Fellowship: The benchmark for American surgery

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The American College of Surgeons has a distinguished history of selfless service for better care of the surgical patient. Canadian surgeons are proud of their heritage in the conjoint founding of the College with the American surgeons and their participation in its pursuit of high quality over the years. You have done me, a Canadian surgeon, extraordinary honor for which I am deeply grateful, but which I am sure reflects most on Canadian surgery and my surgical science, neurological surgery.

In putting my thoughts together for this convocation with our esteemed Honorary Fellows, it became apparent to me that your addition to the ranks this year as new Fellows is the real harvest of the College's effort; you have become the benchmark for American surgery, renewed each year in ever increasing numbers.

Your designation as a benchmark came to mind as a result of a formal discussion last year on hospital accreditation with some officials in the AMA who seemed not to appreciate the depth and extent of the education and training necessary to form first class surgeons. They expressed doubts about the recommendation in the new medical staff standards of the Joint Commission on the Accreditation of Hospitals (JCAH) that "specialty board certification or eligibility is an excellent benchmark to serve as a basis for granting clinical privileges." They felt that this ideal was not necessarily a preferred option for granting hospital privileges, even in surgery. This stance by some AMA officials may be viewed in conjunction with the proposal by the late W. C. Bornemeier, a Fellow of this College and one time president of the AMA, that general and specialty surgical training programs be sharply abbreviated, so that surgical operations might be done by partially trained physicians.[1] No data were presented to support this contention, one that would seem to belie common sense.

Definitions

The specialty lists of the AMA are based on self designation as to the nature of one's practice, no matter the background of training. As W. Dean Warren noted in his 1983 Presidential Address to the American Surgical Association[2], the AMA is not committed to the fundamental concept that surgical operations should be performed by the completely trained and tested surgeon, although recently in the AMA's *Principles of Medical Ethics*, it was recommended that "the physician should not undertake the care of a patient whose medical condition is not within the physician's competence, skill and training."

A benchmark is not an option in any sense. It is a level of attainment that serves as a standard by which others may be measured—at least in its modern usage outside the surveyor's realm.

From the College's inception, it has struggled to upgrade the standards of surgery in North America and elsewhere. This was the reason for its origin. In the beginning, it was a matter of providing a forum whereby surgeons, having no other opportunity, could come together in the presence of their senior colleagues to learn the advances and changes in surgical knowledge and technique.

It soon became evident that Fellowship in the College had to be related to established criteria that would indicate to physicians and the public that College members were properly qualified. Fellowship in 1913 was based on a 100-case survey of a surgeon's work after a training period of one to two years after internship, and then an assessment of his moral, ethical, and other personal qualifications; this in lieu of an organized residency training and examination system, which was rare in those days.

By 1920, the Regents accepted, as sound evidence of appropriate professional training, the certificate of the American Board of Ophthalmology, the first American specialty board. The Regents believed that this would allow other groups that were better suited for the task to give examinations and grant certification for fitness in training. They strongly believed that they should concentrate on the improvement of hospital standards for patient care, and on the ethical and professional practices of their Fellows while contributing to continuing education in surgery. In short, the Regents favored separation of responsibilities for education and certification.

Quality control

Untrained and unethical surgical practice in North

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America must have been a source of deep concern to the early Board of Regents. Otherwise they would scarcely have stepped away from the initiation of a formal examination process, which was the primary responsibility of the older surgical Colleges in Great Britain and Ireland, and was later to be assumed by the newer Colleges in Australia and Canada. Even so, this was the first organization that attested to proficiency *and* character in surgeons. As Rudolph Matas said in 1926, "The public now knows that it is our purpose that only men who have given proof of their competence by fulfilling the requirements of the College should be entitled to public recognition and trust, as surgeons."[3]

These criteria for Fellowship prevailed (not without some controversy) even after formation of the American Board of Surgery in 1937, when a rigorous system of education and practical training in approved programs and a final examination were introduced to upgrade the standards for certification as a surgeon. The American Surgical Association Presidential Address of W. Dean Warren in 1983 graphically portrays the difficulties and personalities involved in this story. Beneath it all, however, was the desire of senior American surgeons to provide capable and ethical surgeons for the general public.

Meanwhile, the requirements for Fellowship in the College had been geared to what was attainable by the majority who wanted to be accepted as surgeons. "Board eligibility" (an unsatisfactory term) became the usual criterion, particulary after Dr. J. Englebert Dunphy issued his compelling statement on the education and training of surgeons in 1963: "in short, it falls upon any doctor who aspires to be recognized as a surgeon to follow the established and clearly defined requirements of the American Specialty Boards."[4] Only in 1977 did board certification become a prerequisite for membership in the College.

In his 1924 Presidential Address to the College, Dr. W. W. Chipman of Montreal noted that about one of every six practicing surgeons in this country was a Fellow of the College.[5] The ratio has more than doubled in 60 years to almost 40 percent, based on 1981 AMA data denoting approximately 98,000 active surgeons in the US, 38,000 of whom were College Fellows. If only board-certified surgeons are included, the ratio is even better, since 50 percent of the board-certified surgeons in the US are Fellows of the College.[6] Even so, an estimated 22,000 uncertified surgeons are practicing surgery in some degree.

The earliest form of quality control for surgeons is training in an accredited program and success in the examination system. A substantial number of surgeons have completed accredited training programs satisfactorily but do not intend or are reluctant to take the board examinations; others have tried and failed. The widespread acceptance of board eligibility as a standard for hospital surgical privileges is obviously a factor in the decision not to take the examination for some who find it difficult to make the time or effort in the midst of a busy practice to prepare; for others it is the fear of failure. Surgeons who fail have at least completed accredited training and have been judged eligible to sit for the examination. But for many, already having unlimited surgical privileges, there is no incentive to prepare themselves again. Even incompletely trained surgeons are given privileges in some hospitals.

Dr. Warren has called attention to another problem. Because of some weakness in the accreditation system, not all residencies meet the national standard, but recruit the majority of less well-qualified trainees. Few would contend that successful completion of either the accredited training or examination system is invariably reliable in distinguishing those who should be recognized as competent surgeons. But at least these criteria constitute a comprehensive, fair national standard that surgeons should meet to merit the public's trust.

Canadian system

Since Canadian surgeons are a founding part of this College, it may not be inappropriate to discuss the current Canadian system. With the 1929 founding of The Royal College of Physicians and Surgeons of Canada (which certifies both internists and surgeons) a similar objective was stated: "To contribute to the improvement of health care for Canadians through the provision of a designation for specially trained surgeons, whereby it may be known that they

are properly qualified." This knowledge was to be circulated to the public, as well as to the medical profession. But even after World War II, about 60 percent of surgery in Canada was done by occasional surgeons who were general practitioners with little surgical training, operating in great part outside the teaching hospitals.

Gradually, with the surge of specialty training after the war, communities welcomed the influx of well trained surgeons for their hospitals. Thereafter, the occasional surgeons did less and less as a result of changes in referral patterns and attrition. Now, most hospitals require Royal College certification for the granting of surgical privileges.

Even Canadian provincial governments recognized the importance of qualified surgeons when Medicare was introduced into Canada in 1966. Every surgical procedure was recompensed through a schedule of fees which the health ministry would recognize only for those surgeons holding Royal College or Quebec certification. Until 1981, in Ontario a differential fee schedule was in place, with unqualified practitioners recompensed at much lower rates. The term "board eligibility" has no official recognition, although it is occasionally used for limited, temporary surgical privileges in special circumstances until success at the certification process is attained.

Virtually all surgery in Canada is in the hands of certified surgeons, due to the successful extension of Canadian training and certification programs and their recognition by the public, the profession, and the governments. Except in the province of Quebec, which has a separate certification process, over 95 percent of certified surgeons in Canada have chosen to become Fellows of the Canadian College with its expanded objectives.

Commitment

Therefore, I can say that as the newest members of this College, you are the real benchmark for American surgery, just as the Fellows of The Royal College of Physicians and Surgeons of Canada are for Canadian surgery. It is not just that you have concluded the certification process successfully and have been judged morally and ethically fit. Rather, you have aspired to more—to continue your learning and to be part of what is best for the surgical patient, for surgery, and for surgeons by committing yourselves to the tenets of this College.

The significance of your designation as the benchmark of surgery was not come by easily. It was the result of a long struggle by your forebears in this College and in the Canadian College to elevate hospital standards, to promote surgery by qualified surgeons, and to eliminate those odious inducements to referral: fee-splitting, ghost surgery, and itinerant and unjustified surgery. This is a remarkable record of achievement. You and I, as well as the public at large, owe much to the foresight and resolve of these forebears.

That you now serve as the benchmark for surgery confers great privilege while imposing stern obligations. What deeper pleasure can there be than trying to help people as a surgeon with your hands, as well as your mind, but always as a professional—having knowledge of what is important in our scientific past and present, and using this as best we can for those who are sick or hurt; to teach others gladly, freely, and with devotion; to reflect on what was done and how it might be better done; and to seek new avenues for management of the diseases we face. It was for this skill and dedication that western society, in a history dating back to Edward the Confessor, has granted the professions self-government including self-control of their educational process.

However, this professional privilege is being sorely tried. Recently, there have been tremendous changes in the United States: alterations in traditional concepts about medicine and the delivery of health care, stemming largely from the desire to contain health-care costs. These changes apply to hospital and possibly physician reimbursement. They include the perception of an oversupply of physicians, the pressures from non-physician health-care providers and from the legal profession, and the increasing emphasis on hospital management as a business enterprise. Many of the changes have been made without deep consideration of the effect on quality of care.

While these pressures from society are little of our doing, we would do well to listen and act appropri-

ately in this politically charged environment. An economic storm is gathering over access to health care and its quality and cost, perhaps leading even to restriction of options for patient care. But the major concern of this Fellowship is quality—access and cost will be largely matters for society to decide.

Influencing the public

The public perception of your attitudes is important. On the subject of law and medicine, Newton Minow said, "Most of the time, the law follows and reflects social values. Therefore, the legal implications for the practice of medicine in this decade, and for as long as our society remains free, will depend on how society values and perceives physicians. If the public looks upon physicians as you and I like to see them—individuals selflessly committed to healing the sick and comforting the suffering with compassion and care for the emotional and psychological needs and the financial circumstances of the patient and his family, then the law will smile upon the practice of medicine."

"But," he continues, "on the other hand, if the public comes to regard physicians as highly trained men and women who are in practice only to maximize their incomes and who have little interest in the needs of those whom they treat, then the law will frown upon physicians and the implications for the independent practice of medicine will be bleak."[7]

The influence of this surgical Fellowship in the public domain can be profound. From each of your patient encounters, there will be some impact that will help mold society's attitude toward our profession.

Arnold Relman has warned of a growing sense throughout the country that physicians are highly trained, highly technical businessmen.[8] He cited advertising, recent FTC rulings, and physician involvement in corporate concerns: "Medicine can lose its special position as a learned profession if health care is regarded as a commodity to be dispensed like any other service." Recently Mr. Justice Emmett Hall, who headed the first Royal Commission that led to the establishment of Medicare in Canada in 1966, had a carefully worded message for doctors: "Their profession is not and cannot be a law unto itself."[9] He was speaking on the new Canada Health Act, which requires Canadian doctors to adhere to a negotiated fee schedule and reduces federal grants to provinces that permit a hospital surcharge by an amount equal to that collected. He said that physicians' monopoly on an essential service meant government must be involved in the profession.

Concerns

The struggle for quality continues against the erosion of standards and ethics so long fought for, yet now threatened by pressures of economics and litigation from those who would demean quality. We must protect the public by promoting the concept that surgery should be done by surgeons.

The College, in 1919, developed the first hospital standards for the improvement of your workplace and was responsible for them until 1952, when, because of the magnitude and cost of this effort, it had to reliquish its sole authority to the JCAH, in which the AMA and the AHA held a strong majority representation. This majority can stifle the voice of the College, which for so long has been concerned with the best achievable in hospital standards. The concern of the College is appropriate, especially when one recalls that nearly half (45.2% in 1981)[10] the patients admitted to acute-care hospitals had surgical procedures performed.

Just over a year ago, this College was deeply involved in a campaign to prevent the degradation of hospital standards and care by a proposal of the JCAH that threatened to remove licensed physicians from overall responsibility for patient care in acute-care hospitals and, in some circumstances, to remove control of the hospital medical executive committees.

Such was the outrage of the profession that this folly was withdrawn and the symbolic term "medical staff" reinstated. Because the other "parents" of the Commission feared massive litigation, sufficient support could not be sustained to revoke the remaining stipulations in the standards that permit limited licensed practitioners to admit patients independently to hospitals without pre-admission consultation by a physician and, further, to allow such practitioners to practice independently in the hospital—presum-

ably even operate. Under a new law, District of Columbia hospitals cannot deny clinical privileges to podiatrists and nurse practitioners and anesthetists, among other non-physicians. As Dr. Hanlon notes, "such expansionist strivings are encouraged by the highly debatable notion in Washington that services of equal quality may be provided by individuals with lesser education than the physicians they aspire to replace."[11]

In another matter, the College is defending, in litigation at substantial cost, its basic ethical prohibition against itinerant surgery, wherein a surgeon operates occasionally at a distance from his principal hospital and leaves the patient in the care of those less qualified to manage all the critical events that may emerge in the postoperative period.

Surgery has been called an act without appeal. It is self-evident that surgery should be done by those best qualified, surgeons who have met a national standard of training and assessment—American or Canadian Board certification. An *informed* public would want no less.

In the ACS poll of 1980, the overwhelming majority of Americans, including Congressional opinion leaders, felt that only medical doctors with specialized training should be allowed, *by law*, to perform surgery.[12] At that time, remarkably few Americans were familiar with this College and its dedication to surgical accountability and competence, and were being confronted with the massive media misrepresentation of unnecessary surgery and the family practitioners' advertising campaign. It was time to let the public know about the College and its Fellowship.

Since May 1980, the College's public information campaign "Surgery by Surgeons" has had wide publicity, in a syndicated column that has appeared in community newspapers, and by advertisements placed in consumer magazines. The message has reached tens of millions: "You trust him with your life, shouldn't he be a surgeon?" The campaign is an effort to help the public determine the criteria for a qualified surgeon, including Fellows who have pledged to continue to learn, serve, consult, care, and uphold the ethics of our profession.

Conclusion

The strength and integrity of this surgical organization is derived from its member surgeons. Officers and committees can only consider and act on the concerns and convictions of the membership and with its support. It follows that collaboration with community, state or provincial, and national organizations is very important. It is there that the strength of the College will be organized for the direction of its influence.

Let your views be known and become involved in some aspect of the College's affairs. Your work is cut out for you if you are to stand up for first-class, responsible surgery with high principle, and are to be counted in the struggle against the erosion of standards or other action that would limit the impact of good surgery. It can only be said again that the high quality standards of this College are self-imposed. They are not in the interest of surgeons, but are designed for improved care of the surgical patient.

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