

Unity of Purpose

by John M. Beal, MD, FACS, Chicago
President of the American College of Surgeons

Since its founding in 1913, the American College of Surgeons has been devoted to the ethical and competent practice of surgery. The Regents believe that this goal can be achieved best by carrying on broad educational programs for its Fellows, the medical profession as a whole, and the general public and its elected representatives.

Subspecialization

At the present time, approximately 44 percent of the Fellows of the College are general surgeons, so that the majority of Fellows represent other surgical specialties. In considering how surgery can best serve the public, we surgeons must carefully examine the trend toward fragmentation or subspecialization in surgery. The current system of specialty boards was developed by the medical profession as a method of assuring the American public of competent physicians. Before the formation of specialty boards, self-proclaimed "specialists" were numerous and guidelines for judging the qualifications of such "specialists" were uncertain and varied widely. Following World War II, a remarkable expansion of training programs occurred, and the public has benefited from this abundance of well-trained and highly competent specialists in all fields of medicine.

Under the guidance of the Graduate Education Committee, the American College of Surgeons has been working to elevate the standards of training and continuing education for surgeons through Fellows who serve on specialty boards and residency review committees. In addition, the College sponsors scientific and educational programs both at the chapter and national level.

The expansion of medical education and research has been accompanied by remarkable developments in technology, therapy, and diagnostic methods that were undreamed of 50 years ago. The establishment of specialty boards reflects a recognition of special fields of knowledge. Thus, surgeons have concentrated their efforts in such well-defined specialty areas as, among others, orthopedic surgery, urologic surgery, and obstetrics and gynecology.

The results of such specialization in surgery have been of great benefit to the American public. Specialists generally are recognized by hospitals and,

more and more, by the public as those who have been trained in carefully supervised residency programs and certified by one of the American boards after taking comprehensive examinations. The system of thorough training and education in residency programs followed by certification by specialty boards has resulted in higher standards of surgical treatment over the past three decades.

In line with these developments the American College of Surgeons has been conducting a public education and information campaign entitled "Surgery by Surgeons." Through the efforts of the Communications Department, advertisements placed in consumer magazines advise patients to seek treatment by qualified surgeons if they require an operation. In addition, television and radio announcements have been developed to inform the public on the meaning of board certification, how to select a surgeon, how to obtain a second opinion, and other areas of importance to patients.

Fragmentation of general surgery

After the specialty boards were established, some surgeons began to specialize in more restricted areas of interest, such as hand surgery, the treatment of burns, pediatric surgery, and vascular surgery. Such fragmentation is not confined to surgery but involves other disciplines as well. Internal medicine, which already includes many specialty groups, is now facing problems associated with specialization in geriatric medicine.

The proliferation of additional specialty groups has been justified as desirable in fostering research, improving teaching, and affording more effective residency or fellowship training. The Committee on Issues of the American Surgical Association addressed the problem of increased subspecialization within general surgery at its meeting in April 1982. Its report warned of the potential hazard of developing additional surgical specialties separated from general surgery. One such risk lies in the area of surgical education and training. The concluding paragraph of the report says:

"It is essential that general surgery continue to develop a critical core of knowledge and basic principles essential to all fields of surgery. When a special

area of interest develops within surgery, it should remain in the department of surgery as a program or division and should not be separated off as an autonomous unit. Fellowships in special areas of interest, education and training must not encroach on the opportunities of the general surgical resident."

The recommendations set forth in this report, which was concerned specifically with the fragmentation of general surgery, might be considered carefully by other established surgical specialties.

Increased subspecialization may be confusing to patients and may result in many undesirable referrals of patients by physicians who treat only one anatomical area. There are the obvious disadvantages of repetition of examination and tests, duplication of effort, and increased costs of care.

Horizontal competence

Speaking to an American Board of Medical Specialties committee in July 1981, Dr. John Benson, Jr., president of the American Board of Internal Medicine, referred to geriatrics as an example of "horizontal competence" because it encompasses several disciplines, including internal medicine, urology, and psychiatry. Some other subspecialties could be similarly labeled. The jurisdictional implications and legal considerations are complex. The overlapping among specialties has already resulted in "turf" battles and disputes over hospital credentials, as well as competition among surgeons for patients.

Physicians who limit their practice to a subspecialty usually establish societies to discuss advances in therapy and research in their special area of interest. These subspecialists, in turn, attract residents who note the volume of patients, the expertise of the subspecialists, and the concentrated experience available. Often fellowships are developed, either under the aegis of the institution where the practice is conducted or under the guidance of the specialty society. In an effort to gain recognition of the fellowship and the subspecialty practice, certification may then be sought. Certificates of special qualifications have been granted by specialty boards as one solution. In some subspecialties, such as emergency medicine, certification

is granted by conjoint boards; that is, training and certification examinations are approved by two or more specialty boards.

The clamor for recognition among subspecialists is increasing, and unquestionably additional groups will achieve certification one way or another. Certification should certainly be kept within the structure of the existing specialty boards. In areas of "horizontal competence," recognition by conjoint boards would appear to be a satisfactory approach. This would enable each appropriate specialty board to determine the content and structure of training programs and to share the responsibility of developing certification for the subspecialty. Each candidate for special certification should be certified first by one of the sponsoring boards.

This method should allay suspicion and decrease acrimony among those presently certified. It would also maintain the current specialty board system and provide a method of assuring that subspecialists are qualified. I hope that the American Board of Medical Specialties will be able to foster certification of special qualifications by the individual specialty boards in an equitable and rational manner. Sir William Osler said in 1910, "The extraordinary development of modern science may be her undoing. Specialism, now a necessity, has fragmented the specialties themselves in a way that makes the outlook hazardous. The workers lose all sense of proportion in a maze of minutiae."

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Major issues

These remarks are made with concern for all specialties of surgery, and with optimal care of the

surgical patient in mind. The American College of Surgeons depends upon the support of the surgical specialties and the involvement of their representatives in College activities at all levels, including chapters, the Board of Governors, advisory councils, committees, and the Board of Regents. This broad representation enables the College to address subjects that are of importance to all of surgery.

At its planning meeting last spring, the Board of Regents sought to identify major issues that surgery and surgeons will face in the coming years. By virtue of its membership and organization, the College may serve as coordinator, consultant, data resource center, liaison to other umbrella organizations, and an effective spokesman for surgery when required.

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The Board of Governors, with its broad cross section of surgeons, has identified medical liability as the most important issue currently facing the practicing surgeon. The College has initiated a comprehensive approach to analyzing the factors involved in the increasing number of suits filed and the rising costs of medical liability insurance. The Patient Safety Program has been expanded, and the College's Patient Safety Manual has been more vigorously brought to the attention of the specialty societies. A series of meetings has been conducted to enable the specialty societies to exchange ideas and experience. A number of articles have appeared in the *Bulletin* of the College that have surveyed the problem of medical liability, both with regional and national information. The College's Committee on Medical Liability has been reactivated and has broad specialty liaison representation.

Although the problems associated with medical liability are complex and an immediate solution is unlikely, I believe that improvement can be achieved by a united approach by the surgical community. By sharing information and experience, organized rec-

ommendations can be made. The medical community tends to overlook the widespread problems in liability that affect business organizations and other groups. In addition, variations in state laws further complicate efforts to find solutions. In this regard, chapters of the College provide a remarkable source of information. By accumulating data on claims made, awards granted, and the assistance available from our legal colleagues, and by consulting with members of the business community, a multidisciplinary surgical group should be able to develop a more logical approach to the medical liability problem.

At a recent meeting, representatives of specialties discussed factors that influence professional liability. It was apparent that nonsurgical specialists do not share the surgeons' concern, in large part because their premiums are lower. In addition, surgeons present an image of high income. Patients report that some surgeons do not spend sufficient time explaining reasons for operations, alternate methods of therapy, and the nature of the operation to be performed. The impression that the surgeon makes rounds early in the morning before the patient is alert enough to ask questions and is too rushed to answer later in the day has some basis in fact. The patient's expectations have been raised in recent years by remarkable advances in medicine, and this may be a factor in the increasing amount of litigation if unsatisfactory or disappointing results occur after surgical intervention.

Continued education of both the profession and the public is needed. It is unlikely that the basic legal system in medical liability will change significantly until the public understands that such changes are in the public interest and not self-serving to the medical profession. Cooperation among all of the surgical specialties is required to reach this goal.

Cooperative efforts

The effectiveness of cooperative efforts among the surgical specialties is well-illustrated by the College's Committee on Trauma. This committee has representatives from all of the surgical specialties. Its educational activities include holding symposia on trauma for the medical profession, publishing a list of essential equipment for ambulances, and sponsoring advanced trauma life support courses for surgeons and residents. The committee has developed standards for emergency room care that serve as a model for those who have established trauma centers. The document, "Hospital Resources for Optimal

Care of the Injured Patient," identifies the essential elements that most states require before designating a facility as a trauma center. This document also serves as a guide for hospitals in improving the care provided in their emergency rooms.

These examples are cited to emphasize the benefits that are engendered by cooperative efforts. At times, overlapping interests have led to acrimonious disputes among competing specialty groups. Some of these disagreements are the inevitable result of the evolution of specialty fields. It is said that Harvey Cushing was proud of his general surgical heritage and continued to perform an occasional hernia repair after he had been established as a neurosurgeon.

The separation of anesthesia into a discipline independent of a department of surgery has been achieved only since the Second World War. Training programs in the surgical specialties have changed their requirements as years have passed. In the 1940s some neurosurgical training programs required full training in general surgery before a neurosurgical residency was undertaken. This requirement gradually disappeared but the certifying examination in neurosurgery retained in-depth testing in general surgical topics for several years. Other boards have lengthened the training time or have expanded the scope of residency experiences required for board examinations. For example, several boards require training in gastrointestinal endoscopy or experience in bronchoscopy. These changes have ultimately been reflected in practice patterns and have led to conflicts in delineation of clinical privileges.

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The most important consideration in the resolution of such disputes must be in the assessment of the quality of patient care. There is general agreement that the standard of medical care in the United States has progressively improved and that we now possess more and better qualified physicians than ever before.

Therefore, if there are disputes between competing specialties, the first issue to be addressed is whether the quality of patient care is being maintained. The solution to interdisciplinary disputes may be difficult to achieve because there are frequently a number of emotional issues involved, as well as overlapping professional interests.

A dispassionate forum is the preferred setting for discussion by the involved specialty groups. The College has offered its services and resources on several occasions to ameliorate disagreements among surgical specialties and remains committed to assist in the future. This approach is preferable to publishing allegations in the professional or lay press.

Guy de Chauliac described the requisites for a surgeon in the 14th century: “The conditions necessary for the surgeon are four: First, he should be learned; second, he should be expert; third, he must be ingenious; and fourth, he should be able to adapt himself. . . . Let the surgeon be bold in all sure things, and fearful in dangerous things; let him avoid all faulty treatments and practices. He ought to be gracious to the sick, considerate to his associates, cautious in his prognostications. Let him be modest, dignified, gentle, pitiful and merciful; not covetous nor an extortionist of money; rather let his regard be according to his work, to the means of the patient, to the quality of the issue, and to his own dignity.”

There are many advantages to cooperation among surgeons. The American College of Surgeons serves on behalf of its Fellows, who represent the established surgical specialties. In this capacity, the College is available to serve as a forum, if needed, in which to discuss areas of controversy. If requested, the College will attempt mediation, but it is not an accrediting agency nor does it serve as a court of appeals for surgeons or for specialties in individual disputes. The College does not function as a disciplinary body for all of surgery, though it strictly enforces the stipulations of its own bylaws and the pledge that each Fellow makes to abide by the College rules.

By virtue of the broad representation of surgical specialists within the College, it is hoped that a unity of purpose may be maintained in the future. It is apparent that surgery will be influenced by many social, economic, and political changes, as well as scientific and technologic advances. Surgery will need a united organization to maintain its high standards of patient care in the coming decade.