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Presidential Address

The Road to Recognition*

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BECAUSE of my long association with The American Proctologic Society and my complete involvement in it, I want to confine my remarks to some historical facts and some unmentionable observations about it.

The American Proctologic Society was founded in 1899 by a small group of men who managed to hold it together through all its difficult years and until such developmental events as The American Board of Colon and Rectal Surgery assured its continuation.

The American College of Surgeons, founded in 1913, was the "first national organization to function somewhat as a qualifying Board in a specialty."

The National Board of Medical Examiners, from which the Advisory Board for Medical Specialties developed, was formed in 1915. In that year the young American Proctologic Society slept. The American Board of Ophthalmology was incorporated in 1917, followed by The American Board of Otalaryngology in 1924, the American Board of Obstetrics and Gynecology in 1930, the American Board of Dermatology in 1932.

Sporadic attempts to get the "specialty" movement underway, being made all through these years, ultimately were spearheaded by a committee of the four established specialty Boards which I have just mentioned. Thus, the Advisory Board for Medical Specialties was formed in 1933, at which time twelve suitable fields for certification of specialties were defined, and proctology was not among them.

The American Proctologic Society now stirred, and in 1934 the American Board of Proctology was incorporated. Between 1934 and 1940, no development of this new Board was possible, despite the attendance of Drs. Hirschmann, Buie, Fansler, and Rosser at every meeting of the Advisory Board for Medical Specialties.

In 1940, a compromise arrangement was made by which certification of Proctologists could be effected through a "Central Certifying Committee in Proctology of the American Board of Surgery."

In 1949, the American Board of Proctology was approved by the Advisory Board for Medical Specialties and the Council on Medical Education and Hospitals of the American Medical Association. No mean feat! In that year I attended my first meeting of the American Proctologic Society

* Read at the meeting of the American Proctologic Society, Hollywood, Florida, April 12 to 16, 1970.

in Columbus, Ohio, and was impressed by the appearance and papers of world-famous British surgeons. I have since learned that this is a to-and-fro arrangement on a five-year cycle, and I now recognize it as one of our great international functions.

In 1955, certification in anorectal surgery alone was discontinued, and at that point the stature of the Board and of our specialty began to grow. However, also at that point, most of our members were doing anorectal surgery only. It is due largely to the forbearance of this group that the day was carried despite the fact that thereafter there was no certifying body for them and no hope for Board recognition. The American Proctologic Society is indebted to the selfless support of these members, who quietly encouraged refinements of our specialty certification without regard to their own sacrifice. At present approximately 356 of our members are not Board-certified.

In the past few years the make-up of our Society has shifted, and there are now 441 members certified by the American Board of Colon and Rectal Surgery, The American Board of Surgery, or both.

Until 1957, a record of our proceedings was published annually under the title of *Transactions of The American Proctologic Society*. In 1957, this was supplanted by the Journal, *Diseases of the Colon & Rectum*, another important adjunct to progress and recognition.

There are now 813 members in all categories of The American Proctologic Society. Our greatest growth has occurred since the mid-forties, when more awareness of the specialty movement was stimulated in the massed medical groups of World War II. Another spurt in membership occurred in 1955 following the end of anorectal certification.

The American Proctologic Society is governed by an annual meeting of its Fellows. The Fellows are continuously advised by an Executive Council, which also conducts all internal business for the Society. The Executive Council consists of our six officers, Past President, President, President-Elect, Vice-President, Secretary, and Treasurer, and three members elected at large.

Duties of the Council are neatly spelled out in our By-Laws. In general they include the conducting of all interval business in the best interests of the Society.

Beyond those written regulations, however, are several nonwritten responsibilities of the Council which, in my opinion, include the following:

1. Constant review and modernization of the By-Laws themselves. Things necessary and good in 1930 or 1940 may not be pertinent in 1970. In the past few years there has been increased willingness on the Council's part to modify the By-Laws annually, and I hope this continues.

2. Constant review and modernization of the Council's own structure. As in any other society or organization, a hierarchy of control tends to develop and to preserve itself unless it recognizes this defect in itself. I feel that there has been too much of this in our Council and also in our Specialty Board. Therefore, it is recommended that every effort be made by the Council and by the Board of Colon and Rectal Surgery to utilize the talents and services of our younger members, those 35 to 50 years old, as often and consistently as possible. It is also the responsibility of you, the members, to see that this refreshing approach is maintained.

3. Constant review and modernization of our relationship to general surgery and our difficulties in recognition as a specialty by general surgery. It must not be forgotten that we are, and always will be, indebted to gen-

eral surgery for an ingrained discipline of thought and conduct. General surgeons are not our antagonists, they are our colleagues who are in the last throes of a struggle against the steady advance of specialization. It is quite natural for a general surgeon, head of a department, to resist the development of a Colon service and to welcome the development of an Anorectal service. Though it may seem to be a one-way street at the moment, I suggest that an enlightened spirit of compromise and a willingness to establish anorectal services might again be considered. Your Council has always been disturbed by the active opposition of General Surgery to our specialty. A change in this attitude cannot be forced or revolutionized or legislated in any way. It can only be evolved through thoughtfulness, courtesy, open-mindedness, compromise and excellence of service to patients.

So, as I see it, let's hold it steady-as-she-goes, we *are* on the right course and will continue to grow in stature providing there is continued mutual respect among *all* of our members and with other surgical specialties.

Announcement

First Basic Surgical Exams to be in 1972

Examinations to be Constructed and Given by a Joint Committee from the Various Surgical Boards

At a meeting of the Surgical Council of the American Board of Medical Specialties, consensus was reached on a common examination in basic surgical principles for candidates of the various surgical specialty boards. The meeting was held in Chicago on October 17, 1970 and was attended by representatives from the American Boards of Anesthesiology, Colon and Rectal Surgery, Orthopaedic Surgery, Neurological Surgery, Obstetrics and Gynecology, Otolaryngology, Plastic Surgery, Surgery, Thoracic Surgery, Urology, and the American College of Surgeons, the American Medical Association Council on Medical Education, the American Board of Medical Specialties, and the National Board of Medical Examiners.

It was explained by Dr. Frank McDowell, who retired as Chairman after guiding the Surgical Council during its formative years, that the Council is composed of the official representatives from those organizations. The American Board of Ophthalmology is not officially represented, since ophthalmology is one of several specialty fields in which surgery constitutes only a portion of the specialty practice. "However," Dr. McDowell states, "we are still hoping that it will elect at some time to participate in the affairs of the Surgical Council, including the construction and giving of this examination."

The first examination will be held simultaneously at many medical centers in the U.S. and abroad in December of 1972. It will seek to determine the candidate's knowledge of basic surgical principles, and the questions will be generic ones of broad import. Subjects to be covered will include such things as wound healing, bleeding and clotting, shock, responses to injury, surgical metabolic and nutritive problems, surgical endocrinology, surgical anatomy, some general recognition of regional problems in the injured (common injuries of the head, chest, heart, abdomen, skeleton, eye, etc.), infections and antibiotics, anesthesia and respiratory care, neonatology, general knowledge of surgical pathology, burns, psychological problems common in surgical patients, grafting and transplantation of tissues, common surgical complications, clinical pharmacology, resuscitation, and surgical neurophysiology (including evaluation and relief of pain).

The Basic Surgical Examination Committee is composed of one representative from each of the boards in surgical and related fields and is chaired by Dr. Rubin Flocks of the American Board of Urology. The Committee is working with the National Board of Medical Examiners to construct an examination that will test the candidate's knowledge in solving problems common to surgical patients.

It was emphasized that the Surgical Council would not prescribe how the candidates obtain their basic surgical knowledge. The only goal is to be certain

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