THE RENAISSANCE OF ABDOMINAL SURGERY; THE PASSING OF THE GYNECOLOGIST*

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IT is commonly recognized that abdominal surgery and gynecology, as we know it today, owes its renaissance to the introduction of ether and more particularly to the development of aseptic methods of operation, and that with the conquering of pain, hemorrhage and infection, the three great evils which for so many centuries retarded surgical progress, the pathway was opened for the development of modern surgery. But even the most enthusiastic abdominal surgeon gladly recognizes the fact that the surgery of the upper abdomen owes its rise to the fearless and ingenious work of the early gynecologists.

There is perhaps no more dramatic era in surgical annals than that which marks the beginning of gynecologic surgery. The story of that bleak day in December, 1809, when a woman "with her pendulous abdomen resting on the pommel of her saddle" rode sixty miles into Danville, Kentucky, to seek relief for an ovarian tumor that was sapping her strength, reads almost like a work of fiction. She did not come in vain, for she found in Ephraim McDowell a man with the courage of his convictions and willing to suffer bitter and hostile criticism for his temerity in attempting to extirpate the ovarian growth by surgical removal of the ovary itself. This same fearlessness characterized those who came after McDowell. The efforts of his followers, Smith, Peaslee, the Atlees, Dunlap and others to create a legitimate place in surgery for the operation of ovariotomy reads like the strangest story of perverted persecution of men, branded as butchers and murderers, those whose sole object was the relief of suffering womankind.

To these pioneers we owe our everlasting gratitude. Surgical principles and operative procedures which they laid down are accepted today unaltered. Many methods of investigation are the outcome of those which they evolved, and strategy which they employed is still and probably always will be effective.

In the decade that followed these pioneer days it was only in the field of gynecology that abdominal surgery was at all active. With these times are intimately associated the names of Sims and his ingenious treatment of vesicovaginal fistulas; of the elder Emmett and

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his plastic repair of the lacerated cervix; of Warren and his plastic perineal surgery; of Dudley and others in the development of the reduplication of the round ligaments for the correction of the retroverted uterus, etc. While all these endeavors mark the rise of gynecology as a specialty, as distinguished from general surgery, they also hail the advent of the surgery of the upper abdomen as distinguished from pelvic surgery. Stimulated by the fearlessness that characterized the early gynecologic surgeons and encouraged by their triumphant overthrow of prejudice, and what is most important, armed with the panoply of anesthesia and antisepsis, abdominal surgery began its slow and gradual march to its present-day perfection.

There is one very good reason why gynecology should have been the earliest specialty in abdominal surgery. It is no doubt due to the fact that the operative field is superficial and the parts present a greater amount of natural resistance and were more easily drained, so that the risk of operation was not so great as in surgery of the upper abdomen. It is only natural, therefore, that the surgeon of largest experience was to be found among the gynecologists *per se*.

There are one or two commanding figures of the times that can be mentioned without in any way detracting from the glory of that array of lesser lights to whom surgery owes an inestimable debt. In speaking of the renaissance of abdominal surgery one's thoughts naturally revert to the gigantic figure of Lawson Tait. It seems superfluous to more than mention that it was with Tait's epoch-making recognition of the true pathology of pelvic suppuration and his work on the fallopian tubes that gynecology entered into a new era of activity. A close second to this commanding figure is our own Joseph Price, well described as a "bold, rugged, brilliant surgeon," a "militant advocate of the new surgery." Like Tait, Price had to contend against the conservatism of the surgeons and teachers then in authority, and like Tait, he remained callous to criticism and opposition and with singleness of purpose tenaciously forged ahead, bending all his endeavors toward establishing the new surgery. His work was marked by simplicity and thoroughness, and it is no exaggeration to say that, even today, surgery in this country still demonstrates the influence of this master surgeon. We also recall the names of J. Marion Sims, the first to attack the gall-bladder by his drainage operation. But attractive as it may be to recount the early days and dwell on the remarkable progress of abdominal surgery, it is not this aspect of the subject that I have been asked to present at this time, but rather to discuss the effects of the renaissance of general abdominal surgery on gynecology as a specialty.

We, as general and abdominal surgeons, recognize and congratulate you upon the contributions which your predecessors have made. In

the search for truth these men have made invaluable contributions. Few of them knew or thought that the mantle of recognition would fall upon them and that their work would be a beacon light in the future. But little did they care as long as they had the personal satisfaction of having taken a step forward. There is nothing so interesting in the entire history of surgery as this tireless and relentless persistence which led to the conquering of the mysteries of the abdomen. It has meant the alleviation of the suffering of countless thousands and the restoration to perfect health of many more.

Gradually there developed an imaginary line more or less arbitrarily placed, which supposedly differentiated the abdominal from the gynecologic surgeon. The isthmus which joined the two specialties was the ileopectineal line, but years of watchful waiting have shown us that it is a false boundary. It is like taking Alsace and Lorraine from France, eventually, in the evolution of mankind, natural boundaries only are able to withstand the onslaught.

A survey of the work that is being done by those who are known in each specialty indicates quite clearly that none hesitates to invade the field of the other, and that the term abdominal surgeon may well be applied to both. While this may indicate the passing of the gynecologist *per se* it would in no way be contrary to prevalent facts, inasmuch as neither the abdominal surgeon, as we have him with us today, nor the man who claims gynecology as a specialty is practising as a specialist in the accepted sense of the term.

There is a time in every new movement when the pendulum swings to one extreme or the other. This is as true in medicine and surgery as it is in politics and religion. It is characterized by closely drawn lines, by prejudices and by selfishness. A survey of the history of the surgery of the abdomen and pelvis will show that we have just passed through such a period.

There has been, and unfortunately still is, a feeling among some gynecologists that the general surgeon should confine his activities to that region which anatomically lies above the ileopectineal line. There is thus an attempt to create specialists in a domain where specialism frankly does not exist. It is entirely analogous to a situation where an automobile mechanic would tell you he could bore your engine cylinders, but he could not replace the piston rings.

There is no actual separation between that area above and below the ileopectineal line. It is an imaginary, scarcely even a potential separation. It is true that the functions of the viscera in the two portions are not the same, but the problems encountered are closely identical and very frequently coexisting lesions are present.

How then are these to be dealt with? Should the surgeon and gynecologist always be present whenever the abdomen is opened? Even were this in harmony with modern organization and efficiency

it would perhaps be against our better judgment, for just where would the one stop and the other begin? For instance, who would remove the pelvic appendix which has its attachment in the right iliac fossa?

Because of these conflicting problems there has developed, at least among most general abdominal surgeons and gynecologists, a disregard for the supposed domain of the other, each invading whatever area demonstrated pathology regardless of his "supposed" jurisdiction. At first this occurred when operation demonstrated the presence of coexisting lesions, and it has gradually spread so that each specialty came to invade the field of the other for primary lesions. Thus both may more aptly be termed abdominal surgeons, for if the gynecologist is to forsake his birthright he must needs forsake his title also.

A condition such as I have pictured of course presages the passing of the gynecologist. It is not contrary to the facts as they exist today, since finding himself cramped in the narrow confines of the bony pelvis he has emerged into a larger and more liberal field.

In the accepted sense of the term, therefore, neither the abdominal surgeon nor the gynecologist is a specialist, and it would be fitting clearly to meet the issue and openly acknowledge that which both of us are doing by a back door method, for neither of us is devoting attention exclusively to that part of the body which we claim as our specialty.

Anatomically, as I have said, this is impossible. It is not comparable to the specialties of otology and ophthalmology, but is analogous to that of rhinology and laryngology—who would attempt to draw lines between these two?

The solution of the problem lies in openly discarding that which we have not practiced for years. Should not the so-called gynecologist be trained to deal with the lesions of the upper abdomen, just as the general abdominal surgeon should be prepared to apply his skill to pelvic lesions? Neither should have any temerity when the peritoneum is opened in attacking that which the aseptic scalpel has brought to the light of day. And when the mystery is dispelled and truth revealed, the revealer must go ahead with the same confidence of bringing the case to a successful conclusion, as if the diagnosis had been correct.

Surgery by force of circumstance must fall in line with modern accepted economics. We cannot go along groping in the past and ignoring the present. The principles and reasoning I have elaborated I believe to be sound. During this present generation we will see the refinement of the field of the specialist. The modern surgeon who enters the abdomen should know equally well the anatomy, the physiology and the pathology of all that lies within. The problem

of hemostasis, of asepsis and skill in the gentle handling of the viscera are as applicable to the upper as to the lower abdomen.

This striking change is coming regardless of our individual feelings. The patient of the future will entrust himself for operation to the abdominal surgeon who can accurately deal with any lesion he may encounter. He will not accept the greater risk imposed upon him when he accepts the so-called absolutely pelvic specialist. Unquestionably, therefore, the work of the two will converge and be replaced by the one. It does not mean a replacement of either, but a development of both, and as each becomes a craftsman in the field of the other, as they are doing today, their fields will converge and overlap and they will be merged into a homogeneous whole.

Greater progress, no doubt, is assured by the merging of specialities. As Harvey Cushing has aptly said, "When progress ceases to be made through the incentive studies which the smaller field of work permits, there is every reason why the vagrant specialty should be called back under the wing of its parent, general surgery, from which, under no circumstances, should it ever be permitted to wander too far." The time has not, and may never, come when the specialty will go back to the general surgeon, but the time has come when the abdominal surgeon because of broader experience must assume control of the situation.

It may be bold, but I see in the not distant future a realignment of surgery, and in the picture which rises before me I fail to see any one of the nomenclature of a gynecologist. Expediency in surgery, just as in all processes of evolution, demands that those only survive who are capable of dealing with that larger field which lies between the diaphragm and the levator ani.

Unfortunately, also, in our medical schools where the chairs of gynecology and obstetrics coexist there is rarely harmony and nearly always a duplication of teaching. The obstetrician has reached out for the operative side of the diseases of women. He should content himself with the process of gestation and with the normal and abnormal phenomena which occur during it. There is a serious question as to whom the plastic surgery rightly should fall, but we may say that repairs of the pelvic floor should remain with the obstetrician as long as he gives promise of productivity. However, intraabdominal lesions should be turned over to the general abdominal surgeon and the obstetrician should not be permitted to develop a complete Frauenklinik.

There would thus be developed two specialties whose lines are delineable, whose results would be more apt to be proficient, and of whom we could say they have seen the bidding of the times and have answered it.

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