Editor's note: *Dr. Anderson delivered this Presidential Address on October 16 at the Convocation in San Francisco, CA.*

Some years ago, the leadership of the American College of Surgeons made a conscious decision to become what was termed "gender neutral." This involved some changes over past practices and the appointment of many women to leadership positions, committee chairs, and the development of a governor position from the Association of Women Surgeons. I believe that the epitome and success of that resolution has resulted in my standing before you tonight as the first woman President of the American College of Surgeons. This is a landmark for the College and the greatest personal honor for me. I look forward to the time when having a woman President will no longer be remarkable.

Each year, the President of the College has chosen a theme for the year. This past year, the theme was "unity among surgeons," chosen by

sound from the patient. Dr. Collins is said to have had tears in his eyes when he said: “Gentlemen, this is no humbug.”

The practice caught on very quickly. In England, that remarkable lady, Queen Victoria, delivered her fourth son while under chloroform anesthesia; thus was anesthesia established in England.

It was unfortunate that the early pioneers of the use of anesthesia were involved in tragic arguments as to whom the credit should go for its invention. But the humanitarian crisis was alleviated nonetheless, not only in terms of allowing operations to be done without pain to the patient and resulting distress to the surgeon and observers, but also from the fact that more and longer operations could be tackled, and patients were more likely to seek help in earlier stages of their disease.

Sepsis

Since death from sepsis is a relative rarity in these modern times of antibiotics and aseptic practices, it is hard to imagine the horror of the mortality from infection that followed open fractures, childbirth, and even clean surgical procedures. But a young Hungarian surgeon named Ignatz Semmelweiss, in his first job as assistant in a delivery ward in Vienna, was distressed by the huge mortality rate of recently postpartum

operations that could now be done with a successful outcome.

This solution of the crisis of infection eventually led to the practice of asepsis, when it was recognized that bacteria came not just from the air but from the hands, clothes, hair, and breath of surgeons and observers in the operating theaters. And so caps, gowns, and masks began to be used. The story of Dr. William S. Halsted's invention of rubber gloves to protect his fiancee's hands from the irritating acid is well known. The advent of steam sterilization extended asepsis to instruments, but even today, antisepsis, according to the tenets of Dr. Lister, is still widely practiced in wound care and in the sterilization of instruments that cannot be heated.

Dr. Lister, unlike Dr. Semmelweiss, who he acknowledged as his forerunner, was recognized for his achievements and

will rank in American history as one of the worst crises, in which families were divided, brother fought brother, and many more men died of disease than were killed in battle. In addition, the "surgeons," especially in the southern states, were largely untrained rural practitioners who acquired their surgical skills on the battlefield. At the time of the Civil War, anesthesia for surgical procedures was in pretty general use. The war had ended, however, before Dr. Lister described his antiseptic principles, and so deaths from gangrene and sepsis were distressingly common. The wounded lay around the

emerged, and in sophisticated mobile army surgical hospitals (so-called MASH units), soldiers received definitive treatment within four to six hours of being wounded. Frank Spencer, MD, FACS, a Past-President of this College, responded to the military order left over from World War II—that injured vessels must be ligated—by simply ignoring the order. He explained to me, "I risked a court martial if repairing injured arteries didn't work and accolades

perception by society that an adverse outcome is a "mistake"; this makes us justifiably concerned about litigation and we practice preventive medicine as a result, adding to the separation from our patients and to the cost of medicine. The public also demands the ultimate in diagnostic technology and the very latest in treatment modalities without being willing to pay for these. We ourselves are unwilling to consider rationing medical care. So we have decreasing reimbursement, more unfunded mandates, and falling incomes, yet we are working harder than ever. In spite of this, there is still the public belief that doctors are all rich and that it is somehow immoral to be adequately compensated for our work. In the words of the late Alexander J. Walt, MD, FACS, a Past-President of the College: "…we have a public greatly impressed by our technical achievements but disgruntled by what they regard as our careless, callous, thoughtless, or even absent psychosocial sensitivities."

But let's stop for a minute and define the real problem. I believe it is this: there is less and less of an outlet for the charitable desire to truly serve our patients. We need to work harder and more efficiently in order to make ends meet and therefore spend less time with each patient. We must deal with more and more bureaucratic mandates, which we don't necessarily believe enhance patient care. And this is frustrating.

So what are my suggested solutions for this present-day crisis in humanity?

Never forget why you went into medicine in the first place. You can't always be clever, but you can always be kind. Remember the Fellows Pledge you just recited with John Gage, MD, FACS, ACS Secretary: "…I will place the welfare and rights of my patients above all else. I