NEUROSURGERY IS WHAT YOU MAKE IT*

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AT THE BEGINNING

The middle thirties was a stimulating period for neurosurgeons. The new specialty was about halfway through the years of expansion, with an increasing demand for its services. This expansion was not yet apparent to the general medical profession. There was still some unbelief about the practicalness of such a restricted field. Because neurosurgery dealt chiefly with the brain its votaries appeared to move in a rather exotic atmosphere. Almost all of the members of the Harvey Cushing Society were professors, major or minor.

Into this galaxy two unorthodox members were introduced. They were starting to practice neurosurgery in far western communities that did not boast of medical schools. The entrance of Dr. Haven of Seattle and myself from Vancouver illustrates the dictum that there are no absolute truths. We never did hear the reason. We would like to think that it was because of the interest of Dr. Cushing himself, but he hardly knew us. When I first met Harvey Cushing in 1932, and again in 1935, he seldom saw me except in the company of Dr. Ken McKenzie. So I became, as I supposed happened to Hale Haven, what Dr. Cushing termed a “spiritual grandson.”

During my early years in the Society I was always chagrined to admit that there was no medical school in Vancouver. One missed the atmosphere of the teaching center when away out West and always felt like a student again, when back. Later on, the large centers seemed to lose some of their glamour. Envy for opposite numbers changed to a wonder if they would not like to trade places. There came a day when one enjoyed, as always, meeting university colleagues, but welcomed a return to the “wide open spaces.” I could not say this with free conscience next year, for this fall, at long last, a medical school is due to open at the University of British Columbia, in Vancouver.

Since the policy of this Society was changed from that of a small, restricted group to the equivalent of a National or North American Association, there has been a rapid growth of our membership. The expansion has been paralleled by an increase in the proportion of members who do not have direct affiliations with teaching or research institutions. To these men, in particular, I address my preliminary remarks.

The introduction of a new specialty in medicine to a community is seldom

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the occasion for a committee of welcome. A few leaders in the local profession will say, with conviction, that "there is always room for a well trained man." They will help to set the stage for the neophyte by arranging a suitable hospital appointment and then, as a sympathetic audience, sit back to watch Act One unfold. The remainder of the doctors will appear to be singularly disinterested. They have hitherto not recognized any special need. Patients in the new category may be a rarity in their experience. Or they may always have treated, with satisfaction, the lesser conditions in the new field, and hold the conviction that what they cannot treat should go to another center, preferably far away.

One’s early experience in actual practice is apt to shatter the complacency that years of sheltered post-graduate study usually provide. The first patient who appeared on my doorstep complained of blurred vision, and had some obscure form of retinal degeneration. I was almost as shocked by his name as by my failure to recognize his disease. His family name and surname were the same as a very distinguished neuropathologist. The significance of this curious coincidence I was never able to fathom. If the first surgical case had presented himself with the same name I might have heeded the obvious warning and been spared an ordeal. There was little doubt that this patient had a brain tumour but localizing evidence was not overly clear. It was a shock to find that the gallery was crowded with interns, nurses, and a generous sprinkling of staff doctors. After expertly turning down a bone flap I was unable to remove the tumour. Indeed, I could not find it. The audience would have regarded removal of that tumour as a near-miracle. Having seen one try hard and fail, they were satisfied and friendly. The decision to take up a life of logging or fishing, which had been resolved by the operator during the course of his unsuccessful endeavour, was abandoned. A career in neurosurgery was launched.

Fifteen to twenty years ago it was easier for a neurosurgeon to obtain special dispensation for equipment and operating room than it is today. There was no need for reserved beds. Most of the major neurosurgical operations were tedious, and impressive by virtue of their length. “How do you ever stand those long operations?” was the daily query of our colleagues. Only the irreverent asked “What are you doing all that time?” Nowadays, our operating time corresponds with the average major procedure in general surgery. Operation on the chest and heart may be much longer and perhaps more impressive. A bone flap for brain tumour is inconspicuous on the daily operative list of a large general hospital. Any air of grandeur which might still have lingered has been dissipated by the very serious pressure for hospital beds, which makes even our most sympathetic colleagues look with a jaundiced eye on special indulgence.

To accomplish good neurosurgery in a non-teaching general hospital, within the framework of a department of general surgery, requires a certain tenacity of purpose. Whether one works exclusively in a single, specially designed operating room, or in several different hospitals, or in six different