Responsibility and Authority in American Surgery

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FIFTY YEARS AGO AN IDEAL conceived by Franklin H. Martin became a reality. The American College of Surgeons was established "not for pecuniary profit, but for the benefit of humanity . . . ."* The aims of this organization and the reason for its existence lie in its disinterested and unselfish efforts to elevate the standards of the profession, moral as well as intellectual, to foster research, to educate the public.

Today, this College, a fellowship of more than 25,000 accomplished surgeons pledged to this ideal, is the most influential surgical body in the world. It is my honor to welcome the initiates of 1963 to this Fellowship and my duty to speak to them of matters surgical. I have chosen to discuss the relationship between authority and responsibility in surgery. It is axiomatic that one cannot accept responsibility without authority. It is less evident, and generally forgotten, that since Magna Charta and the negation of the divine right of kings, most authority, at least in a democracy, derives from responsibility. The subject has cogent implications for all of us.

Responsibility is an essential condition of the surgeon's daily work. It is the guiding circumstance of his life. Yet, because of this overpowering concentration on the problem at hand, namely the lives of his patients, the surgeon is often less conscious of his responsibility to larger but less immediate issues. Let me illustrate this by an obvious, and for those of us who occasionally look backward, a somewhat painful example. There was a time when the surgeon assumed responsibility for all the details of operating room conduct and asepsis. This responsibility gave him authority. He was the master of the operating room. If he requested a change in procedure, it was done, and no questions asked. Today if he proposes the same sort of thing, he is apt to encounter a wall of bureaucratic opposition extending through several echelons of nurses to hospital administrators, and finally to a committee, some of whom have never been in an operating room! The responsibility has been shifted and with it has gone much of the authority. There are many reasons for this and the result is not necessarily all bad, but it illustrates what can happen.

I invite consideration of an area where we possess authority but where we must look to our responsibilities if we are to keep it. Standards of surgical education and training have been established in America without infringing upon the initiative and freedom of the individual surgeon. Although this has made the highest quality of surgical care available, there are forces in our society which in a misguided attempt to make things better would so regiment the practice of medicine and surgery that the result would be stultifying mediocrity.

It is a curious paradox that the more closely an organization approaches perfection, the more flagrant its shortcomings appear. This is true of a Navy ship or of a baseball team and is particularly the case with the medical profession today. We have never before produced such high quality and generally available care to the public. The reputation of any individual doctor with his patients has never been better.

Yet, as a group, as a social body, we have never been so criticized.

The problem can be illustrated with particular reference to surgical education and training. Any social body, whether it be a private club or the government of a great country, requires a combination of central control and individual independence if it is to function effectively. Without central control and guidance, progress is impossible. There is either confusion or anarchy. Without independence and initiative there is stagnation and mediocrity. The stronger the central control

*Articles of Incorporation, A.C.S., *Directory*, 1962, page 727.

Address of the President

WHEN DR. J. ENGLEBERT DUNPHY became the forty-fourth president of the American College of Surgeons on October 31, 1963, at the Convocation in San Francisco, he addressed the accompanying statement on responsibility and authority in American surgery to the 1,063 surgeons who had just been inducted into Fellowship.

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and the less it represents the social group as a whole, the more initiative, independence and ultimate freedom are suppressed. The record from pre-war Germany to present-day Cuba is the same. But these changes do not come about solely because of a misguided or evil leader. The social body itself allows it to happen because its members become indifferent to their responsibilities.

I would like now to consider the profession or medicine as a social body. Our mission is the prevention of disease and the best possible care of the sick and injured. To this end we have built great schools, vast research laboratories and splendid hospitals. We have eliminated the charlatan, the quack and the proprietary medical school from our ranks. This has come about through a loose but effective central control, namely, joint co-operative action on the part of our leading medical societies, particularly the American Medical Association, the Association of American Medical Colleges, our medical schools, state licensing boards, charitable organizations and foundations such as the Rockefeller and, increasingly of late, the federal government. All of this has been for the good, but we must bear in mind that today the strongest single figure in this coalition for progress is the federal government.

Masters Establish Authority

Now let us focus down on the surgical profession as a social body. We must go back nearly 600 years to the Guild of Surgeons in London. At that time, the practice of surgery was in the hands of the barber surgeons, and represented nothing but initiative and independence. There was no central control. All was confusion and anarchy and the victims were the public. It was essential that some mechanism be established to distinguish between the skilled and the unskilled surgeon. To this end two masters selected from the Guild of Surgeons were sworn before the court of Aldermen of the City of London and authorized to supervise the practice of surgery. Since that time, there has been a background of authority influencing the practice of surgery in England. Fortunately, the origin and exercise of this authority has rested largely with the professional body of surgeons. Today in Great Britain, no one can practice surgery or a surgical specialty without being properly qualified and having a specific appointment as a consultant.

In our own country, the situation is quite different. The American College of Surgeons was founded in 1913. It was modeled somewhat after the Royal Colleges but with no legal authorization. It sought to improve the quality of surgery by stimulating postgraduate education and by recognition of surgical attainment. Much was accomplished. Further progress came in 1916 when the American Board of Ophthalmology was founded, followed by American Boards of Otolaryngology, in 1924, and of Obstetrics and Gynecology, in 1930. The American Board of Surgery was founded in 1937 for the protection of the public and the good of surgery. It also has no legal authority and, therefore, has consistently refused to define requirements for membership on hospital staffs, and it has never concerned itself with the attainment of special privileges or recognition for its diplomates in the practice of surgery. Its primary purpose is to pass judgment on the education and training of broadly competent and responsible surgeons and not to designate who shall or shall not perform surgical operations.

Qualifications Assured by Boards

However, the Advisory Board of Medical Specialties, which is made up of representatives of the various specialty boards, the Association of American Medical Colleges, the American Medical Association and other interested groups, has specifically stated that the purpose of a specialty board is "to insure the public that persons claiming to be specialists presumably with special efficiency in one or another branch of medicine, actually possess the qualifications they claim." No legal support for this concept has ever been sought or thought necessary. It has been assumed that with the education of both the public and the profession, individuals seeking to specialize in various fields would naturally follow established channels. Generally speaking, this is the case. The public has become increasingly conscious of the identity of qualified specialists. Indeed, on recommendation of the professional staff of many hospitals, only qualified specialists are listed as such. Finally, the federal government has recognized the existence of board certification both in the Armed Forces and in the Veterans Administration.

Last year this College, through the Board of Regents, issued a fundamental statement* on the education and training of surgeons which should be familiar to all Fellows. In short, it calls upon any doctor who aspires to become recognized as a surgeon to follow the established and clearly defined requirements of the American surgical specialty boards. In essence, this puts in writing what

*Bulletin, January - February 1963, page 40.

has been recognized for many years, namely, that the basic aims of this College and the specialty boards of surgery are the same—the benefit of humanity.

Surgery as a social body is calling upon its members present and future to recognize their responsibility. The authority for this must come from our own responsibility.

Best Care for Ill Is Common Objective

What are our specific responsibilities? First, vigorous, intelligent and self-sacrificing support of existing surgical societies, especially this College and the Surgical Section of the American Medical Association, is essential. Surgeons have been lax about this, as a result of which we have witnessed attempts to establish a spurious "board of abdominal surgery." Secondly, we must enlist the support of our colleagues in medicine and in general practice. The Academy of General Practice has as its primary aim the education, especially the continuing postgraduate education, of the generalist and family physician. There is no conflict of interests here. There is plenty of room to discuss details, but we have but one common objective—education and training for the best care of the sick.

The question is not who should or should not do surgery. The question is how can anyone who intends to do surgery be so educated that he will bring only the best to his patients. There is real need for a study of this problem. There are many small communities where, at least at the present time, a surgeon cannot restrict his practice to surgery. We have some very able surgeons in my part of the country who are obliged to do general practice. They operate as well and they operate very well because they have been educated as surgeons. We must so improve our educational programs that for the small or isolated community we can provide surgeons who also engage in general practice rather than general practitioners who do a little surgery. I would say the minimum requirement should be a rotating internship and three years of surgical residency but this is a matter for serious study and re-appraisal.

Americans Indebted to A.M.A.

Finally, the American Medical Association must formally support the utilization of established educational programs for all who seek to become surgeons. More than any other body, the American Medical Association is responsible for the high quality of care at present provided to the American public. For more than 100 years, it has given responsible leadership in such vital areas as medical education, internship and residency training, hospital standardization, approval of new foods and drugs, medical ethics and patient-doctor relationships. Being a democratic institution, it moves slowly and not always in a straight line. Its motives are often misinterpreted and sometimes deliber-

New Officers *inducted at the Convocation on October 31, 1963 are (center) President J. Englebert Dunphy, Portland, Oregon, (left) Second Vice President Howard A. Patterson, New York, and First Vice President Reed M. Nesbit, Ann Arbor.*

ately distorted. It is a target for all critics either to the right or to the left of its position. Sometimes its image is marred by its own spokesmen, even as occurs in the government of the United States. But, if it failed either from outside pressure or inside indifference to carry on the responsible leadership it has exercised in the past, it would be a sad day for this country.

Before closing, let me call attention to a closely related problem requiring the authority of responsibility, namely, the increasing need for personalized family care in the midst of specialization. It is a sad paradox that the more specialized we become and the higher the quality of the care we have to offer, the more difficult it is to render it to the whole patient. This is of great concern to surgeons, because surgical care begins with diagnosis and ends with rehabilitation. The decision to operate, especially in diseases such as peptic ulcer, rests upon balancing the effect of environmental and a host of social influences on the course of the patient's illness. All too often, especially in the case of certain cancers, the most carefully planned operation ends in prolonged illness, debilitation and death. Surgery cannot divorce itself from these responsibilities and yet it cannot meet them all alone.

Team work with a competent, sympathetic and broadly educated family doctor is the only way that the surgeon can meet his responsibilities. This is the role that the general practitioner so often performs today. His position is the key to medicine of the future. His stature must be identical with that of the specialist whether family care is eventually recognized as a specialty or not.

This is one of the most pressing problems facing American medicine. Surgeons must take a responsible interest in it, because it is impossible to provide high quality surgical care without that knowledge of the whole patient which only a family physician can supply. Some of the happiest and most enriching experiences of a surgeon's life come from careful and critical consultation with his colleague the physician. When that colleague is a family physician and a personal friend and the decision brings hope, comfort and ultimately health to a gravely ill human being, the total experience is the essence and the joy of medicine. The idea of a "family doctor" is more than an old-fashioned tradition and a thing of the past. It is the key to the future of specialization. It is the only way we can bring science to the art as well as art to the science of medicine. We have a grave responsibility to this end.

Initiates of the American College of Surgeons for 1963, these are not idle matters I have laid before you. Our profession is a "service of friendship." Our joys come from the giving of ourselves to our fellow man. But, our responsibilities extend beyond daily devoted care to the patient. Only in their total fulfillment will we find the authority "to elevate the standards of the profession, to foster research, to educate the public."