

SAJS

Presidential Address

As I have seen it

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Being an African, I have lived with uncertainty all my life. Our continent provides an ever-changing challenge. Being born an African destines you to remain an African. Some of us have attempted to challenge this; most have had only limited success in escaping Africa's grasp.

In Africa things are different; some say this is fun, others are upset by it. The threats that face our profession here are well known to you and are not unique to our continent. The recently held Board of Health Funders Conference during which the country's medical schemes spoke out confirms this. It was stated that health care funding is in a parlous state and that the knives were out for medical aid cheats.

So too with us. Surgeons as a profession have become devalued, and our work is seen as a market commodity.

A need to belong

Coming to our association, the Association of Surgeons of South Africa, our society. I have been associated with ASSA's controlling body for over 10 years. This has been a learning experience for me. 'What does this society do for me?' is a familiar question. Indeed, as a paediatric surgeon I thought that belonging to our own society, the South African Association of Paediatric Surgeons, was surely enough. I saw no reason to join in or contribute. Drawn in for the first time, I still looked for purpose for the association. Worldwide the opinion is held that the only function of an association such as ours is to arrange congresses and officially reward deserving senior or retired members for their contributions. The fact that it is simple to access knowledge electronically has negated a prime reason for joining.

So why join? *There is a need to belong.* At no time in the history of our profession has this need been greater. A group of like people working for a common need, working together, creating the power of unity.

To speak about people by name in public is to make enemies of one's friends, but I need to make a comment. I have seen the question 'Why join?' answered for me in the difference members of the Executive Committee have brought about in the Association. Yes, this is an individual assessment, but it is based on personal experience. It is a pity, however (and here we encounter the 80:20 principle that we need to break), that they are a group of comrades who repeatedly get together to address the same problems, but with differing emphasis, in the Health Professions Council of South Africa, university fora and the College of Surgeons of South Africa. They need at least your support, indeed your physical input. There is an old African proverb that hammers this home. When you pray, always move your feet.

The chairpersons of the Association have been and are today the powerhouses, the axis around which the business

and growth of ASSA takes place. The late Ivan McCusker brought his reasoning to its table. He was followed by Paul Cook, whose expertise gained in the private sector dictated new concerns and directions. Sats Pillay has made great strides during his chairmanship. Not only did his efforts bring the International Society of Surgeons congress to South Africa, but under his direction our movement into Africa has been emphasised and the studies that have been undertaken have started to bring a unified voice to our profession here, this time supported by a database, factual evidence of the problems we face. These moves have introduced a greater degree of professionalism into the leadership of the association. This is confirmed by the latest moves to clarify the relationships between South Africa's surgical associations and to establish a combined secretariat.

Despite reservations, professionalism in its broader context is something we need. This was brought home to me when I evaluated an intercollegiate exit examination at the Alder Hey Children's Hospital in Liverpool in 2005, as an 'outside observer' on behalf of SAAPS. I remembered being evaluated during a college exam in Queen's Square, London, in 1971. I cannot compare that experience with what I saw in 2005. Thought and professionalism had been put into every aspect of the latter procedures. The words *informed, fairness, transparency, humaneness, identical assessments*, pass through my mind as I think about it. Constant review of the process to ensure ongoing correctness is an ever-present concern. Even the examiners' performance is scrutinised. I came home to record how 'amateurish' our whole approach to our examination in paediatric surgery here was. What we do needs this form of constant attention, lest we fall behind and become irrelevant. You can make this happen, make what we do meaningful, by participating in the Association.

Surgery yesterday and today

After a 20-year break, I have been lucky enough to return to the hospital where I was a registrar in paediatric surgery in the 1970s. Much is different. The current attitude of the hospital's health authorities has played an overwhelming role in the major change in *Zeitgeist*, the spirit of the current time, at this institution. But much is still the same. This hospital is still a privileged institution. People, members of staff of all levels, who remain the basis of this spirit, its ethos, and whom I met and worked with many years ago, still walk its corridors.

Looking back at my time in surgery there – what have the current paediatric surgical practitioners lost? The postgraduate students and the younger consultants are all still remarkable doctors. What they do, however, is no longer as completely gratifying as it was in our time. With a few

other distractions, we were completely consumed by what we did. We used to look after our sick patients; 80% of our work was done outside the red line. We ran the ICU and did the ward work. A new discipline has taken a large part of these duties from us. Although we are still part of the team, we have lost much of what was a day-long activity. How has this been compensated for? We have withdrawn inside the red line, where industry and now patient demand has made *how* we do, not *what* we do, our all-encompassing concern. Look at laparoscopic surgery (what one of my colleagues reportedly calls 'stir-fry surgery'). It seems that everything can be done this way, but it can clearly not be done as well by all individuals, as the gap that divides those with polished technical skills from those not so fortunate has broadened. For our patients it has brought improved outcomes, but its use has raised questions. In a training institution it takes longer to do, an unprecedented pressure to use it is apparent, what is done is modified because of the access used, and, of particular concern, unacceptable complications are apparently condoned. The provision of skills courses has become an increasing need, but it is worrying that there are no controls to temper the enthusiasm of those who believe they have the right to use what they have been shown, regardless of known learning curves.

Surgeons now go to the X-ray department to find out what is wrong with their patients – a second observed loss, the loss of clinical diagnosis and the rise of the Default Investigation. The greatest gift I was given by my teachers is an ability to make a clinical diagnosis. This was in the early 1960s, over 40 years ago. Our five senses have been superseded by the scan. Touch, clinical palpation, is no longer accurate enough even in skilled hands, and therefore often deemed an inadmissible method for detecting or confirming the presence of skin-deep pathology. Not to have done it, is not regarded as malpractice; indeed the opposite pertains, and neglecting to image is unacceptable. One of the first textbooks I bought on joining the medical student ranks was the 13th edition of *Hutchison's Clinical Methods*, first published in 1897 and guided through 12 editions under the title *Clinical Methods* by its author Sir Robert Hutchison. It has now been renamed so that his contribution will be remembered, and what he called his baby will not die. After leaving most of my medical books to others, I still have it. But is Hutchison's baby dead? What characteristics were required of the sound medical practitioner? The ability to cope with uncertainty, exclude the dangerous and ignore the irrelevant; others could be added to this list. The first of these is close to killed where body imaging is available.

We have the equipment, so why use the senses? The word 'default' has been introduced to characterise investigations done in place of clinical assessment. A failure to act, justified by the 'culture' that the study is better than the clinical assessment in all instances; a default investigation. This is now the norm, to the delight of those who are paid to do them (individuals who are often personally surprised by what they are asked to do).

The third loss is a loss to other practitioners, the oncologists. Trained to treat solid cancers as an extension of their training as physicians, they are not sufficiently clinically informed, as a surgeon is, to be the first port of call for patients with swellings and lumps. This can lead to inappropriate management of benign lesions, as scans and fine-needle aspiration biopsy further delay referral to a surgeon.

The Google generation

Finally, loss from self to the machine. Today's 'oracle' has the answer to everything; we have at our disposal the sum total of human knowledge, a few mouse clicks away. It is said that our individual intelligence is no longer exclusively located in our own brain and there is not one aspect of our thinking, experiences, interrogations, fantasies or know-how that has not already shown up somewhere on the Web. So why think, let alone use one's imagination!

All our world's major advances in the past were based on human ability to imagine. Our brains have become sensory input junkies. Time for inward thought or reflection is effectively locked out, and self-solving effort lost.

It was Albert Einstein who said 'The problems that exist in this world today, cannot be solved by the level of thinking that created them'. Because of this, evolution has provided us with specific social skills based on collaboration and mutual support; skills that reach their maximal effectiveness within small groups of 10 to 20 people, but no more (the jazz band; team sport), enabling them to function effectively as a team. This is termed Original Collective Intelligence, but we have evolved today towards a Global Collective Intelligence, a single universal knowledge base or brain, via a permanent interaction with cyberspace. I am told that no community today can pretend to be smart if no exchange dynamics are at work in cyberspace, for there we find the most advanced knowledge, the most fulfilling experiences and the best practices. We used to see ourselves as knowledge possessors, a little like reservoirs; it is no longer so. 'Knowledge is like luggage, it's best to travel light.' So why study? The more I study, the more I know; the more I know, the more I forget; the more I forget, the less I know. Retained knowledge decays; it has a shelf life, and we have no dump facility.

The Ancient Greeks consulted the oracle; we go to the web – the Google generation. There are 1.5 billion pages on the Internet and counting; 25 new pages are added every second. Yes, and you yourself can contribute to this collective knowledge base through the use of web blogs, an easy-to-use publishing tool contributing to an aggregation of individual knowledge, and what are termed wikis, editable pages forming a mini knowledge galaxy through the principle of dynamic interaction, which is so powerful that today the most important encyclopaedia is a wiki named Wikipedia where entries converge to an optimum state. A downside, however, is that we have moved away from self-done work, 'your own thoughts, in your own words', to an era of shameless cyber-cheating, 'patchwork plagiarism' using the Internet to copy and paste information.

The first recorded instance of plagiarism occurred in AD561 when an Irish monk lent another monk a religious manuscript and he appropriated intellectual property, without proper attribution. Unlike a breach of copyright, stealing ideas for financial gain is not illegal, but it is theft. The development of writing isolated reader from writer, an element of depersonalisation resulting in the reader feeling that the information presented lacked a voice and thereby an owner.

Cyber-cheating is at perhaps its most extreme (anything for money!) in the Internet Papermill. Simply typing in 'term paper' in an internet search engine gives access to over 50 online papermill sites of two types, free or commercially run: \$5 - 9 dollars per paper, \$100 to write a custom paper.

How do we handle this cyber-sloth that threatens Academe? We turn to the machine to detect it. The software program TURNITIN.COM boasts 20 000 plus registered clients, including major universities, and cyber-cheating is detected in much the same way as DNA samples are matched in the forensic laboratory.

Digital inclusion has changed our lives; ICT (Information, Communication, Technology) has had an enormous effect on everything we do. It has even overwhelmed the lecture room, transformed our lives as teachers. PowerPoint is Microsoft's presentation graphics, making your point powerfully, but how well? We are told that PowerPoint is of little or no value for enhancing learning; it exists to promote the lecture, adding colour, motion and even sound. 'If your car don't go, or lacks performance, chrome it' – at least make it look good. A chromed lecture is still a lecture, well organised perhaps, stimulating hopefully, maybe even exciting to look at and listen to, but in the end it's fundamentally passive, a poor tool as a facilitator of learning. Your emphasis is on the quality of your presentation, rather than its content or your audience's learning. Your eyes and theirs are on the screen rather than each other. Before Alexander Graham Bell, verbal communication was face to face, eye to eye. People want to know about your experiences, your personal interpretations, your findings. It's personal; eye contact is vital. Visual communication sets up your cognitive thinking. It reaches the brain first, and influences how verbal communication is interpreted. Shakespeare knew this: 'The eyes of the ignorant are more learned than their ears'.

One of the aphorisms of C. F. M. Saint concerned Psittacism: 'Parrot-like study without thought, is futile. Teach to think, is the essential object.' This he learnt from his mentor Rutherford Morison, the main aim of whose book *An Introduction to Surgery*, published in 1925, was to aid the student in thinking out for himself the problems presented to him in the ward.

These are then the major losses that come to my mind as I interact with those who follow in my footsteps. Obviously there is another side to this coin – the advances and gains you have probably already addressed during the scientific sessions you recently attended – and I leave you to ponder on them.

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Immediate Past President
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