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**Presidential Address**

**A Return to Academia  
A Goal for Colorectal Surgery**

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FOR ME, THE GREATEST REWARD from my close involvement with this Society has been the opportunity to associate with leaders in colon and rectal surgery; men and women of vision, dedication, and action, who have been, and are, a source of challenge, insight, and inspiration. Under their influence I presume, this morning, to suggest a goal for the future of our specialty. First, I wish to review some aspects of our past, with particular attention to the relationship with the academic community.

When this Society was founded at the beginning of this century, surgical training in this country was unstandardized, frequently self-taught, obtained through visiting a clinical center here or abroad, or by attending a series of lectures.<sup>1</sup> With good fortune, one might be a preceptee to one of the eminent practitioners of the time. In our specialty, a tour to St. Mark's Hospital in London, soon to be celebrating its 150th anniversary, was the way chosen by Joseph Matthews, first president of this Society, and many of his, and our, colleagues who followed.

Formalized training of surgeons by the residency system in the United States, set forth by William Halstead in 1904 and shown effective at the Johns Hopkins Hospital, was gradually adopted by private and academic surgical

training centers, and standardized, initially by the American Medical Association, and later joined by other interested accrediting agencies.<sup>2</sup> Thus, Halstead's vision shaped the form of the residency system and has become the general pattern of training for most medical specialties.

Where has our specialty been in the last half century, in relation to academia? Our specialty was first formally recognized by the American Medical Association in 1916 as the Section of Gastroenterology and Proctology, was often a section of medicine in the university, sometimes represented as a diagnostic department in the outpatient clinic and frequently as a minor consulting service for general surgery. Yes, academically, the specialty has taken all of these forms, besides being, on occasion, the butt of jokes in medical student skits and roasts. Nevertheless, it has been a clinical specialty, provided for the benefit of patients at the schools, for the most part, by volunteer staffs.

The nadir, perhaps, occurred in the early 1960s, when our diminishing numbers gave concern that our specialty, which from its beginning had encompassed colon and rectal surgery, but which was producing fewer than ten Diplomates a year, could not be self-sustaining. Furthermore, at this time, the infusion of grant and research monies into the medical schools by the various agencies provided personnel adequate to replace volunteer staffs. This, combined with the ongoing fears of

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fragmentation in surgery, diminished the opportunities for our specialists to participate in academic instruction. In the recent decade, fiscal difficulties of the medical schools, combined with altered patient loads and health care delivery patterns, have done little, with few exceptions, to encourage renewed liaison with our specialty. Fortunately, colon and rectal surgery, which has always thrived under the influence of free market forces, was recognized as vital to adequate patient care and, by public demand, was nurtured by the private sector and the large private hospitals and clinics.

Today, the number of residency programs has tripled, and between 40 and 50 new Diplomates are being certified each year. These changes have meant far more than survival for colon and rectal surgery. They constitute much more than the "changed anatomic limitations of jurisdiction...produced by the stroke of the pen," as suggested by Dr. William P. Longmire,<sup>3</sup> when the American Board of Proctology changed its name to the American Board of Colon and Rectal Surgery. The fundamental changes have involved the selection of residents, the increased spectrum of knowledge required, the longer prerequisite surgical training demanded, and ultimately the expectations and concept of role for the Diplomates.

This Society has also changed to keep pace with the changing role and needs of its members; improved programs and courses, syllabus-assisted self-assessment, and outreach to our general surgical colleagues have been hallmarks of recent progress. The metamorphosis has not been without anguish, apprehension, and even anger! Indeed, the transitions have been so recent that most of our members will have experienced some of the agony, as well as the exhilaration of the process.

Now why do we look to academia, to the medical schools? In his Joseph M. Matthews Oration in 1978, "The Dance of Surgery: Who Calls the Tune?"<sup>4</sup> Dr. Norman Nigro emphasized the important role of the tertiary care institution in the delivery of highly specialized services that cannot be managed in the community hospital. He noted that these "...are of two general types. One is the private hospital, sometimes associated with a large private clinic, and the other is the university or academic medical center." He stated that in contrast to the private centers, the universities have been "...slow to develop close affiliations with community hospitals, and their surgical departments have been slow to develop specialty areas," including colon and rectal surgery. He concludes that, "The academic medical centers would do well to follow the lead of the private medical center complexes..." in providing these services and responding to public demand.

This past year, Dr. Frank Moody,<sup>5</sup> then president of the Society for Surgery of the Alimentary Tract, himself an

academician, has taken a similar view of the academic dilemma, noting that in spite of the trend to further evolution of specialization within general surgery, concern for preservation of the abdomen as the residual arena for general surgery has given little opportunity for the trainee to gain a specialized background in surgery of the gastrointestinal tract. He has proposed the development of fellowships in surgical gastroenterology in academic medical centers having special interests and resources. It is important to note that both Dr. Nigro and Dr. Moody have expressed the conviction that specialty programs directed at diseases of the gastrointestinal tract, in the academic setting, will improve patient care, aid research, and provide for the improved teaching of all residents and surgeons in practice.

Much of the resistance to the development of sections or divisions in Colon and Rectal Surgery, or in surgical gastroenterology, in the academic medical centers has basis in the fears of surgical department chairmen that the result would be less available patient material for the general surgical resident, fewer experiences in care, and less opportunity for a direct involvement with patient management. These fears, not without experiential grounds, nevertheless, are not necessarily the inevitable reality. There are ways, and there exist arrangements, in programs involving our specialty which integrate, share with, and build experience with general surgical residents. The benefits to these university surgical departments have been the enhancement of their status nationally, and in the community, as providers of this highly specialized care, as well as improved teaching in the specialty area. The benefit derived by our specialty is the establishment of an academically oriented cadre involved in scientific research in the specialty, with ultimate improvement in knowledge for all.

I fervently believe that the opportunities and challenges in colon and rectal surgery are greater than ever. In addition to the well recognized public need, the interest in our field is attested to each year by the standing-room-only attendance at the colon and rectal courses at the American College of Surgeons, and by the many welcome general surgical members of this Society. Our Journal, *Diseases of the Colon & Rectum*, in which we take pride, is increasingly read, and a source for publication and reference. We have available excellent residency training programs in many areas of the country. These are becoming increasingly integrated and improved through cooperative liaison afforded by an active and attractive Program Directors' Association. This is, perhaps, the remaining surgical specialty where there has not been overproduction or crowding of opportunity. The emergence of new equipment, new techniques, and new concepts in patient care make our specialty exciting and our choices varied.

This, then, is my proposal. Opportunities now exist for us to return to academia. Let those of us who are able respond to these new needs and new demands: to teach, to research, to share. These are natural functions of physicians. Let us take up our mission.

Let us add to the immortal hymn to the University, "Gaudeamus Igitur," these phrases:

*Vivant Academiae, Semper florescant  
A Colo-proctologia, nun illae crescant.*

Yes, let Colon and Rectal Surgery strengthen and enrich the curriculum in the medical schools. Let us take

our lesson from history, our inspiration from fraternity, and our pleasure from sharing!

### References

1. Dunphy JE. The George Adlington Syme oration: what puts the surge in surgery? *Aust NZ J Surg* 1974;44:313-20.
2. Gray LA Sr. Training in pelvic surgery. *Ann Surg* 1982;195:525-9.
3. Longmire WP Jr. Surgical turf or who should do what to whom? *Surg Gynecol Obstet* 1983;156:76-8.
4. Nigro ND. The dance of surgery: who calls the tune? *Dis Colon Rectum* 1978;21:469-73.
5. Moody FG. Surgical gastroenterology: problems and solutions. *Am J Surg* 1983;145:2-4.

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### Announcement

#### AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY NATIONAL POSTGRADUATE ENDOSCOPY COURSE II

A course entitled, "Endoscopy 1983: State of the Art and Other Artful Statements" will be held at the Westin St. Francis Hotel, San Francisco, California, January 19-21, 1984. The Course Director is Jay A. Noble, M.D. For further information, contact ASGE PGII, 14 Elm Street, Manchester, Massachusetts 01944. Telephone (617) 927-8330.