A peek into surgical practice half a century ago

Fifty years ago, 1966, I had been in post as the foundation Professor of Surgery at the old Westminster Medical School (now part of Imperial College, London) for 4 years. My best way of demonstrating surgical practice all those years ago would be to invite you to spend a few days with me and my staff on our wards, operating theatres and outpatient clinics (four a week – two general, one colorectal and one for varicose veins). You would immediately notice considerable differences from today in the frequency of the diseases being treated and in their management.

Treating ulcers

Patients with peptic ulcers thronged the medical and surgical departments, especially with their complications of perforation, haemorrhage and stenosis. The gastric acid aetiology of peptic disease was universally accepted. We had learned as students that strange organisms existed in the highly acid milieu of the stomach but they were regarded as harmless saprophytes; after all, our large gut teems with organisms that, in health, do us no harm.

The medical treatment of peptic ulceration and its complications comprised a bland diet, milk and alkali medicines, and might involve weeks of inpatient treatment. Surgery was reserved for complications or chronicity.

By now, partial gastrectomy, to remove the acid-secreting body of the stomach in duodenal ulcer disease, was being replaced by vagotomy and gastric drainage via gastro-jejunostomy or pyloroplasty. As professor, it was my job to train my registrars to carry out this common operation – two or three a week on our 'firm' – safely and efficiently. Emergency surgery for haemorrhage, perforation or stenosis was a weekly event. If anyone had suggested that the disease could be treated by a course of antibiotics, he or she would have been met with ridicule!

Professor Harold Ellis is Emeritus Professor of Surgery, Guy's, King's and St Thomas' School of Biomedical Sciences, London SE1 1UL

Cancer surgery

Gastric cancer was common, the fourth most common cause of deaths from cancer at that time, after lung, large bowel and breast, and gave us plenty of work. For some unknown reason, and nothing to do with medicine or more sophisticated surgery, its fatal incidence in my lifetime has dropped progressively below cancer of the lung, large bowel, breast, prostate, pancreas and the newly emerging adenocarcinoma of the lower oesophagus. The last, Barrett's oesophagus, was all but unknown in those days.

> "Emergency surgery for haemorrhage, perforation or stenosis was a weekly event. If anyone had suggested that [peptic ulcers] could be treated by a course of antibiotics, he or she would have been met with ridicule!"

Breast cancer, then as now, was the commonest cause of deaths from cancer in women, and formed a large part of the work of the general surgeon. Fifty years ago, radical mastectomy was the standard surgical procedure for operable cases, but I was impressed by the work of David Patey at the Middlesex Hospital and others, and I was performing and teaching simple mastectomy with axillary clearance. (In 1979 I became an early advocate, in this country, of local excision and radiotherapy as standard treatment of so-called 'early' cases of breast malignancy.)

Cholecystectomy

Gallstone disease, then as now, was common and made up a considerable part of the work of the general surgeon. It was not until 1989 that David Rosin performed the first laparoscopic cholecystectomy in England, at St. Mary's Hospital, London, so 50 years ago open cholecystectomy was the standard procedure, again an important operation for teaching our trainees. By now I was performing operative cholangiography to determine whether or not the common bile duct needed to be opened to remove contained bile duct stones.

Surgical complications

The postoperative complication that was much feared was pulmonary embolism, all too commonly fatal and a virtually unsolved problem to the surgical team. The operation of emergency pulmonary embolectomy, performed by thoracotomy on the collapsed and pulseless patient (Trendelenberg's operation), was described in the textbooks, but in the whole of my career I only saw it performed once, and that was unsuccessful. All the work on deep vein thrombosis using radio-labelled fibrinogen, which led to the use of prophylactic low-dose heparin, support stockings and so on was yet to come, some of these studies being carried out on our unit. I have too many unhappy memories to this day of patients, some in their early twenties, with fatal or near-fatal catastrophes as a result of this complication.

The ward round

Perhaps the most surprising feature of this imaginary visit to my unit of the 1960s would be to accompany me on my ward round in 1966. Apart from myself, there would be my lecturer in surgery (the university equivalent of the NHS senior registrar), the surgical registrar, the senior house officer, the house surgeon and the students. Note carefully the titles of my staff – ones that they were proud of – not the numbers and letters now assigned to them, which were no doubt devised by some administrator, that

put them in the status of employees of the NHS rather than as trainees in an ancient and honourable profession.

Unlike today, when in most hospitals patients are scattered over the hospital, each consultant and his/her staff would have his/her own ward, or share a ward with another team of the same speciality.

Presiding over the round would be the ward sister – a formidable woman who knew her patients, nurses and doctors, and who ruled over them all with a rod of iron. All the stories you hear about them are true! Day case surgery did not exist (except for minor procedures carried out in the outpatient theatre and in the accident department), and patients were admitted 1 or even 2 days before surgery. This enabled them to be carefully worked up, studied by the students, and then presented and taught upon by myself on the unit ward round. In sister's office, after the round, any problems would be discussed and the operating list prepared. Later I would meet the students again for a tutorial.

Of course, I am old fashioned but I believe that today we could learn a good deal from the lessons and, of course, from the mistakes we made 50 years ago. I tell you this; I believe we were happier and more fulfilled. **BJHM**

Conflict of interest: none.

KEY POINTS

- Fifty years ago, the surgery of peptic ulcer, gastric cancer and biliary disease (performed by open surgery in the days before laparoscopic surgery) provided much of the routine work of the general surgeon.
- Postoperative pulmonary embolism was a much feared and unsolved surgical complication.
- The 'firm' system was an admirable and effective method of managing patients and training the junior staff – it should be reintroduced forthwith.