from one of his enormously attended ward rounds without a story to repeat to one's friends, to laugh about and enjoy a second time. But, you see, this was the point. Many of Mitch's aphorisms were couched in terms that were meant to shock and he fully intended that some of those who listened would go away and later say to others "Do you know what Mitch said today?" and then repeat the story; and as one did so one would realise that attached to the story and inseparable from it was some important surgical truth which Mitch had intended to stick—and stick it would.

Pick, then, the aphorist of your choice, one of the random selection I have paraded before you this evening or perhaps one of the host of others I have not even mentioned, for the number of skilled exponents of this valuable art is far too large to include them all. Or would you prefer to grade or stratify them, according to artistry, timing, imagination and so on, into grades or classes. If so I really do not know into which class you would put Mitch—except that he would certainly have to be put in a class of his own—for he was incomparable.

There was nobody quite like him and probably never will be again. His influence is felt today upon British Surgery, through those whom he taught, in whom gratitude and affection have not diminished with the years.

There are still enough of us around to keep his memory green.