A journal devoted to medical history, ethics, philosophy and clinical theory, founded in 1809

Ole Hart Hansen & Finn Hanberg Sørensen: An anniversary publication emerges

The Danish Surgical Society was founded in 1908 by Thorild Rovsing and Eilert Tscherning, both prominent professors of surgery. The personality of the two founders differed extremely and they disliked one another. Nevertheless, they agreed to found a society for surgeons where to meet and exchange ideas and experiences. The introductory article emphasizes that the issue of the anniversary publication was to publish a number of papers describing the influence of the society on research, training, and treatment together with future aspects of the function of the society. A short comment is given on each paper together with a characterization of the authors. It is underlined that the style of the papers differs widely. The aim is to characterize some of the most influential Danish surgeons during the last generation. In 1908, the number of members of the Society was 72, a century years later the number has become more than a thousand.

John Christiansen: The emergence and development of the surgical specialty

The centenary of The Danish Surgical Society raises the question about the origin of the surgical specialty in Denmark and its status in 1908. The first traces of a special surgical discipline go back to the foundation in 1787 of the Academia Chirurgorum Regia. This institution was independent of the University of Copenhagen, and the status of the Academy trained surgeons among the University trained physicians was probably modest.

Soon, however, the practice of synchronous gradation from the Medical Faculty of the University and the Surgical Academy emerged, and this practice became statutory from 1837. After a short while it became evident that the Surgical Academy was superfluous, and from 1842 all medical as well as surgical education was transferred to the University of Copenhagen.

Surgery as an authorized specialty had a long period of gestation. For many years, Danish hospitals were served by doctors appointed without any formalized educational requirements. From 1803, a Royal Health College would evaluate the candidates for surgical positions in state-operated hospitals and institutions, but as for other positions (i.e. in provincial hospitals) the local authorities would be independent, and informal judgements and personal reputations would be decisive.

In 1909, the Danish Health Administration was established, but the official concept of the medical and surgical specialties with formalized educational requirements were not made statutory until 1934 - twenty six years after the birth of the Danish Surgical Society.

Daniel Andersen: The progress of surgery and the surgical science

The founding fathers of the Danish Surgical Society, professor Thorild Rovsing (1862–1927) and professor Eilert Adam Tscherning (1851–1919), would hardly be able to recognize anything in the surgical units of today. Optically guided instruments have to a high degree replaced the surgeon's hand and lancet, and while our old colleagues took pride in their command of the surgical field in its totality, they would now be the astonished witnesses to a rich and steadily growing field of surgical subspecialties.

This is a result of the scientific input surgery has received from a cooperation with physiology, biochemistry, genetics, and many other fields outside surgery. And this was certainly in accordance with the expressed and prophetic visions of professor Rovsing.

While Rovsing and Tscherning were autocratic “kings” of their departments, they would now grudgingly find a flattened pyramid of democratic leadership. Clinical science at their time was almost identical with (and a part of) their clinical care. However, the enormous growth in clinical randomized trials has made ethical considerations mandatory, and the 1960's saw the birth of the Helsinki-declaration and of the scientific-ethical committees, which have changed the conditions for clinical research fundamentally. Rovsing and Tscherning would probably have approved this and realized that new attitudes to human relations within the general society also requires new perspectives on doctor-patient relationships - a shift from paternalism to patient autonomy.

Rovsing and Tscherning did not experience the problem of prioritizing, so often leading modern surgeons into despair. On the other hand, the surgeons of the past struggled with the problem that they had little to offer their patients. The surgeons' feeling of impotence, thus, has changed its essence, but seems to be everlasting.

Tove Nilsson: A brief history of female surgeons

The first female doctor to receive an actual surgical education in Denmark is believed to be Eline Møller – employed as a house surgeon at King Frederik's Hospital between 1907 and 1910. Furthermore, she became the first woman to acquire a doctor's degree in 1906. However, more than 40 years passed, before the first female doctor with an orthopaedic education in 1951 was appointed as a consultant.

No doubt, many female surgeons have been subjected to degrading comments or unfair competition if measured by today's sexual discrimination standards. Fortunately, the tone, working environment, and educational climate within the departments have changed over the years, and no female doctor should let the fear of discrimination be a barrier for choosing the surgical specialties as their line of work. Today, a woman educated within the surgical specialties naturally gains appointment as a consultant, and it is with great pleasure that we can ascertain that an increasing number of women are passing through the education system.

Peter Funch-Jensen: Surgical training

When the Danish Surgical Society was founded, surgery was definitively transferred from the barbers to the medical profession. Surgical intervention at that time was mostly confined to treatment of infective complications including tuberculosis. Until present times, there has been an intense development, so that more complicated procedures can be successfully performed. More and more surgery is reoriented into laparoscopic procedures, and classic open surgery will presumably - with few exceptions - cease to exist in the future.

In addition to practical surgical procedures, the surgical education comprises increasing challenges with regard to diagnostics, communicative skills, and organizational matters (including team organization). The collective agreement of 1981 led to a decrease in working time, although investigations have demonstrated that actual working hours often exceeded the stipulated 37 hours per week. At the same time, more focus was directed towards educational matters, and experimental courses and simulators have improved the practical education. In the future it is assumed that there will be even more focus on education, learning will take place in a combination
between theory and simulator training, and tests will secure proficiency based development. These tests are both important in assuring adequate surgical education and for the young surgeon to progress faster in clinical practice. It will be pointless to canalize young doctors into the surgical specialty, if they belong to the approximately 8 to 10%, who are unable to learn laparoscopic surgery.

Mogens Blichert-Toft, Peer Christiansen & Henning T. Mouridsen: Danish Breast Cancer Cooperative Group (DBCG)

Danish Breast Cancer Cooperative Group (DBCG) constitutes a multidisciplinary organization established in 1975 by the Danish Surgical Society. The aims of DBCG are first and foremost a nationwide standardization of breast cancer treatment based on novel therapeutic principles, collaboration between experts handling diagnostic work-up, surgery, radiotherapy, medical oncology, and basic research, and, further, a complete registration of relevant clinical data in a national database attached to DBCG. Data are processed by the Secretariat personnel composed of statisticians, data managers, and data secretaries making current analyses of outcome results feasible. DBCG is run by the Executive Committee, which consists of expert members appointed by their respective scientific societies. From 1978, the DBCG project gained widely access from participating units, and since then nearly all newly diagnosed breast cancer incident cases have been reported and registered in the national database. Today, the database includes approximately 80,000 incidents of primary breast cancer. Annually, the Secretariat receives roughly 1.5 million parameters to be entered into the database.

Over the years, DBCG has generated five treatment programmes including in situ lesions and primary invasive breast cancer. Probands are subdivided into risk groups based on a given risk pattern and allocated to various treatment programmes accordingly. The scientific initiatives are conducted in the form of register- and cohort analysis or randomized trials in national and international protocalized settings. Yearly, about 4000 new incident cases of primary invasive breast cancer and about 200 in situ lesions enter the national programmes. Further, about 600 women with hereditary disposition of breast cancer are registered and evaluated on a risk scale.

The main achievement of DBCG is a reduction of the relative risk of death of up to 20% and a 5-year overall survival ascending from 60% to roughly 80%.

Ole Kronborg:
Danish Colorectal Cancer Group (DCCG)
Bibl Læger 2008;200:100–11.

The Danish Colorectal Cancer Group (DCCG) became a permanent committee within the Danish Surgical Society in 2000 and included surgeons, oncologists, pathologists, radiologists, and a statistician. The first chairman was Ole Kronborg, followed by Steffen Bülow from 2003. The aims of DCCG were to coordinate the treatment of colorectal cancer (CRC), based on uniform diagnostic procedures and staging, to establish and evaluate new diagnostics and treatments, and to educate and secure a high quality. Furthermore, DCCG should plan national as well as international studies related to CRC. A countrywide database for CRC was initiated in 2001, chaired by Henrik Harling. Guidelines were published in 1998, 2002 and 2005. DCCG was extended in 2005 and became a multidisciplinary cancer group. The group has played a major role in Denmark within diagnosis and treatment of CRC and is active in science as well as postgraduate teaching.

Sven Adansen:
Laparoscopic surgery in Denmark

Laparoscopic cholecystectomy was introduced in Denmark in January 1991. The Danish Surgical Society simultaneously established a Laparoscopic Surgery Committee, which created and managed a national registry in order to prospectively monitor this new technique. All departments taking up the procedure reported to the registry and had regular feed-back allowing them to monitor quality and compare outcomes to the rest of the country. The registry made it possible to assess various aspects of the pre-, intra- and postoperative phases, safety, and to describe the adoption of the technology. Within a few years several other procedures were done laparoscopically, and Danish groups contributed with randomised studies on various laparoscopic procedures, including herniotomy, appendectomy, colonic surgery, and the value of simulator training.

Henrik Kehlet:
Surgical quality - what, why and how?

Surgical quality depends on three factors: Monitoring of outcome, the structure of the organisation and the process of care. Based upon recent developments within the care process ("fast-track-surgery") as well as the unique conditions in Denmark with complete hospital and civic registers, a national strategy to monitor and improve surgical outcome is proposed.

Ib Hessov:
Art in surgical departments - today and in the future

There are only few portraits of surgical pioneers in Danish surgical departments, and they are mostly found in conference rooms and near the offices of elder surgeons. Examples of characteristic portraits made by good artists are given in figures 1–6. The surroundings of the patients (the rooms of the ward where the staff also works) are often depressing. Untidy hospital corridors, where the walls are decorated with a mixture of different notices, casually hung posters, lithographs, and pieces of art donated by grateful patients, often look messy. The waiting rooms and the few common rooms in the ward tend to be boring. Neither corridors nor rooms radiate quality.

Why are our working surroundings so poor? Chief surgeons, who answered a questionnaire about art in the ward, all accepted the hypothesis: "The rooms of the hospital are important for the milieu of the staff and the well-being of the patients - and also for the patients' expectations of quality in the treatment".

In a few surgical wards, modern art of high quality is found - and not surprisingly: In the same wards, care has been devoted to the inside finish, i.e. light, colour, and furniture. Examples of modern art in surgical wards are given in figures 7–11.

The boards of the Danish Surgical Society and Young Danish Surgeons:
Thoughts on Danish surgery now and in the future

The boards of the Danish Surgical Society and Young Danish Surgeons reflect over the changes in society affecting surgeons and surgery in general. The boards describe focus areas in terms of changing the current situation with lack of surgeons as well as recruitment and image problems in the minds of doctors about to start their training. The focus areas are research, training, and recruitment in order to remain the professional society of choice for surgeons. Seen in the light of the growing and increasingly specialized units, a formal training as a leader must be considered mandatory for future surgeon leaders. Quality control is also considered mandatory, but time and funding resources are inadequate. This is something, the Societies will strive to improve. The collaboration with other Danish surgical specialties is considered essential in order to secure the best possible surgical impact in multidisciplinary fields like cancer treatment, and in order to navigate in the modern media and have maximum influence on the health authorities. This can be achieved by a reunion of the professional societies of the surgical specialties in a mutual association.