

Joseph M. Bennett, Columbia P&S Class of 1948:

Nearly seventy years ago I graduated P&S and began my journey in clinical medicine and doing my share to treat and care for patients. With the benefit of P&S's comprehensive education, and the many inspiring practitioners, including Drs. Loeb, Wipple, Blakemore, Humphreys, and Atchley my life's work was set in motion. I came to appreciate that the practice of clinical medicine was both science and art, and from the theoretical to the practical, I learned that medicine was necessarily open to further refinement and advancements.

I recall early on when I was chief resident at Lincoln Hospital (NYC) a conversation I had with Dr. Amendola, then chief of surgery at Lincoln and Roosevelt Hospital. I innocently inquired about how he spent his commuting time between hospitals, as well as, his downtime. His answer was unexpected and had a lasting impact. He emphasized that he would think about his patients and focus on how he could improve all aspects of their care whether pre or post-operative, and how surgical procedures could be bettered.

After all these years, I can confirm that stopping to consider and taking time to reflect on how to improve patient care and health care delivery has been vital in my general surgical practice. It led me to more effective treatments and methods. In fact, taking the time do this and making reflection a habit seemed to become a "force" that empowered and broadened the ramifications of each patient's illness.

Being part of an academic or university hospital or major medical center was not a requirement. Whether it was in the office, the clinic, the community hospital, or other treatment center, innovation, refinement and progress was possible. Indeed, it is fair to conclude that contributions and advancement in medicine can originate almost anywhere.

For me, taking time and reflecting in this manner allowed me to improve treatment of my patients, and allowed me to conceive a variety of original surgical techniques. In 1958, while working at community hospitals on Long Island, I designed a new instrument for common duct exploration that eliminates dependence on the blind impression of patency of the ampulla, and the error created by invaginating the ampulla and simply displacing the opposite wall of the duodenum. The instrument and its proper use removed any doubt that the selected size dilating tip has passed or not passed the sphincter of Oddi into the duodenum permitting a more informed decision as to the necessity of a duodenotomy. See, "A New Instrument for Common Duct Exploration" (N.Y. State Journal of Medicine Vol. 58 No. 10 May 15, 1958).

In December, 1964 I began using subclavian vein catheterization (normally then used for central venous pressure monitoring) for intravenous feeding and/or serum or blood replacement for patients suffering from peripheral venous collapse. At this time, this approach of using the subclavian vein for both monitoring and

feeding was not yet in vogue. Note, the feeding I used was not hyperalimentation which was later introduced by others to the medical literature. The work was exhibited at the N.Y. State Society of Anesthesiologists Postgraduate Assembly entitled “Subclavian Vein Catheterization for Monitoring Central Venous Pressure and Intravenous Feeding”; the same exhibit was later presented at the Congress American College of Surgeons, October 1965, Atlantic City, N.J. entitled “Percutaneous Subclavian Central Venous Catheterization for Infusion or Venous Pressure Measurement”.

In 1965, I described the procedure I had developed for repair of hiatus hernia associated with intractable symptomatic gastric reflux that was not satisfactorily responding to medical treatment or had developed a complication. See “Fixation of the Posterior Gastric Wall in Esophageal Hiatus Herniorrhaphy” (The American Surgeon Vol. 31, No 8 August 1965). Years later, in a letter to the editor of The Annals of Surgery I reviewed the history of posterior gastric fixation. (Annals of Surgery Vol. 234 No. 3 p 425-2001).

In 1972, I described my earlier modification of the Bancroft procedure for selected cases (starting with a vertical incision through the anterior wall of the antral cuff and pyloric ring, removing the antral mucosa, and continuing the closure) for management of the difficult duodenal stump avoiding duodenal stump leakage or trauma to adjacent structures and averting serious morbidity or

mortality. When this modified Bancroft procedure is indicated it makes subtotal gastrectomy a much easier and safer operation. See “Modified Bancroft Procedure for the Difficult Duodenal Stump” (Archives of Surgery Vol. 104, Feb 1972).

In 1975, after demonstrating the *in vitro* effectiveness of small pieces of antibiotic soaked lap pads, I began to use such lap pads (cefoxitine 2 gms /2000 cc saline) to protect the incision and intra-abdominally for constant topical antibiotic protection throughout the surgical procedure, remoistening when required. This was adjuvant therapy used in combination with standard protocols of oral or parenteral antibiotics. This continuous antibiotic application was in addition to the transient irrigation of the operative site with an antibiotic solution prior to the close of an open abdominal procedure. In my experience, this method significantly lowered surgical site infection in cases particularly involving dirty and contaminated cases.

What this all leads me to is to recommend that P&S initiate a program to train its medical students to reflect, imagine and innovate. As Mary Carruthers observed “people do not have ideas, they ‘make’ them.” Whether the graduates practice at P&S or in community hospitals in urban, suburban, or rural locales, or whether they are providing clinical care or working in the laboratory they will benefit as I did, and others before me, in taking time to think about how to practice medicine better.