Review article

Forty years of European paediatric surgery

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Summary. An attempt is made to outline the development of paediatric surgery in Europe since the last war. The pioneering work of a few surgeons before the war led to the systematic introduction of paediatric surgery during the post-war period. In spite of considerable opposition, this branch of surgery progressed rapidly and by the 1960s paediatric surgery was recognised as a specialty in most of the countries in Western Europe. The mechanism of this astonishingly quick progress is analysed. During the 1970s and even more in the 1980s the success story of paediatric surgery became marred by several negative developments, including the increasing tendency of organ specialists to take over certain areas of surgery in childhood. These developments are reviewed with reference to the views expressed to the author by 19 paediatric surgeons from 14 West European countries. Some ways of overcoming these difficulties are proposed.

Key words: European paediatric surgery

As the subject of this paper I have chosen a brief survey of European post-war paediatric surgery, and this for several reasons. In this century we have become accustomed to the breathtaking speed of advances in science, technology, and politics. Even so, the development of a virtually completely new surgical speciality from its first very tentative beginnings to its present status in less than half a century strikes me as astonishing. There are still a few men such as I about, whose professional life spans the whole of this period. We thus can give the new generation of surgeons a bird’s eye view of the past. As a more difficult task, we may even give encouragement and warnings for the future.

Europe was the cradle of paediatric surgery. This and the fact that developments there have perhaps been more difficult because of the widely different cultures and languages should make it of interest to paediatric surgeons wherever they practise in the world. Of course, one cannot divorce the development of a surgical speciality from the socio-economic state of the countries where it is practised. Paediatric surgery as we know it can at present only flourish in highly industrialized and therefore wealthy countries. The problems are very different in underdeveloped countries; time does not permit me to discuss them here.

Furthermore, experience has shown that there are marked differences in the development of our speciality in democratic and totalitarian countries, and my remarks here will therefore only be concerned with Europe west of the now finally crumbling Iron Curtain. Still, I believe that within these limits many lessons can be learned from the development of European paediatric surgery over the last 40 years.

The pre-war period

Paediatric surgery, in contrast to medical paediatrics, could only develop within the confines of children’s hospitals or large children’s units in general hospitals. It is a curious fact that the first children’s hospitals in Europe were built roughly during the first half of the 19th century. Italy is an exception, as the first known children’s hospital was the Ospedale di Santa Maria degli Innocenti in Florence, which dates back to 1485 and is still existing, but these early Italian hospitals were really institutions for foundlings who were given virtually no medical treatment.

Although children’s hospitals existed in most European countries during the last century, very few surgeons devoted their work entirely to children. Before the last war there were only a handful of pioneers working in this field. The reasons were largely economical: without adequate pay for their hospital work surgeons were unable to concentrate entirely on the non-remunerative practice of paediatric surgery. They either had to look for private patients amongst the adult population, or – as happened for instance in Scotland – once having been appointed to the staff of a children’s hospital they tried their very best to leave it as soon as possible in order to obtain a more lucrative position in an adult establishment.
All the more we have to admire those lonely and determined spirits who saw the career in children’s surgery as more than a stepping stone. These men were appalled by the low standard of their craft and were trying to come to grips with the major problems of our specialty. There were men like this in most European countries; names likeombredanne in France, Sir Denis Browne in England, and Drachter in Germany come to mind.

These few men developed new operative techniques for children, having come to realize that the techniques practised in adult surgery were unsuitable for their small patients. They observed, catalogued, and devised treatment for a vast number of congenital malformations and other complicated surgical conditions of childhood. These had hitherto been of interest only to pathologists as they could not be corrected. These pioneers were swamped by the clinical practice of paediatric surgery. They had to overcome the vigorous opposition against them and thus had no time to concern themselves with attempts to obtain recognition for paediatric surgery as a specialty. However, they did much for postgraduate training and it is no surprise that the majority of the men and women of my generation who went into paediatric surgery immediately after the war were mainly the pupils of these pioneers.

The early post-war period

Why did paediatric surgery suddenly emerge on the post-war medical scene? Why did it make such spectacular advances during the late 1940s and 1950s? I believe there were a number of reasons for this phenomenon.

The last war had destroyed hospital practice in most European countries. Large numbers of young medical and surgical specialists were demobilized from the armed forces; there was a glut of specialists. They were looking for jobs and were not only searching for careers in the well-established specialties, but were also exploring new possibilities. There was a spirit of adventure about that was exhilarating. New specialties like anaesthesiology, clinical biochemistry, and somewhat later intensive therapy came to the fore. Paediatric surgery could not have progressed as it did without close collaboration with these specialties.

In addition, for the first time attention was drawn to the differences in standards between the few centres of medical excellence in the countries concerned and medicine and surgery as it was practised in the rest of the countries. The new generation of physicians and surgeons was not willing to tolerate these glaring discrepancies and was moving into the periphery. New centres and new universities sprang up; they all needed medical staffing and organization. A great increase in the numbers of specialists was needed. The young men and women who filled these posts ensured that the practice of medicine and surgery tended to become more uniform in quality. National and international standards tended to approximate.

Those who practise today sometimes forget that in the not too distant past the standard of paediatric surgery was very low indeed. When I came to Liverpool in 1949, a city with two large children’s hospitals, I discovered that until then only two newborn infants with surgical abdominal conditions had ever survived. No child with oesophageal atresia had been saved. The mortality for such conditions as pyloric stenosis, intussusception and even appendicitis with perforation was forbiddingly high. Liverpool was not an exception; it closely mirrored the situation in provincial centres all over Europe. A great deal of clinical and administrative work was needed to change these conditions.

It is not surprising that the newly emerging specialty of paediatric surgery made many enemies, first and foremost among the general surgeons. They had not been very much interested in the surgical conditions of childhood, but they now saw part of their empire wrested away from them and did not like it. The resistance of general surgeons to paediatric surgery as a specialty varied from country to country. It was perhaps most marked in Germany, where even today paediatric surgery is not fully recognized as a specialty of its own. In France the orthopaedic surgeons put up most of the resistance. Up till then they had been the only surgeons interested in children, in fact, nearly all the so-called professors of paediatric surgery in France were orthopaedic surgeons.

Next to the general and orthopaedic surgeons, the urologists also resisted the new specialty. Many of the major operations in childhood outside the neonatal period are, after all, urological in nature. Up till then urologists had not been much interested in the management of congenital malformations; now they resented the claim of paediatric surgeons that they were better equipped to deal with these conditions.

One would have thought that the newly emerging specialty of paediatric surgery would have been vigorously supported by the paediatricians, who had only recently had to fight for the recognition of their own specialty. In many centres this support was at best lukewarm. Paediatricians had been quite pleased to rule alone in their little kingdom. If a child under their care suffered from a surgical condition, they would make the diagnosis and conduct the preoperative management before calling in the general surgeon and would tell him where to operate. Now a new breed of surgeons arrived who wanted to look after their patients themselves from beginning to end. It took a long time to persuade the paediatricians that their attitude was outmoded and not in the child’s best interest. Paediatric surgeons had to prove that they not only had knowledge about the medical conditions of childhood, but also about the physiology and pathophysiology of infants and children.

Paediatricians have, I believe, another quite legitimate objection to our specialty. Whilst paediatric surgery developed mainly in university centres, paediatricians practise all over the country. Surgically ill children therefore often had to be sent to far-off hospitals to be operated upon. The paediatrician thus lost all contact with his patients, and this was made worse by the fact that paediatric surgeons frequently carried out the postoperative follow-up in their own clinics. The peripheral paediatricians thus feared that they would lose all contact with their patients. These fears were not unfounded and still persist. They explain why even today major operations on children are often carried out in peripheral hospitals by general surgeons. I believe that this problem can only be overcome