

Lessons

Arthur S. McFee, MD

Not a part of this article, but equally important in my mind, is an order of business that I want to note. This past summer saw the death of an individual who was a good friend to Iris and me, who labored long and productively in the surgical vineyard, and who became a genuine figure in American medicine, Dr Claude Organ. I wish to mark his passing with a statement of my profound respect and affection for him. He made a significant mark on our profession, which few are privileged to do. I, for one, will miss him sorely; the Western Surgical Association has lost a true pillar in its structure and we are the poorer in consequence. I would ask those who knew him to pause to recall him and something he did for them.

Although the dangers associated with the office of president of the Western Surgical Association are, for all intents and purposes, nominal, the prospect of the presidential address is with one for an entire year and can be daunting. I reviewed at least three quarters of such addresses given before this organization. They fell into well-defined groups: 25% had to do with operations and techniques, many now quite imaginative; nearly one eighth have been devoted exclusively to the Western Surgical Association and its development; at least one half have been concerned with social problems (ethics, fees, costs, split charges, and the like); and the balance dealt with history. There are eminently quotable comments and some very odd views. I have elected to rely on something that I know well: my own experience.

For this talk, I want to review some of the situations I have encountered personally in 3½ decades of helping to develop 2 surgical departments in 2 new hospitals. We did many things right and some wrong. There are some object lessons to be learned. There is, as always, a disclaimer. The views expressed are mine. They have not been expressed elsewhere; they are not supported by independent research or study; they are not the views of the University of Texas Health Science Center at San Antonio and probably not of all my colleagues; certainly they are not the views of the US Navy.

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Quite possibly, the first lesson I learned from my review of presidential addresses is the distinction in American surgery held by a number of the presidents of this organization. It is a singular honor to be invited to join this group, especially in the light of their individual and collective contributions to the art. We (Iris and I) became part of the Western Surgical Association family in 1975. We have been privileged to serve as a couple in at least one half of the available offices. Each role has provided an entirely different challenge; all of them have been enjoyable and vastly rewarding. In each we were privileged to meet some of the kindest and the most effective people we have known, and we truly felt that in 2002 our service then as first vice president was full and complete. The nomination to the presidency in the fall of 2004

was indeed unexpected, but I simply do not have the intestinal fortitude of a very recent predecessor in this office and a good friend to congratulate the nominating committee for its work. I would be less than honest, however, if I said I disagreed with them. We are grateful that we have been asked to serve in this very distinguished position and can only say "thank you" as directly as possible.

USS REPOSE

I graduated from medical school in June 1957. In January 1959, the Texas state legislature called the South Texas Medical School into existence. On June 15, 1965, the *USS Repose* (AH16) was moved from moth balls into the Hunters Point Naval Shipyard in California to begin refitting for duty in Vietnam. I completed my surgical residency in November 1965. I had no idea that my entire professional career would center on these 2 recorded events and the development of surgical services from the ground up in 2 new hospitals. It was to prove a very enlightening series of experiences.

The *Repose* was constructed as a cargo hull in 1943 and 1944. It was one of a series of the largest hulls then built for World War II. One of 6 sister hospital ships, she saw service in World War II and Korea. One of these 6 ships became the justly famous hospital ship *Hope*; 1 sank in 1951 having collided with a merchant ship off San Francisco during sea trials. That event required 17 minutes and cost 50 lives. For all intents and purposes, in 1965, the *Repose* was a worn-out ship with an antiquated engine system and a hull that had been repaired after major damage in Korea during a typhoon. The ship displaced 17 000 tons and could receive more than 750 patients. Hospital ships today are much larger, displacing 190 000 tons but still receiving approximately the same 1000 patients. They are built in super-tanker hulls. Comparisons of the *Repose* and the *Mercy* are significant for similarities and basic design flaws: without a full load, there is a great tendency to be top heavy and a need for much ballast.

My presence on the ship was a fluke. I was a 2-year US Naval Reserve Berry Plan resident. I owed my position on the *Repose* to my chief, Dr Owen Wangenstein, bringing me to the attention of the then naval surgeon general, Admiral Robert Brown. The position was a great gift for me. It taught me trauma, it showed me how to act successfully in a very regulated society with layers of bureaucracy, and it provided me a totally unprecedented opportunity to face a group that I had never experienced before. It was a magnificent learning experience. Three major lessons came from this experience, 2 negative and 1 positive.

Each of the ships in the Navy has an initial outfitting list, which encompasses all the items on the ship when it is first commissioned. It is reproduced exactly with each new outfitting. This list gave us much medical equipment (some ordered and some built specifically) that was current in 1944 but not useable in 1966. Other items did not anticipate the needs of an active war zone in 1966. As we made our way to Vietnam, the medical staff, who were warmly welcomed by hospitals in Hawaii and the Philippines, rapidly became pariahs as we set out to obtain equipment that was current or had been overlooked. Newer ships are, in many respects, much more up-to-date than ours. Certainly they are not state-of-the-art in all medical tech-

nology because that is an impossible situation to attain, requiring a complete refit on a fairly frequent basis. Additionally, as we made our way across the Pacific Ocean, it became increasingly clear that the power sources on the ship were simply not reliable. They were outdated and worn out. Power failures in mid-ocean were not uncommon, and in July 1966, we were required to spend 1 month at the Japanese naval base in Yokosuka to rebuild and replace the engines. An absolute requirement of a hospital ship is an effective and reproducible source of power. Attaining this requirement should have been priority 1 prior to sailing, probably more than current equipment. Of course, no one objected to the stay in Japan, and ultimately the repairs probably saved the ship in the following fall.

In November 1966 in Subic Bay, we had a rather elaborate change-of-command ceremony. The captain of the ship retired and was replaced by a US Naval Reserve active-duty captain. He was known as a bit of a martinet with an aim to increase naval discipline on the ship. One of his icons was adherence to preordered schedules. Thus, 7 days after the ceremony, exactly as scheduled, we left Subic Bay into the only typhoon that ocean had in months. The resulting voyage more than doubled the travel time to Vietnam and subjected the ship to such extremely long rolls that most of the crew, the hospital staff, and 300-plus patients were terrified. My own personal feeling is that had we not undergone a complete overhaul of the engines and power supply of the ship 3 months previously, there is a strong likelihood that we would not have come through that storm. I understand the outcome of this decision to sail cost the captain 7 months of his independent command.

Here are instances of things that we did wrong. Two lessons are apparent. First is the obvious need for simple common sense providing up-to-date equipment for a hospital and being certain that the basic power supply of both the hospital and the ship was reliable and effective. Probably we should have re-examined the outfitting list and spent the additional month rebuilding the power supply before the ship left port initially. The second issue involves both common sense and courage. Common sense should have been effective in a decision that resulted in needlessly exposing an old vessel to certain danger from a fairly violent storm. The second lesson is the lack of courage in facing that issue exactly as it arose and requesting a postponement or delay of sailing because there was simply no pressing demand for the ship to leave as it did, except for the arbitrary demands of scheduling.

When I joined the *Repose* in January 1966, I was shown my responsibility: a massive iron box with many support stanchions to which were attached 48 bunks (24 lower and 24 upper). A bunk was about 2½ × 7 feet with a single layer of coils attached to metal strips and a mattress about 4 inches thick. The lower bunks were permanent, the uppers removable. It was destined to become an intensive care unit (ICU). My first move on assuming the charge of this ward was to discuss with the chief nurse of the hospital a major departure from naval routine, the rotation of personnel. I proposed that she choose a complement of corpsmen for this unit and guarantee them for 1 year. In return, I would take their training in intensive care over and above what they had received in corps school. Graciously, she accepted. Other changes were much easier; the upper bunks

went and some lower bunks gave way to fracture beds. We established a unit of 17 intensive care beds, about the proper proportion for a hospital of that capacity.

In my mind, this is something we did right. The group of corpsmen were all in their late teens and early 20s, with little training beyond high school and that received as corpsman. They were not professional; their enthusiasm was boundless, and their loyalty to their task unending. They realized, consciously or not, that the focus of their work was the group of patients in that unit. All they needed was some direction. The lesson that I learned from this group was that an ICU could be constructed under the most adverse circumstances with basic personnel. If the workers knew what they were doing and could observe the patient, they were dependable and accurate. This ICU had no elaborate monitors built in, no suction systems, and no piped-in gas; the initial observer was responsible for the patient and noting his changes. It remained intact as a unit for 12½ months of my duty on the ship and was responsible for a number of minor miracles.

The lesson is obvious; in medicine, especially in the medicine of today as it was 3½ decades ago, patient observation and care are essential to a favorable outcome and cannot in any way be overestimated. Intensive care is given by people and not by machines. In the course of my year on that ship, we lost only 1 member of this team to an unpardonable infraction in my mind, the falsification of vital signs on a patient on his shift. The young man petitioned to return to the ICU, and, quite possibly, I was wrong in not accepting him back. I think, however, I was right in emphasizing to the team that I had put a great deal of faith in their observations regardless of the situation.

Of late, this concept of the primacy of patient care in academic medicine has come under some review. My strong feeling is that, in all branches of our profession, the patient is prime and any move to certify other aims, however well intended, is fraught with the possibility of getting something wrong. Although education is important in accredited surgery, education without the patient as its focus is meaningless.

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO

In July 1965, rather informally, Dr J. Bradley Aust asked me if I would join him in San Antonio in a new department and a new school. I reminded him of my obligation to the Navy and he replied that the offer was a good fit since the hospital and school had not yet been built. I arrived in San Antonio in January 1968 and found a situation that could be a justification of the adage, "Be careful what you hope for because you may get it."

The first University of Texas Medical School was founded in Galveston in 1881; the second, in 1949 in Dallas. Efforts to move the Galveston school to San Antonio were evident as early as the 1920s and were finally definitively squashed in 1944. In the mid 1940s, significant efforts to site a medical school in San Antonio were undertaken. After 1945, they were under the direction of the San Antonio Medical Foundation. The foundation was a small group of medical practitioners who were in general very astute and visionary. They were led in part by a very canny and able medical politician,

Dr John M. Smith, Jr. This group lobbied, fought, and acquired land in open farm country northwest of the city (greater than 1000 acres and far from downtown San Antonio) when such land was available and cheap.

After more than 1½ decades of activity that included the medical community, the military base commanders, and the archdiocese, a medical school in San Antonio was authorized by the legislature in 1959. A codicil to this legislation required that a teaching hospital be built within 1 mile of the school. It was an effort to defeat the enterprise completely, based on the expectation of tepid local support. Promptly, the medical foundation donated 100 acres of their land to the university for the school, thereby locating it northwest of metropolitan San Antonio where growth was still possible. It should be noted that a rather bitter fight had taken place between the medical foundation, which wanted the school sited outside of the city, where a center could grow and where they owned land, and a group favoring a site downtown, where the patients lived. Remnants of this disagreement still exist. Nonetheless, the gift ensured that the school would be outside of the metropolitan area with plenty of room to grow and develop. Health science centers in both Houston and Dallas at that time were then entirely surrounded by large urban developments. Their growth could only be up. Today in 2005, 175 acres of land still exist undeveloped in the Health Science Center for growth, even though San Antonio as a city has come to surround the entire complex.

In 1967, 8 years after the school was created, 2 years into actual construction, and more than 1 year into active faculty recruitment, a real problem developed. Bexar County, which had voted an enthusiastic bond issue to build a new county teaching hospital, was faced with the annual funding of the institution. The problem was simple. The county property tax rate was set at \$0.75 per \$100 valuation, and valuation was set at 25% of the real market value of the property. When computed, there was simply not enough county money to run a hospital. The obvious solution—to tax for the hospital district at a higher percentage rate of market value—was presented as a voter referendum in January 1967; it was resoundingly defeated. A state legislative mandate to allow Bexar and Dallas County Commissioners to tax at a 50% rate for their hospital districts quickly passed and was accepted in Bexar County by 3 very courageous commissioners out of 5 on the county board. Texas is not a state prone to approve taxes. The action ensured that the hospital construction could continue.

Thus, we had a hospital and a school. The school was built by the state; the hospital was built by the county, which had enthusiastically voted its construction and reluctantly paid a portion of its annual cost. Three and one-half decades later, the annual hospital budget, which was \$16 million in its first year (1969), is now just short of \$600 million a year. The 2 institutions were noted by the chamber of commerce of the city in 2004 as the central dynamos of a local health care industry of \$1½ billion annually.

These actions were remarkable moves in getting something right. The foundation acquired land cheaply and still controls much of it. Consequently, we have the largest health science center in the University of Texas system with still a great deal of potential for lateral growth. For the members of the medical foundation, it was example of setting out to do good and doing very well indeed. Individuals form-

ing the San Antonio Medical Foundation in essence put their money where they spoke and have, in the course of time, enjoyed an appropriate reward.

The basic lessons are obvious; showing vision, persistence for more than 1½ decades in the face of failure and rejection, and the courage to take a calculated risk paid off handsomely. In retrospect, the decision to locate the health science center apart from metropolitan San Antonio was entirely correct but bitterly opposed at the time. It has been justified by the growth of the city.

With regard to the adage “be careful what you hope for because you may get it,” there is no lack of evidence that our community worked hard over more than 2 decades to procure a medical school in San Antonio in the face of repeated failure. No one, however, informed all those involved in support of the school effort exactly what they would get if and when it came to pass.

In the 1960s, San Antonio was a notably unsophisticated medical community. Medicine was dominated by the general practitioner who did much of the actual procedural operating. Referrals were among close friends. Hospitals were open, the staffs loosely run. The irruption of a medical school into such a community was no insignificant item. Whatever supporters collectively or individually expected for their efforts, it certainly was not what they got.

From 1967, a series of revelations came to the San Antonio medical community. Probably the first one was that faculty members would be recruited. The local practitioners would not automatically be selected with an appropriate rank and stipend. Second was that the new community hospital would bring a whole new concept to the city, the closed-staff hospital requiring certification as a basic criterion for membership. It does not take much imagination to realize that righteous indignation aroused by the first revelation could turn into downright hostility when most of the medical community found that they were not even eligible to practice in their new hospital, built with a local bond issue and funded by local taxes.

This situation in 1968 and 1969 was not in any way helped by the arrival of the first chair in medicine and physiology. Bright, arrogant, brash, and dangerously outspoken, he allowed himself to be quoted widely in the news media to the effect that “20th-century medicine had finally reached San Antonio” and “one quarter of a million underserved Hispanics would now be treated well for the first time.” As Basil Pruitt has observed to me, that he may have been right had little bearing on the issue. Many of the readers of these items had been providing the disparaged care on a pro bono basis for a long time. The upshot was a major town-gown rift in which the school rapidly came to be recognized as a business competitor. Faculty membership became an automatic reason for denial of hospital privileges outside the county institution. Nearly 4 decades have been required to negate much of this animosity, and a great deal still remains.

That same department chair was an eminently jealous guardian of turf. Within the department of medicine and physiology, the division of hematology provided the scene of a final major clash. The department of pathology had engaged 3 individuals who provided by far the best hands-on hematological service I have ever seen. They were present when needed personally in the operating room. Their advice was sound and backed by quick action. By contrast,

the medical group was largely theoretical, “hands off,” and had little to do with actual surgical problems. We regarded them as incompetent and unnecessary. It was, however, an article of faith for the department of medicine that members of the department of pathology should not have clinical practices. I happened to be the consulting surgeon on the specific case that set off a major and final in-house controversy. That issue, together with 3 years of mounting political pressure on the dean and the university regents about faculty practice and the remarks quoted in the press, finally produced a major debacle. In the ensuing fight, the chair of pathology was relieved but not fired, the chair in medicine was fired, the greater percentage of the faculty in each of the 2 departments resigned, and the dean felt obliged to leave. It was a monumental catastrophe and one that very nearly killed the school within its first decade.

In both of these issues, we got many things wrong. The simple fact of setting a medical school in a community overwhelmed the need to explain just what it would entail. The absence of any meaningful communication to the medical community until the very last moment worsened the issue. Arrogance is another basic issue, and its effect is always bad. It was particularly evident in this situation in the early days of our school.

The lessons learned should be fairly obvious. However well supported, one cannot bring a major new system into a community and appear to force it down the collective throat simply because it is a good institution. Individuals were turned off by our expressed attitudes and then further alienated by the perception of an institution in competition for compensated patients. The school lost gifted practitioners because they were able to practice well, and a department protected those who were unable to do so. In the overall brouhaha, the department of surgery remained unscathed. It is interesting to note that the individual called on by the university to resolve the damage was a surgeon of substantial reputation and a man of extraordinary stability, Dr Truman Blocker of Galveston.

In 1982, in the late fall, 2 faculty members, our senior cardiothoracic surgeon and a pediatric neurologist, separately raised issues about nursing care in the pediatric ICU. There had been instances of unexplained respiratory and near cardiac arrest in routine postoperative patients or those admitted for long-term care without major pulmonary problems. At that time, the department of pediatrics had a weak interim chair, and the ICU was under the faculty supervision of 1 individual who attempted to provide personally all the care for every patient in the unit. Throughout November, December, January, and February, 3 in-house investigations were carried out with no resolution of the problem and no real definition of fault. For all intents and purposes, it was a fairly open secret that 1 individual, a licensed vocational nurse, was a major suspect. Unfortunately, she had an unblemished evaluation record that included no complaints and a uniform string of excellent ratings. The administration of both the hospital and the school, and especially the nursing service, feared a suit or grievance under existing labor laws, and that fear prevented appropriate counseling and transfer for this individual. It was such that nothing was done for 3 months. Fortunately, no deaths occurred in our institution.

In February 1983, because I was the director of the surgical ICU and because the third of the in-house in-

vestigations recommended closing the pediatric ICU and transferring the patients to us, I was asked to form a group to oversee the unit. I set up a multidisciplinary committee. The hospital made a policy recommendation to the committee to change the unit to an all-registered-nurse facility, thereby relieving the suspect individual of duties; we set out reconstructing and effecting these changes in March 1983 using 3 clinical departments.

In July 1983, a graduating pediatric resident offered the nurse in question a position in a new office she was setting up in Kerrville, northwest of San Antonio (a town of approximately 50 000 people). The resident was stringently advised against such a move by a number of faculty members but persisted anyway. The upshot was that by the end of August 1983, in a standard pediatrician's office for mildly sick or well children being treated for routine problems and shots, there were 3 instances of unexplained respiratory arrest all sudden and unexpected. One of them was fatal. The nurse in question was tried and found guilty of injecting children with muscle relaxants. She was sentenced in February 1984, and she remains in jail.

As a result of that investigation, the nurse's history was traced to the county hospital, where no deaths had occurred. The story became public in 1985 more than 2 years later. The hospital was vilified by a crusading district attorney who saw much political gain and an equally crusading and singularly ill-informed press. We were accused of a substantial cover-up. The Federal Bureau of Investigations was called to participate in an investigation; a grand jury was empanelled. I was personally obliged to testify twice before them and was accused of cover-up and fraud. No indictments against any hospital or school personnel were ever issued.

This is an example of something we did desperately wrong. Basically, it was a hospital matter and not a school one. It should have been dealt with by the nursing service with counseling, therapy, and discipline aimed at the individual involved. Regardless of her motives or her sanity or insanity, a consideration of suspected child abuse was clearly justifiable and could have been pursued to attempted murder. Most states have rather clear laws for these incidents. Under those circumstances, had we proceeded straight away, no press coverage would have been needed, and probably no deaths would have occurred had she been relieved of her responsibilities and license at that time.

The discovery of the story 2 years after the fact was taken as ipso facto evidence of cover-up by the district attorney and the press. Our action produced an unnecessary death in a small town and no end of misery for the hospital. The fear of a grievance, the lack of documentation on which to fire the individual, and the absence of courage to face the issue for what it was all compounded the matter.

The lessons to be learned are obvious. Probably the most important has to do with common sense again. In the event of suspected child abuse, by any reasoning, the statement that we had "no hard evidence" is an insufficient argument for lack of pursuit. Administrative duties require courage on the part of the administrators, and frequently courage requires facing unpleasant situations. Whatever unpleasant situations might have arisen between the hospital and an individual nurse, action should have been taken at that level and should have been taken a lot earlier than March 1983.

The fact that University Hospital was not connected to the nurse in question until well after her trial for murder and at least 2 years after the initial events in our ICU was an obvious incident of cover-up for the authorities and the press: never mind that no one in the hospital or the school was ever indicted. What we did was an actual attempt "in good faith" to protect the nurse, the hospital, and the school. The priorities that we used were wrong; what resulted was the release of the nurse, a true sociopath, into society as a free agent and a child's unnecessary death. This problem could have been avoided if the hospital administration by itself had had the courage to face the issue squarely at the outset and to use some degree of common sense in dealing with the basic problem, child abuse. Again, the lesson learned is the use of common sense and to a greater degree courage.

Finally, I would like to note something that I believe we have done right. Dr Aust was recruited to our department in the spring of 1965. In time, he recruited a nucleus of 4 general surgeons from the University of Minnesota, Drs David Root, Waid Rogers, Anatolio Cruz, and me. Two specialists also came from the University of Minnesota, Dr Leo Cuello in cardiothoracic surgery and Dr Jim Story in neurosurgery. Added to that initial group, Dr Carlos Pestana in general surgery came from the Mayo Clinic and Dr Charles Rockwood in orthopedics from the Air Force. With the exception of Dr Cuello, who left very early in the 1970s to be replaced by Dr Kent Trinkle, the group stayed intact for more than 30 years. They provided an evident stability for the department, which allowed us to survive the catastrophe of 1972. They also provided a certain aura of closeness and camaraderie that is not evident everywhere. The lesson of this particular situation is that in surgery, a team of cohesive individuals is valuable if substantial productivity is going to occur on a long-term basis. Building a department is not an individual undertaking.

In all of the foregoing instances, the underlying and unifying lesson is the application of common sense. It is associated with courage, persistence, and vision. It is a bedrock of practice, either academic or private, and it cannot be set aside without the risk of dire consequences.

In 1925, Willard Haines closed his presidential address to this group as follows:

Such was the opinion of the Athenian Thucydides, who wrote 2500 years ago, "Common sense is the alembic in which all causes may be tried and to which most causes relating to human affairs are finally referred for adjudication. There is no appeal from this court; there are few miscarriages, once the facts are submitted. From such judgments, the good have nothing to fear; the bad have nothing over which to rejoice."

I can add little or nothing to this admonition of 80 years ago except to reassert its timeliness now in a period of some general perturbation.

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