Bull. Am. Coll. Surgeons, 1953, 38: 15-23, Jan.-Feb.

A Report to Our Founders*

Alton Ochsner, M.D., F.A.C.S., New Orleans, Louisiana

IT IS EXACTLY FORTY YEARS ago that the American College of Surgeons came into existence. From small beginnings it has become the largest and most active surgical organization in the world. It has exerted an enormous influence not only on surgery but on all other phases of medical practice. It has elevated ethical as well as technical standards. The whole nation is in its debt, for the advances which it has helped to bring about have improved the health and well-being of the entire population.

Our founders, I feel well assured, would have reason to approve the report of the achievements of the American College of Surgeons which I propose to make to them tonight in the address which is one of the duties of the retiring president. For our part, let us never forget that, whatever we have achieved, we owe to them, those wise and far-seeing men who set our feet upon the path that we should tread, who pointed to the stars upon which we should fix our eyes.

Let me begin by recollecting with you those early days of the College, when these surgeons, most of them now gone to their reward, wrought so wisely and so well.

FOUNDING OF THE COLLEGE

The American College of Surgeons came to birth in the mind of one man, Franklin H. Martin, who also has to his credit another substantial achievement, the founding, in 1905, with the encouragement of Nicholas Senn, William J. Mayo, John B. Murphy, and George Crile, of *Surgery, Gynecology and Obstetrics*. The subscribers to this journal were later to form the nucleus of the first Fellows of the College. The College, however, was not to come to birth at once. It was the outgrowth of another organization, also conceived and founded by Dr. Martin, the Clinical Congress of Surgeons. And the Clinical Congress was, in its turn, the indirect outgrowth of still another organization, the Society of Clinical Surgery.

This was a small organization founded in 1903 whose members then, as now, visited one another to exchange ideas and attend operative clinics. Dr. Martin was often a guest at the meetings, and one day as he sat in a popular clinic he had a sudden realization of what this progressive movement could represent in surgical education. It was a marvelous spectacle, he recalled in the address he delivered in 1928, when he was himself president of the College, to see the earnest interest of the leaders from all the great medical centers of the country, to hear their constructive criticism and their instructive replies, and to observe the eager faces of the 100 other surgeons present, men from provincial towns of the United States and Canada, who were not members of the Society but who were welcomed at its clinics. Equally stimulating, when the scheduled program had ended, was the informal round table at which the work of the morning was reviewed and free discussion was engaged in.

From that time forward the idea of permitting more physicians to share in this kind of educational program was frequently in Dr. Martin's mind. One day, walking the deck of a ship in the Mediterranean sunshine, he suddenly realized how the experience in which he had been privileged to participate at the Society of Clinical Surgery could be made available to all surgeons. With him, to think was to act. In February, 1910 he invited the 3,000 physicians who made up the subscription list of *Surgery, Gynecology and Obstetrics* to come to Chicago, to observe the work of the leading surgeons in that city.

The meeting was an unqualified success. Sixteen hundred surgeons registered. Many others attended but did not register. There was general sentiment for making the organization a permanent one. Accordingly, Dr. James B. Eagleson of Seattle, on November 19, 1910, posted a bulletin at headquarters asking anyone interested in forming a permanent organization to appear at a certain time and place. Several hundred surgeons responded and the formalities of founding the Clinical Congress of Surgeons of North America were promptly completed.

The great John B. Murphy, then at the pinnacle of his surgical fame, appeared on the floor to speak in favor of the new organization. His clinics were extremely popular and he was said to be the popular choice for the presidency of the new organization. In fact, the meeting, which was being called to order just as he entered the hall, rose to its feet and cheered him to the echo. When order was

*Presidential Address delivered at Clinical Congress, September 22, 1952, New York.

restored, he spoke in favor of founding the Clinical Congress and in a laudatory speech proposed the name of Dr. A. J. Ochsner of Chicago. Murphy's own name, as Loyal Davis tells the story, was repeatedly shouted from the floor, but he took the meeting into his own hands, obtained a second to his nomination of Dr. Ochsner, and requested a unanimous rising vote, which he obtained. So my own kinsman, and my medical and surgical mentor, became the first president of the Clinical Congress. He served as president of the College of Surgeons from 1923 to 1924, and when he died, a year later, he was buried, at his own bidding, in his robe of office. I think he would be happy if he knew that the young man whom he introduced to medicine has also worn the presidential robe of the College.

At the first formal Clinical Congress, which was held in Philadelphia in 1911, some 1,100 surgeons were in attendance. The meeting was another unqualified success. Indeed, it was almost too successful, for its very success created a number of problems that called for prompt solution. It was clearly necessary to control future attendance in some manner. Attendance at the operative clinics was so large that a ticket system had to be set up to prevent overcrowding. The clinics of John B. Deaver, for instance, were surgical *South Pacifics*. One of the most important, as well as one of the most delicate, problems which demanded solution was the decision concerning what hospitals and what surgeons would act as hosts at future sessions of the Congress. The general level of surgery in 1911 can be gathered from Dr. Martin's remark that "standards, ethics, and the general acceptability of guests and clinicians" raised acute questions.

Many of the surgeons who had founded the Clinical Congress realized the implications of these difficulties and were anxious about them, but none gave them the time and thought which Franklin Martin devoted to them.

The solution came to him, just as had the earlier idea of the Clinical Congress, while he was travelling. This time he was on the Twentieth Century Limited, en route to New York, to attend the 1912 session of the Congress. Calling in the stenographer who was one of the conveniences, and usually one of the attractions, of that then new luxury train, Dr. Martin dictated to her the aims of the College—they are still its aims—in five brief paragraphs.

Immediately on his arrival in New York, he says, filled with "feverish enthusiasm," he sought out John B. Murphy. Murphy was, understandably, not anything like as enthusiastic, for he was routed from his bath, and it was with considerable reluctance, and clothed only in a bath towel, that he consented to read Martin's notes (one is reminded of how Roosevelt broke in upon Churchill, in *his* bath, to proclaim his sudden inspiration to call the new league of nations the United Nations). As Murphy continued to read, Dr. Martin relates, his originally dour expression became more and more sympathetic, and when he had finished, he asked for the privilege of seconding and supporting the proposal when it was submitted to the Clinical Congress.

To the modern surgical mind there is nothing at all revolutionary about the concepts on which the American College of Surgeons was founded, but again we must remember the status of surgery in that day. It was with fear and trembling, Franklin Martin says, that he submitted his plan to the president of the Congress, Dr. Edward Martin of Philadelphia. Dr. Edward Martin, however, was enthusiastic about it too. Friday afternoon, November 15, 1912, Franklin Martin read his proposal to the 2,000 surgeons in attendance at the Clinical Congress and Dr. Murphy, as he had promised, seconded the motion. The "autocratic" Dr. Edward Martin, after "a few choice words of warning against imitating all things of pomp and circumstance of the effete past"—I quote Dr. Franklin Martin's story of the meeting—spoke on the importance of the proposal and recommended a rising vote in its favor.

The document which Dr. Franklin Martin had drawn up on the Twentieth Century as the train sped from Chicago to New York had been put in the form of a resolution, providing for the appointment of a committee of 12, with power to act in setting up a new organization of surgeons, to be closely allied to the Clinical Congress and to aid it in controlling its membership, its clinicians, and its moral and ethical regulations. Thus was the American College of Surgeons born. The committee on organization was selected almost exclusively from among "the old guard of progressive surgeons"—a curious juxtaposition of words and ideas to the 1952 ear—who comprised the Society of Clinical Surgery, which had served as the prototype of the Clinical Congress. The mere listing

of the names brings up memories of the surgical great of another day: Franklin H. Martin, of course, the "autocratic" Edward Martin, John B. Murphy, Emmett Rixford, Albert J. Ochsner, Charles H. Mayo, Frederic J. Cotton, George Emerson Brewer, J. M. T. Finney, Walter W. Chipman, George W. Crile, and Rudolph Matas, the latter happily still with us. Many of these men preceded me in this high office.

The work of organization was, of course, far from finished. Dr. Franklin Martin himself spent the next six months visiting the leading cities of the United States and Canada and conferring with the surgeons of high and good repute in them. In all, 550 were invited to the organizational meeting, which convened in Washington, May 5, 1913. At this meeting a constitution and bylaws were adopted, officers, a Board of Regents and a Board of Governors were elected, and, thanks to the skillful preliminary work of Franklin Martin and the skillful chairmanship of Edward Martin, "enthusiasm was stimulated, criticism modified, and opposition discouraged." The first president was a natural choice. Dr. J. M. T. Finney, then assistant to Halsted at Johns Hopkins Hospital, later his successor, was a man who was as universally admired and respected for his uprightness and integrity as for his surgical skill and judgment. Except for the exigencies of influenza in 1918 and of the war from 1942 to 1945, when the annual meetings had to be omitted, he was the only president of the College to serve more than one term of office.

The first Convocation of the American College of Surgeons was held in Washington in November, 1913. This is the thirty-sixth. We have come far in the years that have elapsed, but we would still do well to think back upon the men who founded the College and to remember that the concept of this great organization germinated in the mind and heart of a man who had great vision and who persuaded others to share it with him.

OBJECTIVES

Now what did Dr. Franklin Martin envisage for this organization—he himself called it a "comprehensive" organization—which he had brought into being? First of all, he planned that it should do on a large scale what the Society of Clinical Surgery had been doing on a small scale. Visiting surgeons, he felt, would profit by seeing their surgical confrères at work in their own environment and by discussing, with the "problems based on practical surgical experience, rather than listening to literary treatises based on theoretical deductions." As John B. Murphy had put it, in his usual forthright fashion, at the organizational meeting of the Clinical Congress, "Hearing papers and reading papers is one thing. Seeing men do things is another." Papers, and excellent ones, are read at the annual meetings of the College, but "seeing men do things" is still the chief objective of the Clinical Congress.

The second objective of the College was to enroll American surgeons who, in the opinion of their confrères, were competent to do surgery, who were "morally and ethically reliable," and who would support the ideals of the profession. Any licensed physician whose credentials, "under proper scrutiny," met its requirements would be welcomed into the College. It was further hoped that the organization, "by dignified means," would assist the public to recognize and obtain the services of these qualified men.

The third objective of the College was to eliminate the "financial dickering" commonly known as fee-splitting, and to bar from its ranks the surgeons who transgressed that rule.

The fourth objective was to seek by all legitimate means to protect the public from "incompetent, dishonest, and unnecessary surgery," and to take the lead, and bring to bear, all the resources of organized scientific medicine in an endeavor to improve what was properly described as "the whole environment in which surgery and medicine are taught or practiced."

Finally, this organization was to aid the public in obtaining all the benefits of scientific advice and all the services of preventive medicine, so that it would be educated "to distinguish between the reliability of scientific medicine and the false sophistries of quackery."

In 1952 those are just as much the aims and objectives of the American College of Surgeons as they were in 1913. They clearly imply the evils and deficiencies of medical practice in the year the College was founded. Forty years later we have come far in our correction of those early surgical sins. I hope you will understand that I do not speak with complacency, though I do speak with justifiable pride, when I ask you to look at some of the special advances in medical and surgical practice which this College has brought to pass.

"FINANCIAL DICKERING"

The pledge against what is commonly known as fee-splitting was proposed at the first meeting of the College, in 1913, by Dr. A. J. Ochsner. It was fitting that Dr. Finney, who was presiding, should speak for the motion. All his long and useful life he never hesitated to denounce what he thought was evil. To him fee-splitting was evil. Therefore, he denounced it. It was as simple as that. The American College of Surgeons, he said in his inaugural address, had within it the power to influence not only the United States and Canada but also the whole world. But it could not fulfill its highest destiny unless its standards were high and its aims lofty. There could never be any compromise with the forces of evil. The character of the Fellows of the College would determine the success of the College, for character "makes a man what he is . . . lifts him above the common herd." Men of character, said Dr. Finney, did not split fees. Again it was as simple as that.

Fee-splitting still occasionally rears its ugly head, as I need not remind you, but the evil which was rampant and a disgrace to the profession in 1913 has been almost completely checked. I think that if Dr. Finney were here tonight, he would be completely satisfied with the distance we have come in achieving that special goal, and would feel that his prophecy of 1913 had come true and that the College which he helped to found has had an influence, as he said, more far-reaching than "even the most sanguine" of his hearers then dared to hope.

HOSPITAL STANDARDIZATION

The new College, when it came to formulate the requirements for candidates seeking admission to Fellowship, found itself at a dead end. There were no standards of surgical training in the year 1913. It was then possible, as the "horse and buggy doctor," Arthur E. Hertzler, was to say with salty wisdom many years later, for a man to wake up some fine morning and declare himself to be a specialist. So the first thing the Regents had to do was to adopt a sound standard of surgical training. And to do that they had to acquire accurate data as to how surgeons were trained in hospitals as well as in medical schools. The latter, thanks to the Flexner Report, which had been published in 1910, were already well on their way to reform.

The Regents were thoughtful men and they realized that their approach to an investigation of surgical training in hospitals involved considerably more than the training of surgeons. They realized that it also involved the training of internists, as well as every other hospital policy and procedure designed for the welfare of patients. Out of this realization came the program that we now know as the hospital standardization program.

The Regents were wise men. They had the wisdom to comprehend, once they had recognized the needs of the situation, that this was not a task which the College might or might not undertake, as it chose. They knew that it was a task which the College must undertake, for, as they put it, this organization was "a responsible society . . . which aims to include in its Fellowship all who possess practical scientific knowledge of medicine and surgery, together with honor, trustworthiness, and strong moral character."

Finally, the Regents were men of common sense as well as wisdom. They recognized that among the hospitals of the United States were widespread differences in the educational opportunities offered. They also recognized that even when the physical facilities of two hospitals were the same, there might be widespread differences and much confusion in the use made of the opportunities available.

The Regents felt, therefore, that they had two problems to solve. The first was to investigate the existing standards in the practice of medicine and surgery. The second was to set up an acceptable standard. Out of that second problem came a comprehensive and uncomfortable question. Were the standards of the best hospitals in the land too good for the humblest patients in the smallest hospitals? That question, of course, could be answered in only one way, and so the American College of Surgeons entered the field of hospital standardization, in which it remains to this day. Last year it was one of my pleasant duties at the San Francisco meeting of the College to attend some of the sessions of the thirty-first conference on hospital standardization.

But let us go back to the beginning. In January, 1916 the Carnegie Foundation of New York made a gift to the College of thirty thousand dollars to assist in the investigation. In September of that year the American Hospital Association was invited to participate in the program and appointed a co-operating committee. After a number of preliminary surveys Dr. John G. Bowman, then

director of the College, was authorized to draft a set of standards, which the Regents, who again showed that they were men of common sense as well as of wisdom, had decided should be minimum. These standards were endorsed in October, 1917 and the Board of Governors soon afterward approved the program, which was to be undertaken by the College alone. The American Hospital Association felt that it could not participate actively in the investigation because its funds were limited, and the American Medical Association, which had also been invited to co-operate, declined for the same reason and because it was deeply involved in the problems of medical education.

The initial survey of hospitals had to be postponed from 1917 to 1918 because of the exigencies of World War I, and the report on the survey had to be postponed until 1919 because the 1918 Clinical Congress, like most of the meetings scheduled for that fall, was among the influenza casualties. In October of 1919 the first report on hospital standardization and the first list of approved hospitals were printed, but neither of them ever saw the light of day. The night before the reports were to be presented to the assembled Fellows of the College, it suddenly dawned upon the committee which had prepared them that the findings were so damning, and the list of approved hospitals had so many embarrassing omissions of important institutions, that the wisest plan would be to suppress the printed reports and the names of the approved hospitals and make public only the number approved. So, at midnight, the formal report and the printed lists containing the names of the "embarrassingly too few" hospitals were solemnly cremated in the furnaces of the old Waldorf-Astoria. That is a hotel of many memories and associations but its furnace room probably never witnessed a stranger sight.

We have, of course, passed far beyond those days. The first three surveys were limited to the same 692 hospitals, each with a hundred or more beds. Only 89, 12.9 per cent, met even the minimum standards in the 1918 survey. Two years later the number had risen to 396, 58.8 per cent. Last year, of 2,279 hundred-bed hospitals surveyed, 2,157, or 94.7 per cent, fulfilled the minimum standard. I am sure I need not remind you that although we have never altered the original minimum standard, its interpretation has been steadily broadened to meet changing conditions.

It was not long before the hospital standardization program spread far beyond its original limits. Hospitals of 50 to 99 beds were included in 1922, and hospitals of 25 to 49 beds in 1924. Last year more than three quarters of the former group and almost half of the latter were accredited by the College. In many respects that is even more remarkable than the almost 95-per cent accreditation of the larger hospitals with their greater resources and better trained personnel.

In 1925 the Veterans Administration hospitals and the U.S. Army, Navy and Public Health hospitals were surveyed, at the request of the responsible authorities. A year or two later the director of hospital activities of the College was loaned to the States of Victoria and New South Wales, Australia, at the request of their governments, and to the Dominion of New Zealand, at the request of the New Zealand Branch of the British Medical Association, to survey their hospitals and make recommendations for future policies and developments.

Unless one has some familiarity with the hospitals of 1913 it is not possible to appreciate the differences between them and the hospitals of 1952. In 1913 all equipment, particularly in the operating rooms, was meager. Laboratories were small, poorly equipped, and not very well patronized. Records were incomplete, if they existed at all. There were few residents and almost no resident teaching. Staff meetings were seldom or never held. If they were scheduled, they were poorly attended, and the critical analysis of therapeutic results, and particularly of fatalities, which make up the agenda of hospital staff meetings today, was almost never undertaken.

Today most hospitals are well equipped. Large numbers are excellently staffed. There are many residency training programs and the number is increasing yearly. Records, while they still leave much to be desired, are a far cry from the records of 40 years ago. Regular staff meetings are held at which errors are frankly discussed and deaths are debated from every aspect. These things are true not only in the teaching and other larger hospitals but also in the smaller ones which have been constructed in rural communities with the aid of Hill-Burton funds. In short, the patient, who is the reason why hospitals exist, is not only better cared for, he is also far safer in the hospitals of 1952 than he was in the hospitals of 1912.

I would be derelict in my duty if I did not say that the initial success of the hospital standardization program is attributable to the efforts of Franklin Martin and John G. Bowman, then secretary-general and director, respectively, of the College, and the Reverend Charles B. Moulinier, S.J., then president of the Catholic Hospital Association and spokesman for the Catholic hospitals of the United States. Malcolm MacEachern took over the program in 1923 and thereafter did more than any single person to make it a success. His high standards, tenacious determination, indefatigable energy and ability to inspire others with his own enthusiasm for this cause made it impossible for the program to fail.

Evarts Graham, in his presidential address in 1941, said that it would be no exaggeration to say that the program had been no less powerful than the trained nurse in carrying the benefits of modern surgery to the general public. He spoke with truth. Had the first Regents of the College not appreciated the need for a reform in hospital care, and had they not initiated and continued the hospital standardization program, it is entirely possible that the concept and its fulfillment would have come to some other organization. As it is, the pride of achievement is ours, and all of us would agree that the two million dollars spent on this program has been a sound investment. All patients in all hospitals have profited from the increased facilities and improved efficiency which have been a natural consequence of the program. We have fulfilled our trust, and we have performed a constructive service to the profession and the public.

Hereafter we shall not toil alone in this field. Over the last years it has become increasingly apparent that the steadily mounting cost of all services, as the result of the current inflation and the relatively fixed income of the College, would soon make it impossible for us to continue this vast undertaking without help. For this reason negotiations were again entered into with the American Hospital Association, American Medical Association, and the American College of Physicians. In November, 1950 these four organizations agreed that a co-ordinated effort toward hospital standardization was both desirable and essential. A little later the Canadian Medical Association was invited to participate in the project. The Joint Commission on Accreditation of Hospitals held its first meeting in December, 1951. This does not mean, of course, that the College has lost any of its original interest in proper hospital service or in the standardization program. It means, instead, that with a sharing of the costs of the program, and with the co-operation of other interested organizations, still wider fields of usefulness will be open to us in the future.

CLINICAL CONGRESSES

I have spent perhaps an undue amount of time on the hospital standardization program, but in a sense it forms the background of whatever the College has been able to achieve in the elevation of the standards of surgery in this country and elsewhere and in the provision of surgical training, without which those standards could not have been elevated.

Let us go back now to the Clinical Congress, out of which the College of Surgeons grew. The thirty-eighth is now in progress. These yearly gatherings have made of the College a great educational institution. If you will compare the program of the first Congress with the program of the current Congress, you will see how greatly we have expanded our activities and our fields of interest. No other organization offers such opportunities as do the Congresses, with operative and dry clinics, formal presentations by authorities in special fields, panel discussions, moving pictures, television, and the Surgical Forum. If the College had done nothing else but sponsor the Surgical Forum, which was conceived and nurtured to maturity by Owen Wangensteen, it would have reason for pride. I can think of no other gathering in which so much new and authoritative information can be obtained so quickly and so easily. In the seven meetings which preceded the current Forum there were 741 presentations of new investigative material, and the 1952 Forum offers equally rich fare.

The troubles which beset the earlier Congresses are, however, now besetting us. The steadily increasing membership of the College—it will be 18,000 Fellows after the Convocation Friday night—has made it physically impossible to hold meetings anywhere except in three or four large cities. The hospital standardization program settled for all time the hospitals in which clinical presentations should be made, but the demand for tickets of admission to the clinics has continued to outrun available space.

The solution of that problem seems to be more emphasis upon sectional and local meetings. This

would be in line with the early planning, in which provincial and state organization was an important component. These meetings are now important, and they will become more important in the educational activities of the College as time passes. Because attendance will naturally be smaller, they can be held in smaller cities and operative clinics can be featured in them perhaps even more than in the annual Congresses in the larger cities.

These sectional and local meetings have other advantages. They provide a forum for the dissemination of surgical knowledge, and they are particularly useful, I believe, to our younger surgeons. I might say at this point that there are now 810 of these younger men in our Junior Candidate Group, which has been active since 1924. I might also say that the first regional meeting of the College to be held outside the United States or Canada took place in Panama last January and was highly successful, and that the second is scheduled in São Paulo, Brazil, in the spring of 1953.

GRADUATE TRAINING PROGRAM

The graduate training program, designed to increase and improve facilities for advanced medical training, has paralleled the work of the hospital standardization program. As of January 1952, 515 programs in general surgery and 652 additional programs in the surgical specialties had been approved.

In our approved residency program we are following the policy adopted in the hospital program, but instead of calling it the "minimum standard" we have called it "fundamental requirements for graduate training in surgery." We have also followed another policy of the hospital program, co-operation with other organizations with similar interests. The College, working in a joint conference committee with the American Board of Surgery and the Council on Medical Education and Hospitals of the American Medical Association, has established requirements for residencies in general surgery and has issued a single approved list of residencies. Similarly, the College and the Council have joined with the American Board of Otolaryngology to establish requirements for residencies in that field and to issue a single approved list. Similar action for other specialty residencies is planned for the future.

SPECIAL COMMITTEES

A good deal of the work of the College is carried out by standing or ad hoc committees. Let me mention a few of them, to show you the ramifications of our interests.

The Committee on Motion Pictures every year reviews many scientific films and approves those which meet the standards it has set up. In 1950, of 135 new films reviewed, 96 received the stamp of approval and the total number approved to date stands at 1,126. Those of you who are accustomed to look at the new listings which appear regularly in the College's BULLETINS can testify to the usefulness of this particular service.

The Committee on Motion Pictures has also stimulated production of a number of films made specifically for teaching purposes. They include such practical subjects as shock, various types of fractures, bronchogenic carcinoma, anomalies of the bile ducts, the diagnosis of surgical lesions of the alimentary tract, and injuries of the peripheral nerves. No doubt most of the medical men in this audience have taught from one or more of these films, or have been taught from them.

In line with its activities in hospital standardization the College has interested itself in a subject of increasing importance in our American way of life, medical care in industry. In 1926 a Committee on Industrial Medicine and Surgery was appointed to survey these services and to approve those which complied with a minimum standard set up by the committee. With the establishment of the American Foundation of Occupational Health in the spring of 1951 College activities in industrial medicine were transferred to this more comprehensive and specialized organization. It is a matter of satisfaction, however, that the last list of approved organizations, published in December, 1950, contained the names of 1,459 plants, 63 per cent of the 2,293 surveyed. The importance of this particular college activity is evident in the fact that 6,045,000 persons were then employed in the plants on the approved list.

Closely allied with the improvement of medical care in industry is the work of the Committee on Trauma. This is an extremely active committee which is responsible for many improvements in the emergency care of fractures and other trauma. It is largely due to the efforts of this committee that ambulances and similar vehicles are now generally equipped with apparatus for the safe handling and transportation of accident victims. At the present time its chief concern is preparation of

a manual on the emergency care of all varieties of acute injuries. The text is specifically intended for general practitioners and surgical residents, as well as for general surgeons, but in the unhappy event of a mass disaster it will find another wide field of usefulness.

The Committee on Cancer was authorized at the initial meeting, in 1913. It has performed various useful functions through the years. One of its earliest duties was to serve as a registry for five-year survivals in malignant disease. Another was to set up a registry of bone sarcoma. In 1935 Robert B. Greenough, who had been active on the committee since its inception, devoted his presidential address to cancer clinics and cancer services in general hospitals, matters which had been occupying the attention of the College for the last several years. At the present time the chief activity and the chief responsibility of the Committee on Cancer have to do with cancer facilities, which are approved or not approved according to a minimum standard. To date, the committee has approved 12 cancer hospitals, 538 cancer clinics, 133 cancer diagnostic clinics, 138 cancer detection clinics, and four departmental cancer clinics. The cancer record forms devised by the committee are in general use, and one of the points upon which the committee has laid the greatest stress is the keeping of complete records, particularly complete follow-up records.

Cancer is now the captain of the men of death. We do not yet know its real cause. With each passing year surgery has become bolder and safer, and other methods of treatment have been introduced and improved, and yet, tragically, we are still seeing most patients with cancer too late to save them from their disease. At the present time, as would be expected, most patients with cancer are seen in private offices, but that does not lessen the usefulness of these College-encouraged and approved clinics, in which early cancer is diagnosed and unsuspected cancer is discovered. This is another of our activities by which the whole nation has profited.

The Committee on Nutrition of the Surgical Patient in Relation to Pre- and Postoperative Care was the inspiration of Dr. Frederick A. Coller. In the three brief years of its existence it has done a remarkable piece of work. Since its personnel is made up of eminent authorities in this special field, it is small wonder that it has already done so much to attain one of its objectives, to co-ordinate diverse problems of preoperative and postoperative management and thus lessen confusion as to acceptable methods of therapy. Useful panel discussions have been held at the Clinical Congresses and at regional and local meetings, and extremely useful papers on various phases of nutrition have already been published or are in preparation. I find the work of this committee significant. It indicates how responsive the College is to the problems of the moment. I need not remind you that when this organization was founded, and indeed until relatively few years ago, nutrition of the surgical patient was not a matter which gave anybody a great deal of concern. Now we are more and more aware of how much preoperative and postoperative management can influence the outcome of an illness and how, in major surgery, it can sometimes determine whether the patient is to live or die.

INTERNATIONAL ASPECTS

At the present time surgeons from 59 countries are Fellows of the College. This did not happen by chance. Almost as soon as the organization was founded Dr. Martin visualized the inclusion of surgeons from other countries in its Fellowship. No active steps could be taken until World War I had ended, but it was not long thereafter that he and other officers visited a number of countries in Latin America, with the idea of interesting the profession in the College and in what it stood for. Thirty-five surgeons from these countries became Fellows at the 1920 Convocation. At the 1951 Convocation there were initiates from 12 different countries other than the United States and Canada.

This is literally an *American* College of Surgeons, for our Canadian brothers have been part of the Fellowship from the time the College was founded. Our ties with Canada's motherland have also been close and intimate. The mallet used at these Convocations was made for, and used by, Lord Lister, and was given to the College by his son-in-law, Sir Rickman Godlee, then president of the Royal College of Surgeons of England, in memory of the honorary Fellowship granted to him in 1913.

The great mace carried in processions at all College Convocations was also a gift from surgeons of the British Isles. It was presented to the College

in Montreal in 1920 by the consulting surgeons of the British Army, with Sir Berkeley Moynihan as their eloquent spokesman. "We pray," he said, "that you may regard it as a symbol of our union in the harsh days of trial, as a pledge of our devotion to the same imperishable ideals, as a witness to our unfaltering and unchanging hope that the members of our profession in the two lands shall be joined in brotherhood forever in the service of mankind." Our two great nations fought side by side again, a quarter of a century later, and many of the other nations represented in the College also fought with us, just as, in the years between the wars and in the years since the last war we have strived, in this organization, to serve all of mankind in the paths of peace.

FELLOWSHIP

And now, in conclusion, let me speak of what Fellowship in the American College of Surgeons means. There are two groups, the active Fellows, who are admitted by examination, and the Honorary Fellows, of whom I shall speak first.

In all, there have been 160 Honorary Fellows, a small number American, the majority British, the remainder chiefly from European and Latin American countries. Among the five men who were admitted to Honorary Fellowship at the first Convocation were William W. Keen, then the dean of American surgeons; William Stewart Halsted, who, it is not too much to say, conceived the system of surgical training by which most of the present Fellowship of the College has been trained; and Sir Rickman John Godlee, already identified as president of our sister organization in England. They had worthy successors. Their names, like the names of our founders, are a roll call of the surgical great. They evoke memories of past achievements. They bring to mind achievements that we have seen with our own eyes and heard with our own ears. It could not be otherwise. From its inception, the policy of this College has been to grant its Honorary Fellowships only where and when they have been earned. We do not traffic in expediency or seek for political profit. We were founded to establish "a standard of competency and character for practitioners of surgery." Our Honorary Fellowships are awarded on that basis alone.

My final word is for the active Fellows of the College who by training and examinations have won their right to this honorable title. Active Fellowship is a mark of accomplishment, a sign and symbol that exacting requirements have been fulfilled. As the years have passed, those requirements have become more stringent. That is as it should be.

One thousand and fifty-nine candidates were received en masse at the first Convocation in 1913. Last year, at the thirty-sixth Convocation in San Francisco, it was my privilege to receive into Fellowship 899 candidates. This year the number will be something over a thousand, about 70 per cent of whom have already been certified by the American Board of Surgery. These are literally chosen men. Each year the class of candidates includes only a certain proportion—sometimes the proportion has been less than half—of those who originally sought Fellowship. I think you will agree with me that this also is as it should be.

The founders of the American College of Surgeons conceived it and established it "for the benefit of humanity by advancing the science of surgery and the ethical and competent practice of its art." I have tried tonight to point out some of the ways in which we who came after them have tried to fulfil the trust which they handed down to us. Some of the things we have done were beyond the surgical horizon when the College was founded, but competency and character and faithful performance of obligations have not changed. They were the ideals of the founding fathers of the College. They remain our ideals. But let us, while working "for the benefit of humanity" not forget another portion of the Hippocratic Oath. Let us not forget that our work is also "for the benefit of the patients," the individual men and women who seek us out in their hours of trial, and who need compassion and understanding as well as scientific care.

If we remember these things, we shall fulfill in the future, as I think we have in the 40 years already passed, the aspirations and hopes that our founders had in their minds and hearts when they conceived and established the American College of Surgeons.

Trauma Group Meets in Chicago

JANUARY 30 AND 31, 1953 will find members of the College's Committee on Trauma meeting in Chicago. Drs. Michael L. Mason, James J. Callahan, and James K. Stack are in charge of the program. Dr. R. Arnold Griswold, Louisville, will preside.