The rhetoric of specialization

The 1978 Harvey Cushing oration

C. Rollins Hanlon, M.D.

American College of Surgeons, Chicago, Illinois

The 1978 Cushing Orator shows the role of rhetoric in the process by which various specialties change in response to sociological and legislative demands. He discusses the effect of applying concepts of restraint of trade to medicine, and welcomes a closer liaison through the American College of Surgeons between general surgeons and other surgical specialties.

KEY WORDS • American College of Surgeons • primary care • antitrust laws • specialization

It is a great privilege, by friendship and Presidential choice, to stand at this lectern today. I am painfully aware of the responsibility of this Oration, but I am thankful for the stimulus it gave me to consider, and to discuss with a number of you, certain broad aspects of surgical specialization.

My personal gratitude recalls for me a previous expression of thanks recounted by Harvey Cushing, 50 years ago. The story concerns President Wheelock of Dartmouth College who audited a lecture by the great medical teacher, Nathan Smith, in 1798. President Wheelock was so impressed by Smith's lecture that he came to evening prayers in the old Dartmouth Chapel and gave thanks as follows: "Oh Lord, we thank Thee for the oxygen gas; we thank Thee for the hydrogen gas, and for all the gases. We thank Thee for the cerebrum; we thank Thee for the cerebellum, and for the medulla oblongata. Amen."

Last year's orator, despite his distinction as a teacher, stated he had never before delivered a formal oration. My experience until now with a named oration has been similar, but I cannot duplicate Professor Ginzberg's story of having watched Harvey Cushing operate in 1930. I did work for a year as Research Fellow in the old Hunterian Laboratory at the Johns Hopkins Medical School, where Cushing had presided for a decade after the turn of the century; his yellowed photograph still looked down sharply from its perch on top of the chief diener's rolltop desk, flanked by a full-length statuette of John Hunter. The juxtaposition of these two strong-willed surgical giants always made a great impression on me.

Some years earlier, in 1933 as a pre-medical student, I had spent many Saturday mornings as a visitor in the operating room watching the work of Cushing's successor, Walter Dandy. Dandy's dramatic operations had a strong impact on me and on a pre-medical classmate to whom I periodically described them. One Saturday, he silently joined me in the visitor's gallery as the scalp was being sutured after a craniotomy. I was
C. R. Hanlon

pleased that my friend was so stoic on seeing his first operation on a human being, considering the usual sanguineous state of the drapes and the surgical gowns. Thus, I was not prepared for his precipitate, demoralized departure in search of fresh air during the draping of the next patient, a baby with severe hydrocephalus. Later that afternoon, he confessed by telephone that the use of large, steel safety pins to secure the towels to the scalp had convinced him that neurological surgery was not for the faint-hearted, and he had abruptly and permanently abandoned his neurosurgical aspirations. Indeed, it ended his interest in surgery as a career.

My own interest and activity in neurological surgery did not end with the safety pin episode. The illness of Dandy's two resident surgeons in 1938 elevated me from an intern's position behind the safety of the Mayo stand to the terrifying proximity of a second assistant handling the suction device. This extra, frenetic month on the "brain team" gave the remaining assignments of the intern year the relaxed flavor of a summer vacation and stood me in good stead during later educational experiences with Joseph Evans, Edwin Boldrey, O. W. Jones, and Howard Naffziger. I owe a great debt to all of these neurosurgeons. Each of them gave me far more than the neurology and the neurological surgery they taught so superbly, and I left this part of surgery behind with considerable regret because of my happy association with these outstanding individuals.

The influence of heroes, or, in modern sociological terminology, role-models, was quite evident in my choice of a career. As with many other medical students three or four decades ago, the common alternatives for a life's calling did not lie for me between general practice and specialization. Rather, the choice lay among the various specialties of surgery, somewhat less numerous then. Now there are more surgical specialties, but statistics show a downward trend in applicants for graduate education within these fields, and a sharp rise in the number of those entering so-called "primary care specialties." These changes are a small part of a broad national movement away from science and technology, as brilliantly expressed in C. P. Snow's controversial Rede Lecture in 1959, reviewing a comparable phenomenon in England. 9

In Two Cultures and the Scientific Revolution, Snow stated that scientists live in a world foreign to those trained in the humanities, and the resultant hostility between these worlds has important political consequences. Such effects were exemplified by English political thought between the first and second World Wars, and by the revulsion against war and technology in our own country during the Viet Nam disaster. Of course this debate between science and literary humanism did not begin with Snow and his opponents, but had enlisted distinguished protagonists in the nineteenth century and earlier. Nor were the lines always clearly drawn, for some of the literary figures in England who opposed Snow were anti-science dilettantes with little social conscience, while many of the physicists who initiated and brought to fruition the atomic bomb became the most ardent opponents of the industrial and political extensions of nuclear energy.

Although it took years to mature, a movement to displace science as a benevolent deity in America began with Hiroshima, and its negative effect on support of biological science was strongly apparent in the 1960's. In the 1950's, the upward curve of support for research in medical centers and the proliferation of residency training positions in all specialties fostered a strong hospital orientation for medical care in America. This correlated with the continuing decline in numbers of medical students electing careers in general practice, a trend now conspicuously reversed. A different pattern of so-called "specialization" has emerged, and it is the strong importance of rhetoric in the current evolution of this pattern that I plan to emphasize here.

Dialectics of Medical Specialization

Scholarly books have been written on medical specialization in America; my treatment of only one facet of the problem must be sketchy and inadequate, serving by a few examples to present a viewpoint at variance with current attempts to diminish true specialization.

Simply stated, the term "specialist" in medicine has lost its original meaning in an explosion of sociological rhetoric. Publications from Washington abound in terminology that is not merely obscure, but at
The rhetoric of specialization

variance with the common sense of mankind. This bureaucratic terminology makes no distinction between facts and concepts. If a family has an income of $5,000 annually, that is a fact. If we say the family is financially underprivileged, that is a dialectical term, standing for a somewhat arbitrary concept defined by negatives or privatives.

When one joins such highly personal value judgments to economic theory and to the jargon of cost-benefit ratios sprinkled with legalisms and murky regulations, it is easy to see how the most outrageous contradictions scarcely excite comment. The rhetoric of specialization is no exception.

Rhetoric may be defined most simply as the art of oratory or the art of speaking and writing persuasively. When rhetoric concerns matters of policy it should begin with a dialectic, to establish firm definitions. But it is precisely in this regard that the modern rhetoric of specialization is faulty; far from clarifying the difference between general practice and specialty practice it blurs the distinction by semantic absurdities such as "specialist in breadth." We can scarcely justify this as a harmless figure of speech, a synecdoche that puts the genus for the species for rhetorical effect. Rather, it is a calculated and currently successful maneuver to change the image of the general practitioner. I can tolerate this aggrandizement of a term as I would the change of the term "elevator operator" into "vertical transportation engineer," as long as we do not deceive ourselves into thinking that such individuals are really engineers, or that we should assign the practitioners of this occupation to the maintenance of elevator machinery.

Forget for the moment the public relations forces pressing for abandonment of the term "general practice," and consider as a theoretical exercise how one might transmute the term "generalist" into "specialist." The term "general specialist" would be even more patently absurd than "specialist in breadth," and logic would reject it. More attractive would be the plan to redefine the general practitioner by emphasizing an object of his major attention. This is the way we named the cardiologist, or the proctologist before we replaced the Greek label with the unhappy combination of an English noun for the upper tract and an adjective for the lower reaches, calling the field "colon and rectal surgery."

In the case of the general practitioner, we might select as the object of his treatment not the young or the old, the males or females, but the "family," a dialectical term still in high esteem. Then we might join "family" to "physician," rejecting "family practitioner" as too closely tied to the older term "general practitioner," and stressing the contact with a nostalgically attractive word "family," despite the battering of this entity by the modernists.

The "family" category is obviously widely inclusive, and if one combines this with what nearly everyone needs at some time or another, that is, a first contact with a physician, we have joined "family physician" to "primary care." This makes the scope and task of family practice enormous, and implies that all primary contacts are the province, if not the exclusive domain, of family practice. Thus, we conclude our theoretical exercise in name changing, recognizing that something comparable to this process might well have occurred.

Physicians other than family practitioners are understandably eager not to be excluded from the primary-care movement, especially when it is so all-inclusive and currently so favored by federal funding and private philanthropy. Let us review the reaction of some older, genuine specialties.

In 1975, the internists formed the Federated Council for Internal Medicine (FCIM) which combined the American College of Physicians, the American Society of Internal Medicine, the American Board of Internal Medicine, and the Association of Professors of Medicine into what Franz Ingelfinger, then editor of the New England Journal of Medicine, irreverently called a "League for Beleaguered Internists." Ingelfinger's editorial drew serious admonitions and corrections from his colleagues in the College of Physicians and the Board of Internal Medicine, who were unhappy that anyone should treat lightly their formation of this prudent and reasonable organization.

An internist named Jensen responded less seriously than the others. His letter to the editor provided his own solution to the problem of explaining to his patients the difference between himself, as an internist, and an intern. An internist, he was accustomed to saying, is a pediatrician for adults. The term internist, he felt, did not
properly codify the specialty. His differentiation was that internists "mostly abhor knives, labor, and small children." (I assume he meant obstetrical labor.) Instead of "internists," Jensen suggested "adultricians," "adultologists," "adultrists," "maturists," or "maturicians." He confessed to feeling an impelling need for a new term coming on.

Ingelfinger considered it unavoidable that training time in general practice for internists would mean less emphasis on internal medicine, as such. Despite the statements of his official peers that there would be no lowering of standards of training for internists, it is worth quoting Ingelfinger's closing sentences. "Perhaps, even though the expertise of the internist will be diluted, all will be well. But it is also possible that the term internist will become devaluated, and a less optimistic 'perhaps' is that the internist, like the general practitioner, will feel impelled to find a new name."

In the field of obstetrics and gynecology, there is no obvious push for a new name, but the decision to label the specialty as a primary-care specialty is official and unequivocal. Even the casual listener hears this specialty portrayed in the full flowering of its primary-care role, dislodging the older reality, before the pill, when it straddled the fence between medicine and surgery.

In 1913, Harvey Cushing addressed the changing role of specialists in a speech entitled, "Realignments in Greater Medicine."1 After indicating that manipulative forms of treatment have broken medicine up into further subdivisions based largely on anatomic lines, he went on to say, "Even the obstetrician — the half brother of the physician and surgeon — reaches for the operative side of the diseases of women, with the complete Frauenklinik in mind." One wonders if Cushing had any idea of the extent to which the concept of "woman's clinic" and "woman's physician" might be taken over by obstetrics and gynecology.

In the past, the world has applauded the magnificent achievements of scientific obstetrics as it moved to understand more fully and to deal more safely with the process of birth in all its complexity. Similarly, the results of trauma to the birth canal, and certain other disorders peculiar to women, have been treated more successfully as a result of advances in modern, operative gynecology. It has long been recognized that the manipulative aspects of both gynecology and obstetrics are founded on the same fundamentals of asepsis, gentle handling of tissues, and applied knowledge of wound healing that undergird all surgical disciplines. With the explosive advances in knowledge of reproductive physiology and hormonal therapeutics, the medical aspects of this combined specialty were at the same time moved forward and rendered more complex.

The pressures for division of this medical-surgical relationship have been evidenced for decades by organizational stresses in medical school faculties and by the segmentation of obstetrical-gynecological practice into patterns wherein some practitioners may totally eschew obstetrical work. None of these objective, evolutionary processes are as profound as the rhetorical dicta which officially denote the function of the obstetrician-gynecologists as primary-care physicians. A statement from the American College of Obstetricians and Gynecologists is as follows: "To a large number of American women the obstetrician-gynecologist is the principal source of medical care and advice and, in this sense, has functioned as their primary physician. This practice has not only been acceptable, but has provided continuity of care that might otherwise not have been achieved. This pattern is unlikely to change, but rather to increase. The College accepts this responsibility and will include the concept of primary care to women in its various activities, including resident and continuing education."1

As a result of such special pleading, the Coordinating Council on Medical Education (CCME) voted to accept obstetrics-gynecology as one of the primary-care specialties, although the United States Congress in the Health Professions Educational Assistance Act of 1976 (P.L. 94-484) omitted obstetrics and gynecology from its definition of primary care. A spokesman for obstetrics and gynecology has attributed Congressional rejection of their thesis not to a philosophical disagreement over the inclusion of obstetrics-gynecology in the primary-care category, but to the "political importance of the percentages for minimum residency training positions...."8 In other words, Congress wanted the number of positions labeled as available for residency training in primary care to be as low as possible.
The rhetoric of specialization

This numbers game has occupied Congress and the medical profession in extended dialogue over several years. Now that prescriptive legislation has hardened the mushy stipulation by primary-care advocates that fixed percentages of all graduating physicians must be herded into first-year primary-care training positions, we find that the 1979 legislative goal in P.L. 94-484 (that 50% of such positions be allocated to primary-care specialties) has already been exceeded. Having refused to listen to specific testimony that legislation was hardly needed to reach a goal we were inexorably approaching by way of market mechanisms, the Congress is now going to be asked to raise the 50% figure to 60% or 70%.

Why, you ask, is it necessary to raise the figure? The usual answer given is “leakage” — a term denoting mainly the passage of general internists into medical specialties, such as cardiology and gastroenterology. What is the prescription for treating the loss of generalists from this leaky barrel of internal medicine? Is it to stop the leaks by institution of programs such as “primary-care tracks” in internal medicine? No; it is to provide 10% to 20% greater capacity in the barrel while the leakage into medical specialties goes steadily on.

Although such additions to the general internal medicine barrel may do little to increase the number of those who persist as generalists or as first-contact specialists, it obviously has a limiting effect on all specialties not grouped under the favored heading of primary care. If 70% of our medical school graduates go into primary-care positions, one needs no calculator to realize that the surgeons, anesthesiologists, pathologists, psychiatrists, and others will be scrambling to perpetuate their kind from a pool that contains only 30% of available graduates each year.

With obstetrics-gynecology half in, half out of the favored category, and internal medicine still firmly in place despite the leakage phenomenon, what of family practice and pediatrics? Family practice trainees are increasing so rapidly that the questions of what, where, how, and by whom they shall be taught are major problems. Concern over the quality of their educational programs has been quietly expressed by some spokesmen. Family practice programs are attempting to persuade, cajole, or coerce various other specialties into providing technical, educational programs for residents in family practice. The pressure is widespread and intense on surgical program directors to do this. It is said that this movement is designed to orient such residents in surgery rather than to train them for attempting operative procedures on their own; such assertions have a hollow ring when viewed alongside widespread efforts for extended hospital privileges for family practitioners. My personal views on this matter have received substantial exposure of late and need not be reviewed here.

An executive of a national radiological organization mentions a Midwestern family-practice program that is insisting on having its residents make x-ray films personally, to permit family physicians to establish their own radiological facilities and evaluate their own radiographic examinations. He notes that this effort seems unlikely to win endorsement by his own radiological organization.

As for pediatrics, there seems to be less friction between pediatricians and family physicians, perhaps because the pediatricians have focused on their collaboration with nurses. The continuing development of shared responsibility between pediatricians and nurses has led to development of the “pediatric nurse practitioner” (PNP) and the “pediatric nurse associate” (PNA) as synonymous terms. More than 3500 individuals have been graduated from some 50 PNA educational programs. Perhaps half of them function in community health and ambulatory care settings, while 15% to 20% are employed by private physicians. They are trained to perform complete physical examinations and to manage health supervision visits, as well as to treat certain minor illnesses. In performing the medical aspects of their role, however, PNA’s must function with the supervision of physicians.

The American Academy of Pediatrics has had a collaborative relationship with the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP); — even the acronym has a happy, postprandial connotation. In 1975, these two organizations formed the National Board of Pediatric Nurse Practitioners and Associates to develop a National Qualifying Examination. It will be interesting to observe the relation of this collaborative model to another entity,
the National Joint Practice Commission of the AMA and the American Nurses Association. Formed in 1972 to define the authority, responsibility, and operations of each profession, it has recently set out to establish a position of greater autonomy for nursing in the hospital administration and to test such concepts in a well-funded hospital demonstration project on joint practice patterns. The supervisory role of physicians over nurses portrayed in the PNA concept is clearly challenged by this Commission's philosophy.

The FTC and Restraint of Trade

I have mentioned a few of the amiable or not so amiable relations between groups within the medical profession and between the medical profession and allied health professionals. Most groups are concerned with upward mobility as it concerns tasks, responsibility, and authority. As autonomy develops, unmet educational or financial demands become apparent.

Spokesmen for the Federal Trade Commission (FTC), as part of their wide-ranging attack on certain practices of the learned profession, have stated that any professional activities which may have anticompetitive effects, such as limiting entry to the specialized field of activity, even if based on considerations of quality and expertise, may be in violation of antitrust laws. Because all consumers cannot afford the highest quality, says a spokesman for the FTC, it would be appropriate, from the antitrust point of view, to keep in mind the public interest in supplying enough professionals to allow consumer choice on quality grounds. Simplifying that sentence and applying it to the surgical field, it seems to say we must supply two or more levels of surgical quality. If we are to follow the FTC directives permitting advertising, shall we then advertise surgical care as good, choice, and prime, with prices appropriate to the quality of the product and the pocketbook of the purchaser? To put it bluntly, does the FTC threaten to constrain us to provide low-quality surgical care?

And if the FTC should lack for ideas of new mischief, it has been recently made aware by circular letter of a new organization, the American Council of Non-Board Certified Physicians (ACNP). The ACNP cites plans for collecting monies to engage an experienced antitrust lawyer to take legal action against the Specialty Boards for restraining the trade of non-certified physicians.

The question of adequate quality does not originate only in relations within medicine, or allied health professions, or from the Federal bureaucracy. We are being sued to force us to deal as professional equals with so-called limited-license practitioners whom organized medicine has for generations denounced as unscientific and unworthy of professional association in our practice. Let no one believe that acquiescent recognition of such practitioners as professional colleagues of hospital-based medical specialists will not lead to further demands for privileges predicated on the gains exacted by out-of-court settlements. It is absurd to speak and work for scientific progress in medical meetings such as this one, and at the same time to throw away all standards by agreeing to deal with limited-license individuals as professional equals. We must recognize, however, the threat that such repugnant associations may be enforced on us by the courts, if not by legislation.

And what of neurosurgery? Yesterday, your president delivered a thoughtful and courageous address, appropriately focused on the concept of excellence in neurosurgery, with a bold plan for achieving it by voluntary peer review and by regional disposition of resources. His wide-ranging analysis of neurosurgical intraspecialty organizations and their amalgamation is a family matter on which I will not presume to intrude. Clearly, this issue has been regularly and vigorously addressed since Frank Mayfield’s proclamation of 1965, and a substantial degree of concord has been achieved.

Such continuing, satisfactory progress toward full resolution of your interorganizational arrangements should be easier than regionalization, in which interrelations with other specialties at a given institution make concentration of care a complex problem. All of us know that formidable personality issues, both human and institutional, stand in the way of a conjunction of societies, just as these issues obstruct the designation of an institution as regionally pre-eminent. Knowing the fierce competition between institutions for the prestige associated with the most modern equipment, not to mention the economic advantage of certain diagnostic instruments, it
The rhetoric of specialization

is easy to predict a rocky road for plans to develop a hospital or service that is to be proclaimed as first among equals. Such rocky prospects should certainly not dissuade us from the effort. But, if unselfishness should prevail, will not the FTC label the resulting cooperation as collusion and restriction of competition?

Role of The American College of Surgeons

Your President spoke also of the newly-strengthened relationship between neurological surgery and the American College of Surgeons. This newly constructed alliance, both organizational and educational, is not only an added source of strength for our two organizations, but an archetype of similar relations we hope may develop with other specialties in surgery. Each surgical specialty has its peculiar problems, related to its size, its maturity, its internal consistency or fragmentation, its clear or obscure sense of mission, and the way in which it perceives its relation to the whole of surgery and to the entire medical profession.

I must emphasize here a point alluded to yesterday by your President: that the Fellows in specialties other than general surgery now comprise a portion of our College Fellowship 8% larger than the segment of Fellows in general surgery. Bear in mind that general surgery has its own peculiar problems, not the least of which is its diminution in scope as each new ultraspecialized surgical segment demarcates its own field of expertise. As an administrator and sometime mediator, I am resigned to the everlasting presence of jurisdictional disputes, especially in areas such as the neck and face, where a topographic discipline may compete with one rooted in oncology or with another oriented toward reconstruction. It is pointless and even destructive for these individual surgical disciplines to spend their efforts in divisive, internal struggles which divert attention from the external enemy, who may not even possess a legitimate background in scientific medicine.

The College continues to pursue diligently the critically important goal of closer liaison with all surgical disciplines. It has done this by interdisciplinary programming, by encouraging specialists to participate in Chapter activities, by liaison through the specialty Advisory Councils, by specialty society Governors, and by Regents and Officers drawn from a wide range of specialties, including many from neurological surgery. We are planning an even more intensive liaison with the surgical specialties by seeking a senior liaison officer whose efforts will be directed at educational and general relations with all specialties in the profession of medicine, especially in surgery.

The role of the so-called “umbrella organization” is difficult to delineate precisely, because of evolving changes in its constituencies, inevitable alteration in the national milieu and a gradual evolution of the umbrella organization’s own idea of its mission and programs. Just as each surgical specialty society related to the American College of Surgeons looks two ways, toward its specialist members on the one hand and toward the larger College on the other, so the College looks one way toward its component specialties and the other way toward certain federated organizations in medicine, such as the American Medical Association (AMA) and the Council of Medical Specialty Societies (CMSS).

Lack of space dictates only a bare mention of the differences in organization between the centralist American College of Surgeons and the federation that is the AMA, or between the organization, membership, and functional character of the CMSS and the AMA. In the short history of the CMSS, it has gone from a “Tri-College Council,” composed of three major specialty Colleges representing internists, obstetrician-gynecologists, and surgeons, to a variegated constituency embracing 22 organizations with the common denominator of a certain type of certifying board for their members. One of the founding Colleges (obstetrics-gynecology), as reviewed earlier, has now put on the rhetorical cloak of “primary care.” A later entrant to CMSS, the American Academy of Family Physicians, was admitted under the anomalous catch phrase of a specialty-in-breadth, after its members negotiated the terminological passage from general practitioner through family practitioner to family physician. It is a curious fact that the inability of the three largest specialty Colleges to secure significant representation in the AMA House of Delegates led to formation of the Tri-College Council, now transmuted into the
C. R. Hanlon

CMSS. Meanwhile, the generalists, whose dominance in AMA policy initiated the formation of the CMSS, have become a powerful force in the CMSS under the new rhetoric of specialization, while the AMA at long last has begun at least a token representation of specialty societies in its House of Delegates.

In summary, I have analyzed the status of specialization in medicine today from the viewpoint of rhetoric, a force that moves men and nations. Seventy years ago, the distinguished pupil of Victor Horsley, Wilfred Trotter, made his fundamental contribution to the literature of applied psychology in two papers on the "Herd Instinct." These seminal papers were republished in a little book at the start of the Great War in 1915. Despite debate as to their validity, they gave a new significance to the entire sociological thought of the early twentieth century. This is surely an astounding accomplishment for a young surgeon whose work in head injuries and in malignancy of the pharynx has been largely forgotten today, although he will never be forgotten by the students and colleagues he taught during a 50-year clinical association with the University College in London.

Trotter examined man’s "opinions, his credulities, his disbeliefs and his weaknesses . . . his altruisms, his charity, his enthusiasm and his power." These were the forces that moved men, both isolated and in crowds. Trotter’s thesis, biased as it may be, was presented with a command of language and a penetrating wit that illuminates the dreary landscape comprising much of the writing on sociology in his time as well as today. It carries us back to Socrates and his philosophical descendants, who thought deeply and significantly on the differences between opinion and knowledge, and whose reflections on rhetoric, as language moving men to action, are applicable with even greater force in the present world of electronic media than in the groves of Plato’s Academe.

Weaver has shown us that rhetorical force is a power transmitted through the links of a chain extending up toward some ultimate source. There are supreme terms in rhetoric which silence all other rhetoric. Examples are well known to all of us, “progress,” “happiness,” “freedom.” We do not ordinarily think of words such as “defense” and “war effort” in this same category, but during our “popular” wars preceding Viet Nam, every departure from our normal way of life was justified in terms of “defense” or the “war effort.” Terms of “bad” rhetoric are equally effective, as the word “infidel,” which moved thousands of men to their deaths in the Crusades. Now we have the magic of “primary care” to divert us from the established benefits of a specialization that has brought us to a position of unparalleled progress in science and in medicine. Fuzzy in definition, ruthless in its legislative enactments, and palpably contradictory in its terminology, it nonetheless has been moved up to a level of ultimate strength in contemporary rhetoric, as were the words “war effort” in the days after Pearl Harbor.

Some may feel it inappropriate, or even precious, that a matter touching so intimately our nation’s health should be treated in Aristotelian terms or, worse, that its treatment be infused with anything approaching wit. They would prefer to approach it by committees, or even commissions, large and scrupulously balanced as to sex and ethnicity, to generate after several years of highly expensive labor a study couched in impenetrable language beloved by modern sociology. The elaborateness of much of this social engineering language fails to conceal the smuggled assumptions and shallow sophistries apparent on close analysis.

As for the light treatment of serious matters, Chesterton once stated, in effect, that the best approach to grave matters was to study them with extreme care and diligence and to present them with the utmost levity. In our review here, I have felt that the painless incongruity of a little humor is a welcome relief from the endlessly serious study of what one fears may be insoluble problems.

Entire peoples under monstrous tyrannies have taken refuge in so-called “black humor,” as when Russians under the Stalinist terror used to mock the widespread, official sycophancy with the expression: “When Stalin has a cold, all Russia sneezes.” Victims of oppression have always had gallows humor as an anodyne. Let me close with a comment about the great author and statesman, scholar and saint, who refused to compromise the truth even though he knew it would cost him his head on trumped-up charges of treason. Sir Thomas More on the scaffold said to his headman, “Wait till I put aside my beard, for that never committed
The rhetoric of specialization
treason.” By the beard of our own rhetoric, let us not be treasonable to the principles of excellence that infuse true specialization.

References

The 1978 Harvey Cushing oration was delivered at the Annual Meeting of the American Association of Neurological Surgeons, New Orleans, Louisiana, April 25, 1978.

Address reprint requests to: C. Rollins Hanlon, M.D., American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.