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Personal Paper

Academic surgery: future uncertain

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Surgeons are practical men: they do things with their hands which every now and again make patients better. As with all craftsmen they have an innate suspicion of the theoretical. Even further, they may discount ideas newly minted and manifestly heterodox by comparison with the coinage of their experience (particularly the experience that they, or their immediate predecessors or contemporaries have gained, for on the whole beyond this they are anti-historical). Surgeons are the farmers of clinical medicine—bucolic of mien, relatively free from the agonies of self-examination, content to plough and harvest. Like farmers they complain—about the theatre, the instruments, and everything else. And like farmers they usually prosper. As with other tradesmen, they may take an apparently joking or casual attitude to their work—an approach which half conceals a proud technical mastery.

Attitudinal differences

The academic life is based on generalisation and concept. It is not necessarily theoretical, and I deplore any attempt to equate the words *academic* and *theoretical*. This usage is a modern corruption of an old and proud term derived from Platonic philosophy. Academic practice, however, tends to be seen as putting generalisations into effect, as much as dealing with a unique here and now. Academics—a word not used much in Britain and which again is a modern substitute for the rather more pleasant academicians—are interested as much in things as in people. I do not mean material things but ideas and their transmission. They need time to be contemplative. As everyone who sits on university or medical school committees knows, the academic mind has a demoniacally destructive ability to see five facets of a four-sided problem simultaneously. Academics are thus often labelled indecisive. As the poet and scholar D J Enright¹ put it: "academics customarily possess such a gift for subtle reasoning and fine distinctions, such exquisite professional scrupulosity and verbal dexterity, that even an intelligent and shrewd observer may fail to perceive that much of the time their basic motive is simple cynicism and self-interest."

He went on to say: "If you are in trouble, throw yourself on the mercy of the nearest peasant, publican or policeman, but never go to an academic; you will be dead long before he has finished formulating his attitude towards you and your problem."

To these characteristics we must add that at least until recently it was part of the academicians' stock-in-trade not to prosper except by devious means such as writing novels under pen names or appearing heavily disguised on television. Nevertheless, in their discipline they are usually deadly serious. Moreover, in both the act of research and its results they must often find themselves taking a heterodox stance. Finally, research requires introspection, intellectual agony, midnight oil, and flashes of insight of uncertain origin—qualities not easy to mix with long hours at the service of patients.

The two contrasting descriptions I have drawn lead inevitably to the conclusion that the words "academic" and "surgery" are totally incompatible, both attitudinally and in practice. While I do not believe this to be absolutely true, like all good fabrications this fallacy contains an element of the truth sufficient to require us to examine it with some concern.

Academic surgery—as represented by academic departments in the clinical field—has come into being at different times in history for three reasons: to provide a voice for clinical medicine in the councils of the universities; to act as a focal point for teaching and training; and to prosecute research. It would be a useful if rather broad series of generalisations to say that the chairs in Scottish schools developed during the first half of the nineteenth century were for the first with a dash of the second; that the growth of academic clinical medicine in the last years of the nineteenth century and the first quarter of the twentieth in the USA was, in the wake of the Flexner report, mainly to do with the second, supplemented at first by a drop of the third, though latterly of course by a flood; and that the ultimate recognition of the need for academic surgery in England in the 'thirties—the story of which I have outlined elsewhere²—was mainly to do with the third. On a slightly sour note I might well add that at least in part the objective in England has been to confer an imprimatur of respectability on institutions otherwise resistant to change.

The 30 years or so since the second world war that have seen such a growth of academic surgery in the United Kingdom, but particularly in England, have been mainly if not exclusively devoted to research. The outcome of this has in many ways been

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splendid, and though I detect a slight slackening of momentum, we can still regard ourselves undoubtedly as leaders in highly applied, but biologically important, investigation. Nevertheless, I think I should reiterate one point. There is a real danger that we will either attempt too much biologically or descend into trivia. The limitations on time and intellectual resources which are an inevitable consequence of the practice of surgery, can lead to poor quality work in the basic biological sciences; concern with the appearances of research can promote contract work—for example, with the pharmaceutical industry or directed towards the short-term goals of presentation to a society which is of little significance. The efforts of surgical research in academic departments are inevitably finely balanced between these two extremes. Moreover, because of this they are threatened. On the one hand, when grant money is in short supply those who can take the least credible stance are likely to get knocked over in the rush; on the other hand, excessive concern with superficial work of a transient kind helps to sap credibility further as well as generating a potential thrall to money sources that are not without strings.

I do not suggest that we are yet in a parlous state in Britain, but I am conscious of a significant cut-back in American surgical research activity and as for Australia, where the 1960s saw such a burgeoning of activity, now, with one or two notable exceptions, research and academic drive is all but gone. We must therefore look with some concern at how we define the research we are to do so that it successfully steers between the Scylla of profundity and the Charybdis of triviality. Such a critical look is repugnant to many who move from one drug house organised cocktail party or symposium to another (and I am no more immune to such delights than anyone) but is vital to our integrity.

Need to build bridges

This attitude in relation to the direction of research leads naturally to a consideration of how we are viewed by our non-academic colleagues today. Regrettably, but not wholly without reason, we are seen as pursuing ideas and investigations which have little relevance to the practice of surgery; to a degree more damaging, we are regarded as not making a basic effort to training in the fundamentals of surgery—in such attributes as sound clinical judgment, adequate technical skill, and the insight and compassion necessary for effective patient management. That this image of the academic surgeon is oftentimes false is of little moment if it is the accepted judgment of the majority. All too often academic surgery is seen to be irrelevant to clinical practice. In consequence, we are little cherished and tend to be demoted in importance.

How may this false view be counteracted? Partly by attitudes which do not set town versus gown in a way which our somewhat adversary society seems throughout the ages always set on doing; indeed, we enjoy conflict rather more than we should and delight in cutting each other down to size. Partly by trying to make the practice of clinical academic surgery more geared to solving practical problems than biological ones. Some advances have been made in this field already, but I do not for a moment think that we have committed ourselves far enough. To build bridges between the so-called practical man and, in O'Shaughnessy's words, "the dreamer of dreams" is vital for the future of surgery as a whole. It will take effort on both sides and at the moment I remain unconvinced that we are working hard enough, or for that matter that our colleagues in "non-academic surgery" are receptive and co-operative enough. Both groups have much to learn about each other—but will they try?

Influence on teaching and clinical standards

Let me go on now to a matter of much more profound concern. If one looks at the other roles that have been outlined for academic surgery—influence on teaching and on clinical

standards—can one truthfully say that we are achieving them today? Do we provide, and are we likely to provide in the future, the conscience of the profession, the guiding star, the standards against which performance can be judged? I doubt it. True it is that a small—very small—number of centres of clinical academic excellence, to which all comers are drawn, exist in Britain. But equally true, there is a sense of independence from, even derision for, the drive of academic surgery within the profession at large. Most clinical centres that really count are not centred on academic departments and rather than cherish its academicians, society perpetually discounts them; rather than foster academic attitudes, it opposes them; rather than be co-operative, it is adversary. Allied to this undercurrent—which I believe has its origins partly in the attitudinal differences with which I prefaced this paper—is a failure to see that unless academic surgery is promoted both in principle and in practice (and I have in mind such simple things as parity in terms and conditions of service), then the country will be the poorer in every way.

Of course, we as academic surgeons may have only ourselves to blame. Hell bent as we have been in the past quarter century on the pursuit of surgical research, we may have insufficiently promoted the concept of the academian as *primus inter pares* in clinical care and operative skill. By sitting in our perceived ivory academic towers we may truly have given the impression that we are theoreticians rather than academicians. Yet, though this may be so, type casting is less our fault than it is the objective of our non-academic colleagues who, sometimes threatened by our opportunities and our potential clinical skills, consciously or unconsciously see it as their task to diminish our stature.

Scenarios for the future

We can then, I think, draw two scenarios for the future. We can remain as we are—doing research interesting for us, but largely tedious and irrelevant for others; and endeavouring—largely ineffectively I believe—to influence others through *their* institutions. This is vibrating mediocrity of which I for one do not wish to have a part. Or we can hitch our wagon to the star of trying to—and here I use O'Shaughnessy's words again—"be the movers and shakers of the world. . . ." By doing so we shall have to admit that we shall not always be popular because this role means criticism, the unveiling of poor results, and the advocacy of the heterodox, which challenges the often smug conservatism of the majority of the practising profession. It means fostering the attitude of intellectual doubt which surgeons least of all care to admit. Without such an *avant garde* and relatively non-self-seeking element, however, progress is impossible, and, as we all know, without progress there is almost inevitably regress. Lack of popularity is inescapable for any segment of the community that wishes to preserve or raise standards. I see little commitment to such a role in academic surgery today; we all want peaceful living with our colleagues, and if this is so I doubt if we have a viable future.

These are unpalatable truths; I am breaking the unwritten code of "do not rock the boat" by voicing them. Nevertheless, viewed not dispassionately but passionately, I have a strong belief in the need for academic surgery which as I see it can do all the things most needed by surgery today: provide unself-interested excellence; lead in research and criticism; and have at least the same stature as those whose only activity is the practice of surgery. Unless it does so it does not deserve a future. In that I fear it is unlikely to adopt these objectives in our present climate of opinion and action, it may well have no future.

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