The President's Address

PROCTOLOGY AS A SPECIALTY

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Thirty-four years ago Joseph Matthews, the first proctologist, lent to this chair a dignity and honor which reflects on all of us who have succeeded him. I would not have this body think me ungrateful for this opportunity to preside over the American Proctologic Society in its thirty-fourth annual session nor unconscious of the distinction you have graciously conferred in permitting me to follow here the many splendid leaders of our specialty who have been so instrumental in establishing it.

While medical history records that the first surgeon crept out from under a barber's chair, pride in the profession's subsequent achievements very properly prevents a too apologetic attitude on the part of the surgeon concerning its humble origin.

Proctologists are prone to regard their work as unduly exposed to illegitimate and unorthodox competition, but the members of several other specialties would assure us that we are not alone. It has, however, been illuminating to observe the decimination in the ranks of the vicious venereal disease quacks since the urologists of this country have offered to the public a trained and interested group and to see the gradual decline in the popularity of the one-flight-up Main Street stomach specialist and colonic laundry once the prospective patient was assured of the ability and special competence of the orthodox gastroenterologist.

Proctology, a field so long abandoned by the general profession to the quack and the irregular, has been in recent years to a large measure reclaimed to orthodox medicine through increasing realization of its import in the general medical scheme by the evolution of undergraduate instruction in anorectal disease and from a definite demand on the part of general practitioners that disorders so widespread in their clientele should have the benefit of careful and scientific consideration in place of the alluring promises of the charlatan.

Certain very definite responsibilities arose from this novel renaissance as an orthodox surgical specialty of a previously neglected phase of medicine. Accurate diagnosis became essential; the cautery on one hand and the phenol solution on the other became insufficient as a complete armamentarium for the management of all rectal disorders; the rectal wound took its place with surgical wounds of quite distant portions of the anatomy in demanding an occasional freedom from bacteria, debris and moisture following operative procedures.

Because proper function during defecation is based on a non-obstructed and flexible channel at the terminal rectum, it became apparent that the routine destruction of simple internal hemorrhoids with the actual cautery

is a faulty procedure for much the same reason that harsh escharotics are condemned, because its use may be followed by deformity, rigidity, or excessive fibrosis.

Some variations of the ligature and excision operation for hemorrhoids is now used by the majority of our Fellows because of the feeling that with the free exposure made possible by proper anesthesia the exact pathology may be determined and accurately removed, bleeding points sutured and the wound loosely coapted with a minimum of trauma.

A new and valuable factor in reducing operative mortality in major rectal procedures and permitting the non-traumatic exposure necessary to properly correct minor anal disorders has been the application of block anesthesia, either caudal or lumbar, to anorectal surgery. Since divulsion of the rectal sphincter has become less popular as a surgical diversion, the complete relaxation offered by complete regional block affords a welcome opportunity to inspect and correct lesions of the anal canal in the absence of the edema which accompanied manual or instrumental stretching. Perfection of the low spinal or "intradural caudal" technique and recent proper evaluation of the merit of the barbiturates as preliminary sedatives have had a valuable application to rectal surgery.

Such progress as proctology has made during the past decade has resulted largely from an attempt to shoulder the responsibility to which reference has been made by more accurate diagnosis and more logical treatment.

Any number of interesting problems and adjustments remain for those seriously concerned with the advancement of the type of work done in this field, and the solution of such problems will index to some degree our future progress. These questions are not concerned solely with the mechanics of the work.

The American specialty of proctology has no counterpart in Europe and even here we have been somewhat uncertain as to the proper range of our activities. In the past the proctologist may have been primarily concerned with more or less medical procedures in diseases of the rectum and colon, he may have carried out the surgical procedures necessary in rectal disease and the medical treatment connected with colonic disorders, or he may have restricted his work definitely to the diagnosis and surgery of the colon and rectum or the rectum alone. Within certain limits the individual may even now properly follow his own preference in this connection—but the trend in recent years in this Society has been toward delineating proctology as a strictly surgical specialty. The limitation of our Fellowship to Fellows of the American College of Surgeons arose from this desire, and the official recognition of the specialty by the College served as external confirmation.

During the past third of a century the American Proctologic Society has served to stimulate orthodox interest in our field and has at the same time been the single force attempting to maintain certain necessary standards for those participating in this special type of practice.

Specialism needs no defense before this body, which knows it to be a natural consequence of the ever-widening scope of medical activity joined with an entirely laudable desire on the part of the individual practitioner to

master some phase of the tremendous whole and thereby make himself a more effective instrument in society.

Specialism has, however, developed so rapidly in recent years as to suggest the wisdom of some type of future control of entry into limited zones of practice and some method by which hospital staffs, medical school faculties, government officials as well as the profession and public may determine who may be trusted to perform services requiring special skill.

The first steps toward this end were the formation of special certifying Boards for Ophthalmology (1916), Otolaryngology (1924), and Gynecology and Obstetrics (1930). These three boards have together certified a total of some 4,000 applicants. Because application for certificates has been purely voluntary, because it has not seemed practical to request any legal recognition of the standards desired, because ethical means of publicizing the special board examinations were lacking and because methods of coordinating the activities of the various specialties had not been evolved, the work of the three boards named has been observed with interest and appreciation; without, however, convincing all the national societies representative of other specialties that the time was appropriate for imitative action.

It is apparent that a definite change is occurring in the status of this very important question and that it is entirely possible that the near future will evolve a unified, coordinated plan sanctioned by the American Medical Association, the National Board of Examiners and the national special societies which will compel the patriotic participation of our own group.

Aided by data and council from Dr. Paul Titus of Pittsburgh, Dr. W. P. Wherry of Omaha, and Dr. George H. Meeker of Philadelphia, I have made a year's study of this question, which I believe justifies me in submitting certain recommendations to this Society.

The American College of Surgeons has a Committee on Graduate Work with Dr. C. J. Heuer, of New York City, as Chairman "to study graduate and post-graduate teaching and surgery and surgical specialties," whose work may have some bearing on certification. The House of Delegates of the American Medical Association in 1931 instructed its Council on Medical Education to investigate and make recommendations looking to the establishment of proper qualification of physicians who shall engage in special practice. In February, after a prolonged discussion, the Council adopted the conclusion that if so ordered they would extend to special fields of medicine a service consisting of acquainting the medical profession and others concerned with information by which they "may be able readily to distinguish those who have received training in the various branches of medicine from those who are merely self-constituted specialists." Presumably this service is to be rendered in part through publication of selective lists in the Journal and the Directory. The method of selection is not set out.

It seems clear, however, that valuable as would be the coordinating and supporting influence of the American Medical Association, it is not an examining body and must receive information from some outside source to collect a combined list of recognized specialists. A very logical course would be for each specialty, through its national organization, to set up a

qualifying board and supply some central body with a list of physicians to be certified and listed as recognized.

A very important recent occurrence was the Joint Conference of national examining boards in Milwaukee on June 11th last, which was also participated in by representatives of the A. M. A., the National Board of Examiners, and the American Association of Medical Colleges. The American Proctologic Society was represented by invitation. It is the hope of this group to establish an Advisory Council to the Examining Boards allocated to the specialties which shall formulate a scheme of qualification and registration acceptable to all concerned.

Because recent developments indicate a very general interest in this phase of post-graduate education and medical practice and justify the expectation that two previous objections to qualifying procedures (lack of coordination and lack of moral enforcement) may be overcome shortly, it is my opinion that proctologists will desire to keep abreast of this movement by entering into the deliberations of the Advisory Council established.

I therefore recommend to this Society that it empower the Executive Council to appoint a committee of three of our Fellows and that it also request the A.M.A. Section to similarly appoint three of its members,* the resultant group being instructed to study the questions involved, meet with the Advisory Council to the Examining Boards and, if the committee's judgment so dictates, present formulas for further participation by proctologists in one year.

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*The committee which was constituted as the result of this recommendation is made up as follows:

Appointed by the American Proctologic Society:
Dr. Curtice Rosser, Dallas
Dr. Frank G. Runyeon, Reading
Dr. Louis A. Buie, Rochester, Minn.

Appointed by the Section of the American Medical Association:
Dr. Louis J. Hirschman, Detroit
Dr. Walter A. Fansler, Minneapolis
Dr. Desetim C. McKenney, Buffalo