BULLETIN
American College of Surgeons
November · December 1967 volume 52 number 6

The heritage and obligation *of Fellowship*

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Address of the President. Reed M. Nesbit was inaugurated president of the American College of Surgeons on October 5, 1967, at the Convocation in Chicago. He is professor of surgery, University of Michigan Medical School and head of the genitourinary section, Department of Surgery. In accepting the insigne of office from his predecessor, Walter C. MacKenzie, of Edmonton, Dr. Nesbit said:

"Receiving from you the insigne of the president is a personal satisfaction as our friendship of over 30 years has been a treasured and rewarding experience.

"From the earliest days of the American College of Surgeons, Canadians have played an important guiding role in the organization and in the conduct of its affairs. The presidency has been held by five Canadians. Armstrong, Chipman, Gallie, and Philpott, preceded you in office, but none served with greater distinction and devotion than you.

"During the nine years of your Regency, your wisdom, courage and diplomacy added great strength to that Board.

"Your presentation of the new Canadian flag in 1965 was a heart-moving experience for all who witnessed the ceremony.

"When you became president elect, you brought to us the additional luster of your presidency of the Royal College of Physicians and Surgeons of Canada.

"Walter MacKenzie, the American College of Surgeons acknowledges with grateful appreciation the devoted service you have performed."

THE AMERICAN COLLEGE OF SURGEONS was conceived in the fertile and imaginative mind of Franklin H. Martin of Chicago, whose first great achievement was the founding, in 1905, of *Surgery, Gynecology and Obstetrics*. George Crile said of him: "He will long be known among the great dreamers in medicine. He dreamed a dream and the greatest surgical journal in the world was born; he dreamed again, and the Clinical Congress of Surgeons of North America appeared; he dreamed yet again and the American College of Surgeons came into being."

This man was an occasional guest of the Society of Clinical Surgery which had been founded in 1903 by Crile, Cushing, the Mayo brothers, and a few others. The members of this society then, as now, visited each other annually to attend operative clinics and exchange ideas of mutual interest and concern.

Martin observed the great educational value that this practical type of meeting held for the young men who comprised the Clinical Society; he also envisioned the value that the same type of meeting, on a larger scale, would hold for all surgeons. He conceived the audacious plan of organizing such a clinical meeting and proposed that his journal invite its subscribers to visit the surgical clinics of Chicago. The *Journal* would organize the clinics in the hospitals of Chicago and invite prominent surgeons of the city to participate in its activities.

The invitation to attend this meeting was issued as an editorial in the September 1910 *Surgery, Gynecology and Obstetrics*. The staff estimated and planned for an attendance of 200 visitors: 1,300 doctors came! The ten-day meeting was such an overwhelming success that before its conclusion there was a spontaneous movement which created an organization to make it an annual event. It was named "The Clinical Congress of Surgeons of North America," and Albert Ochsner was elected president. Membership was to consist of all reputable surgeons who were subscribers to *Surgery, Gynecology and Obstetrics*, its official organ, and also those who were registered each year at its regular meetings.

The second Clinical Congress was held in Philadelphia and attendance and enthusiasm were so great that Martin and his associates realized that further growth might well bring

about chaos at the meetings. They found that much of the confusion stemmed from the attendance of physicians who had not registered. They also learned that those who considered themselves to be qualified surgeons wanted the others excluded from the clinics.

The third Clinical Congress was held in New York and Brooklyn in 1912 and the attendance was even greater than before; indeed, it was greater than the attendance that year at the American Medical Association meeting. Martin had foreseen that some means of controlling attendance was needed to prevent a complete breakdown of this popular meeting. His solution to the problem was to form yet another organization so that only clinicians of the highest standards and ethics could attend. The concept of this society came to Franklin Martin while en route to New York on the *Twentieth Century Limited* to attend the Clinical Congress. He then and there formulated a program to form the new organization and the plan was dictated to the train stenographer and in its complete detail was carried to the meeting in Martin's pocket. He made his proposal at the business meeting of the Clinical Congress and the 2,600 doctors who attended voted to approve the formation of the society, which would be called the "American College of Surgeons." A committee on organization was authorized to plan this society. One ironic aspect of this action was that many of the physicians who attended that meeting and voted approval of the plan were later to be excluded because they were unqualified for membership in the new society which they voted to create.

Immediately after the Clinical Congress adjourned, Dr. Martin obtained an Illinois charter which secured to the organization the legal right to the name "American College of Surgeons." The objective of this society was declared to be to "elevate the standard of surgery, to provide a method of granting fellowship in the organization and to formulate a plan which will indicate to the public and to the profession that the surgeon possessing such fellowship is specifically qualified to perform surgery." The general management of the corporation would be vested in a Board of Governors which, in turn, would delegate the details of the management to a board of trustees to be known as the Board of Regents.

The organization committee drew up a list of 500 leading surgeons of the United States and Canada, and Franklin Martin, representing the committee, traveled for six months calling upon all of them, explaining to them separately and in small groups the objective, enlisting their support in its founding and inviting them to attend a meeting to be held in Washington on May 5, 1913, for the organization of an American College of Surgeons.

Four hundred and fifty of the invited surgeons attended that meeting and the new society officially was launched and officers were selected. J. M. T. Finney, of Baltimore, was elected the first president. A constitution and bylaws were adopted and methods were designed to provide for fellowship in the new organization. Those surgeons who had been invited to attend the organizational meeting in Washington were to be approved by the Regents for Fellowship as "Founders." Other individuals, who limited their practice to surgery and its specialties and whose "surgeonship" was of unquestioned quality, and received the unquestioned approval of the Board of Regents, would be eligible for Fellowship without examination. Other surgeons would need to qualify for Fellowship by examination or other evidence of competence to be determined by the College.

Dr. Porter's declaration makes history

After these proposals were approved by vote, one of the assembled founding members, Miles F. Porter, of Ft. Wayne, Indiana, made a declaration that was destined to influence the College of Surgeons as much as any other event that occurred in the founding of the College. Loyal Davis has related this drama in his book *Fellowship of Surgeons:*

"Porter arose," he said, "to inquire whether all men invited to become Founder Fellows, and who had signified their willingness to do so, would become by virtue of those acts alone, Fellows of the organization without any further formality. Will Fellowship extend further than the mere ability to do surgical work?

"Edward Martin, chairman of the meeting, was at once aware that this mild speaking, meticulously dressed older man might be concealing a bomb. 'It would be the responsibility of the Board of Regents to determine the

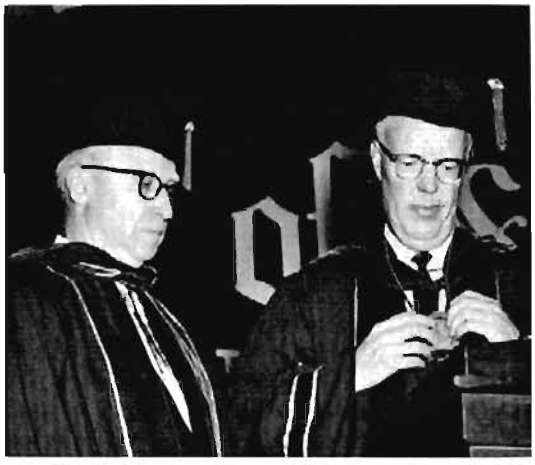
quality and reputation of candidates for Fellowship,' the Chairman said. 'It was hoped that the entire organization would have confidence in the discretion, wisdom and justice of the Board.'

"Porter then became specific. 'As one who has agreed to become a Founder, I want to say I have no doubt that, while I have quite as much confidence as anybody else in the Board of Regents, I think we are very likely to overlook what I consider a very vital thing. There are a great many men doing surgery in this country who can and do it well, yet who from a moral standpoint are unfit. I refer to fee-splitters. Such men should not become members of this body.'

"The applause was thunderous. For the first time, one of the worst evils of the profession had been named publicly. It was to remain a question of bitter controversy—a principle upon which disagreement would bring about the formation of new societies and the passage of prohibitory laws. Miles Porter did have an explosive bomb in his possession. He set it off and for the remainder of his professional life remained quiet and firm in his convictions in the background away from the field of battle."

This, then, was the genesis of the historic role of the American College of Surgeons in its crusade against the unethical practice of fee-splitting.

For those who might not fully understand the reason why this practice is unethical and immoral let us consider what George Stephenson says about it: "Because of the peculiar relationship with his physician, the patient has the right to expect that he will receive treatment which is not influenced by his ability to pay. He has a right to expect to pay a charge which is commensurate with the services rendered. He has a right to know what he is being charged by his physician and he has another right guaranteed by implication, by humanity and by law. This is the right to assume that he is not being sold by one doctor to another. Grudging acknowledgment of this right is the explanation why those who traffic in living human bodies do so in secret."



Outgoing President MacKenzie removes insigne of office to give it to incoming President Nesbit at latter's inauguration on October 5, 1967.

Invectives for visionaries

The founders of the College were probably regarded as impractical visionaries and dangerous usurpers by the great mass of practicing physicians in 1913 when the proclamation against fee-splitting was first enunciated. Certainly the College was subjected from that moment on, for several years, to a relentless barrage of criticism and invective. Some of the opposition to the College's crusade against this evil as well as itinerant and ghost surgery came from ethical physicians, including a few Fellows of the College, who felt that the reputation of the entire medical profession was being unnecessarily damaged by it when only a few were guilty. Paul Hawley, former director of the College, answered these well intentioned critics by saying: "Some of you fear such exposures will do damage to the medical profession. No institution, with as high an average of honesty, competence and integrity as the medical profession *can be* damaged by its own exposures of weakness in a sincere effort to increase its usefulness to humanity. It might be damaged by willfully concealing its defects until they are exposed by outsiders."

Fee-splitting began at the turn of the century when surgery became safe enough that it was accepted by the public and many self-trained surgeons of the era vied with each other in competition for patients for profit. The extent of the practice at the time the College was founded was indicated in a study by the American Medical Association Judicial Council, which disclosed that only 77 per cent of the

physicians interviewed believed that secret fee-splitting was not justified.

Today the public is aware of fee-splitting and why it is unethical. Where it goes on, it is practiced clandestinely on penalty of public disgrace. A recent survey on fee-splitting was conducted by a committee of the Regents and the results indicate that the practice is a continuing problem but that it ought not to be regarded as rife throughout the United States and that it is now not too serious either in its frequency or its effects, except in certain locations.

The report of the Mahorner committee was presented to the Board of Regents in February 1967 and at that time the Regents endorsed an eight-point program* against the unethical practice. It stated that an increased effort on the part of Fellows in each community and in each hospital can do much to eliminate this evil. The Regents urged that state and provincial advisory committees, local chapters and local surgical organizations investigate promptly and diligently any report of fee-splitting, that they work with other leaders in medicine to substantiate the facts, and that they report to the Central Judiciary Committee any case of fee-splitting, including the evidence which substantiates its existence. In this way accused Fellows who are innocent can be exonerated while those found guilty can be properly censured or expelled.

The College is sometimes accused of having a "do-nothing" attitude about matters of unethical practice. Those persons who make such accusations must be reminded that the College can do nothing at all except when specific and documented charges are brought against its own Fellows. This is one of the great obligations of Fellowship. A great English lawyer-statesman once said: "All that is necessary for the triumph of evil is that good men do nothing."

Two other actions taken by the third Clinical Congress in 1912 were destined to develop into major and proud objectives of the Clinical Congress and later the American College of Surgeons.

One was a resolution that "the time has arrived if the surgeons of America are to do their duty to the citizens of this country that a campaign of publicity should be at once undertaken to bring to the attention of every woman the early symptoms of cancer of the womb, and to point out that if the cancer be detected in its earliest stages it can often be cured; that a committee be named to disseminate this information; and that they be instructed to write or have written articles to be published in the daily press, the weekly or monthly magazines, as may prove most expedient." This was the beginning of the cancer program, which has grown in scope and usefulness to the profession as well as to the public.

The following year a symposium on cancer was held which stimulated public interest to such an extent as to inspire the formation of the American Society for the Control of Cancer.

Government recognizes cancer program

The standing Committee on Cancer, created in 1921, has become a leading force in developing interest in the early detection and treatment of this disease. In 1967 the United States government recognized the preeminent position of the American College of Surgeons in its development of cancer detection and treatment centers. To the College's Commission* on Cancer has been assigned the development of optimal standards for hospital facilities and staff in the cancer program of the Regional Medical Programs under the National Institutes of Health. Warren H. Cole is director of this project (page 407).

The third significant action taken at the Clinical Congress business meeting of 1912 was a resolution "that some system of standardization of hospital equipment and hospital work should be developed to the end that these institutions having the highest ideals may have proper recognition before the profession, and those of inferior equipment and standards should be stimulated to raise the quality of their work. In this way patients will receive the best type of treatment and the public will have some means of recognizing those institutions devoted to the highest ideals of medicine."

This was an ambitious as well as a highly idealistic objective that the new society was undertaking and a blue ribbon committee of

*Published in February *FACS Newsletter* and May - June 1967 BULLETIN.

*Committee became a commission in 1965. John W. Cline, San Francisco, is its chairman.

knowledgeable and distinguished surgeons was selected to carry into effect the spirit of the resolution.

They were Ernest Codman, of Boston; William J. Mayo, Rochester, Minnesota; Allen B. Kanavel, Chicago; John G. Clark, Philadelphia; and W. W. Chipman, Montreal. But it was an ironic twist of fate that the objective of this committee, which was attained gloriously by the College, did not stem from the activities of this distinguished group; it was achieved fortuitously and unexpectedly through the activities of the membership committee of the new College of Surgeons.

The Regents had decided to require candidates for Fellowship, instead of an examination, to submit hospital records on 100 patients as evidence of their surgical competence. The inspection of these records was a colossal undertaking. It was performed by a group of leading Chicago surgeons who comprised the Examinations Committee. They met at the College once or twice a week in the evening and it is said that an evening's work for one member was to pass on two sets of records.

Watch for new **A.C.S. Directory** *to be shipped early in 1968; it is gift to accredited hospitals*

THE NEW *Directory of the American College of Surgeons* will be shipped to Fellows and to accredited hospitals in the United States and Canada early in 1968. Copies of the *Directory* are also sent to medical schools.

Hospitals and medical schools receive this publication as a gift from the College.

The *Directory* contains alphabetical and geographic lists of Fellows. Such data as address, affiliations, specialty and year admitted to Fellowship are included in the alphabetical entry. Geographic entries give name, address and specialty.

The 1,445 Fellows admitted in 1968 will be included in the listees.

The *Directory* is published every three years. Cumulative supplements are published in each of the two intervening years.

The first *Year Book*, as it was then called, was published in 1913.

They soon discovered that much surgical work was being done in hospitals which lacked many facilities essential to the scientific care of the patient. Cases were unsystematically recorded; laboratory and x-ray facilities were woefully deficient; medical staffs were unorganized; and the professional work was generally without supervision. In short, many of the hospitals were not fit places to care for the sick. Furthermore, they were unsuitable facilities for the maturation of surgeons in training. The examinations committee members came to realize to their surprise and dismay that they were assessing not only the competence of the candidate for Fellowship; they were also evaluating the efficiency and effectiveness of the hospital from which his patients' records had been assembled.

Poor records prompt hospital program

If the Regents had sent out survey teams to evaluate the quality of hospitals in America, they could not have designed a better system of assessment than the one which was provided unwittingly by the candidates from all over the country; nor could they have possibly contrived so prompt a nationwide survey of hospitals. In the first three years about 60 per cent of the candidates, previously approved by the state and provincial as well as the central credentials committees of the College, were rejected for Fellowship because of poor surgical records. When an applicant was refused admission because of unacceptable records, he and his hospital interested themselves in the College's requirements and asked that it furnish an outline of an acceptable record and suggest standards for laboratories and for staff organization. This the College set out to do and that was the first step in the program of standardization of hospitals.

For several years the matter of improving the standards of hospitals in America had been considered and had been discussed by the American Medical Association and the American Hospital Association, and the need for such a movement was almost universally conceded. Yet nothing had previously stimulated an active and aggressive movement to achieve this end until the College recognized and accepted the challenge which suddenly confronted it. The time was ripe and the College acted and, as

Victor Hugo said: "No army can withstand the strength of an idea whose time has come."

The Regents realized and asserted "that the particular training ground for the surgeon is the hospital. Forced upon us, then, is the obligation to know what this training ground is and what kind of a standard we should hold up to ourselves as to the proper training ground of a surgeon in a hospital. The problem involves us in the whole question as to what is the proper care of sick people."

When the College entered this field, it did so with exceeding care, for it had no precedent to guide it, and it had also to provide itself with the necessary personnel, office machinery and financial support to carry out the work. For two years a preliminary analysis was quietly pursued among hospital staffs, with city, county and state medical societies, with hospital superintendents and hospital trustees. The program was built upon the cumulative wisdom of all those concerned with it. The Catholic Hospital Association under the presidency of Reverend Charles B. Molinier together with His Eminence James Cardinal Gibbons endorsed the standardization program and offered its cooperation. Formal endorsements were also received from the Protestant Hospital Association. Finally an outline of the program was presented to the American Hospital Association and it was unanimously approved by the council of that organization.

Before the College finally embarked on the program, the Regents approached the American Medical Association with the suggestion that it, rather than the College of Surgeons, perhaps should undertake the vast problem of hospital standardization. The Regents were informed that the Board of Trustees had considered it to be too extensive and too expensive an undertaking and had decided not to accept the responsibility of the task. This left the College of Surgeons alone to undertake the project.

A series of meetings was held to formulate plans and policies and finally "Minimum Standards for Hospitals" were adopted in December 1919. The finished document was brief and explicit. It comprised one printed page but it was soon heralded the world over as one of the great advances of all time in promoting patient welfare.

This set of standards was sent out to all hospitals and those which voluntarily sought approval were inspected by a doctor-surveyor from the College. If a hospital did not qualify, the reasons were explained to the trustees and the staff. The hospital was then given six months to a year to correct its defects, and was then again surveyed. When approved, the hospital was given a certificate and was listed in the published roster of approved hospitals.

List is disappointing

In the first year, however, only 89 of 692 hospitals met the established standards. The College had planned to publish a list of approved hospitals each year but this poor showing was so disappointing that the Regents decided not to publish the facts in fear that disappointment over the project would cause the program to succumb before it could get started properly.

The second year, 198 of 692 hospitals met the standard; and the third year, 407, over half the hospitals surveyed, were approved.

Franklin Martin's last published statement before he died in 1935 was concerned with the hospital standardization program. He said: "This movement has proved itself to be of distinct benefit not only to the hospitals which have achieved approval but also to the patients, the physician, the intern, the nurse and the community. Hospitals which are not approved are shunned by those seeking intern and nurse training. Any community deems it a tragedy to possess a hospital that is not on the approved list of the American College of Surgeons."

Frederick Coller in his presidential address to the American Surgical Association in 1944 said: "The American College of Surgeons not only attempted to designate the skillful in practice but it improved the tools with which the surgeon worked. Through the standardization of hospitals, it provided the surgeon with an environment in which he could have every facility in which the well being of the patient was safeguarded."

By 1950 the College was able to look back over the 35 years of the hospital standardization program with great pride. There were 3,290 hospitals on the approved list. The College had spent about two million dollars from Fellowship fees and dues on its development

and operation from the beginning without help from other organizations. The strain on the budget was severe, and the plan was expanding rapidly. Indeed in the fiscal year of 1949 the expenses of the program had been over $68,000 yet the program had failed to meet the demands made upon it. At the same time the College was involving itself in many other projects that needed money as well as personnel. The time seemed right to determine if other organizations might wish to share in the administration as well as the cost of the program. Eventually the American Hospital Association, the American Medical Association, the American College of Physicians, and the Canadian Medical Association agreed to collaborate with the American College of Surgeons in the establishment of an independent commission which would be financed jointly by contributions from the participating organizations. The commission would be representative of each group but would administer its own affairs independently.

Thus in March 1952 the Joint Commission on Accreditation of Hospitals was formally organized in Chicago. The formal transfer of the hospital standardization program of the College took place in December 1952.

Today the scope and extent of the activities of the Joint Commission are enlarging and standards are being constantly elevated. In January 1967 the Joint Commission assumed the additional responsibility of setting up standards and accrediting nursing-home and extended care facilities. This enormous task has been necessitated by recent legislation enacted by the Congress of the United States.

The Joint Commission is revising its code of standards at present and especial attention is being given to incorporation of the recommendations concerning the standard for the emergency department which has been proposed by the College's Committee on Trauma.

Commission proscribes unethical practices

In December 1966 by unanimous vote of the commissioners the Joint Commission revived the long inactive standard prohibiting fee-splitting, ghost surgery, and itinerant surgery. The proscription of these unethical practices had not been enforced since the College of Surgeons turned over the program and its return to the requirements of accreditation has been a source of great satisfaction to the Board of Regents. To this end the Regents have agreed to supply the Joint Commission verified information regarding these unethical practices, when requested by the Joint Commission in its investigation of hospitals for accreditation. The Regents have urged increased efforts on the part of Fellows in each community and in each hospital in the implementation of this policy; for only at the local level can these practices be discovered and reported through proper and established College channels. This is one of the great obligations of Fellowship.

The last U.S. Congress, in passing social legislation laws creating Medicare and Medicaid, performed an historic act of emancipation of which all citizens of the United States of America can truly be proud. For this legislation made possible to a large segment of the population a right that had long been denied: the right to select his own physician, and the means to pay for the services. True, the doctor by long tradi-

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Total distribution of this Bulletin *is 39,947*

SIX TIMES EACH YEAR the College communicates directly with each Fellow by means of its BULLETIN.

This sixth, or November-December 1967, number of Volume 52, goes to 29,078 Fellows; 4,887 members of the Candidate Group; 5,024 hospitals accredited by the Joint Commission on Accreditation of Hospitals and by the Canadian Council on Hospital Accreditation; and 958 other recipients, including organizations, editors, science writers, and medical schools. The total distribution is 39,947.

Each BULLETIN sent to an accredited hospital is marked for the attention of the medical library.

The BULLETIN is not available by subscription.

The index for Volume 52 is on page 426.

Another means of direct communication with the Fellows is the *FACS Newsletter*, also published bimonthly, alternating with the BULLETIN.

Heritage and Obligation

(*Continued from page 389*)

tion has always cared for the poor as well as the rich and has based his time-honored custom of Robin Hood fee schedules upon this proud tradition.

But the medically indigent spawned by the industrial revolution has been another story. He is often an urban creature who in times of illness has had to depend upon the social agencies of the community. He has been provided whatever medical services were available in the community, some excellent, but many not very good. If lucky, he has been cared for in a well organized medical center as a service patient. More often he has ended up on the charity wards or dispensaries of city hospitals where the personal attention of a well qualified physician has sometimes been lacking.

Today this economically underprivileged person has been relieved of the stigma of medical indigency. One result has been a depletion of census in the charity wards and city-county hospitals across the country. There has been a corresponding increase in demand for beds in the private section of the hospitals, an indication that these patients had tried the previous systems of medical care that had been available to them and had found them wanting.

When the effects of this legislation became apparent there was at once a wave of apprehension across the country by surgeons in charge of residency education and training programs who feared that the traditional patterns were being threatened by the diminishing number of service patients. Early polls of residency program directors indicated that about half of their programs had suffered a significant drop in service patient census—in some instances a drop of over 50 per cent. This was true especially in hospitals which operated charity ward training services. In community hospitals where the preceptor system of training has been carried on and the preponderance of patients have been admitted by the preceptor surgeon as a private patient, the decline in patient census has, if any, been little. Indeed many such hospitals have reported an increase in patient census.

Among those program directors who reported a drop in census on the charity wards and in charity hospitals a significant number voluntarily reported that they felt they would need in some way to upgrade patient care supervision if they were to attract back to their depleted services the patients who were asking for private physician services. Many also voluntarily stated that better supervision of the resident in training on their charity services would without doubt result in improved training but that they would need more staff surgeons to achieve this objective.

In February 1966 the Regents called upon the College's Committee on Graduate Education to assign a task force to study the problem. They conferred with administrators of the federal program regarding implementation of the new legislation. This group met again during the 1966 Clinical Congress in San Francisco and discussed the issues involved. The Board of Governors also held discussions on the matter at the 1966 Clinical Congress, and members of the Graduate Education Committee conferred with them about it.

The Governors, believing that the threat to the residency programs was a real consideration which needed clarification, called upon the Regents to organize a nationwide conference for the exchange of information and viewpoints on the impact of federal and state legislation on residency programs, especially as related to the community hospital.

The Regents considered this matter at their meeting in February 1967. They took the view that this legislation was not a threat but rather a challenge to American surgery since the College of Surgeons had long supported the principle of prepaid insurance against the risks of illness and its economic consequences. As long ago as 1934 the Regents as pioneers, proclaiming the position of the College in this matter, asserted that such protection of the patient was desirable provided there was no interference with the patient's free right to choose his physician and provided that the insurance carrier would in no way interfere with the physician's freedom to serve the patient.

The College of Surgeons has found nothing in Medicare or Medicaid legislation that is contrary to this principle and asserts that patient indigency is not an essential factor in the structure of providing the highest quality medical education of undergraduate or graduate students.

A nationwide conference was arranged and in May 1967 Fellows representing all fields of specialization and all types of training programs were assembled in Chicago to exchange ideas on the impact of federal legislation on residency education and training programs and how best to adapt to the changing needs imposed by

new laws. They met in the Murphy Memorial Auditorium for two days. Representatives of the federal agencies and of the private insurance industry, and also experts from the College's own Fellowship, presented talks on the various facets of the problem. Philip Lee, administrator of the federal program, addressed the assembly. There were several workshop discussions which were reported back to the Conference.

The entire proceedings of the meeting were tape-recorded and the Regents have authorized that a transcript of the meeting after editing be published and sent to all who attended the conference and to program directors of Surgery throughout the country. It will also be sent on request to other interested persons. This will doubtless become a valuable and unique reference source.

A summary of the conclusions of this Conference is on page 390 of this BULLETIN. This provides guidelines for the organization of residency programs in meeting the great challenge of Medicare.

Yes, the American College of Surgeons has made and will continue to make every possible effort to fulfill its obligation in this timely and important area of change which affects surgery, the surgeon and the patient.

The American College of Surgeons, with more than 28,000 Fellows in 83 countries is the largest surgical organization in the world; and it is without doubt the most influential surgical society in America.

The Board of Governors is made up of 185 Fellows who represent Fellows from states, provinces and countries, many surgical associations and societies, and the federal medical services. The Board of Governors acts as a liaison group between the Board of Regents and the Fellows and as a clearing house and advisory group for the Regents.

The management and authority of the College are vested in the 19-member Board of Regents, 18 of whom are elected to a three-year term by the Board of Governors at its annual meeting. This method of selecting the Regents imposes on the Governors the responsibility and obligation of selecting Fellows who are truly representative of all segments of surgery and its several specialties. The president serves as the nineteenth Regent during his one-year term. The other Regents may serve up to three terms.

The president, vice presidents and Governors are elected by the Fellows at their annual meeting. The secretary, treasurer, director, comptroller and chairman of the Board of Regents are selected by and are responsible to the Board of Regents. The president, the director and the chairman of the Board of Regents are the servants of the College and are its spokesmen, but they do not establish the policies of the organization. That responsibility belongs alone to the Board of Regents.

The Regents have set up advisory councils in each of the surgical specialties. These councils have a dual function: They set up programs representing their specialties at the Clinical Congress and at the regional meetings. Also the advisory councils comprise an avenue whereby the specialty societies which they represent can communicate directly with the Regents on matters relating to their specialty interests and concerns. The surgical specialties are also represented on all of the College's major standing committees, including the Graduate Education Committee, the Program Committee, and the Committee for the Forum on Fundamental Surgical Problems.

One of the proudest claims of the College is that it is a fellowship of *all* surgeons. In its meetings specialists in every phase of surgical practice exchange ideas and explain new techniques and practices of common interest. We have a common heritage as surgeons and we have much which we need to share with one another. The College justly represents the whole body of surgery in matters which encompass the areas of common concern to all surgeons.

Fellowship in the College carries prestige not only in the United States and Canada but also throughout the world. F.A.C.S. after a surgeon's name means this:

He is a specialist in one of the recognized areas of surgery.

He has had formal, approved surgical training and education.

His ethical standards and professional competence have been attested to by Fellows of the College in his community who are familiar with his practices.

He has pledged himself to place the well-being of his patients above all else.

He is dedicated to serving all with skill and fidelity.

This is our heritage and our obligation as Fellows. One of our greatest leaders, Charles H. Mayo, put it this way: "Medicine gives only to those who give, but her reward to those who serve is 'finer than the finest gold.' "