II. PRESIDENTIAL ADDRESS

THE AMERICAN COLLEGE OF SURGEONS—THE PAST, THE PRESENT, AND THE FUTURE[1]

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I. The Old Guard Versus the New Guard

THE years 1885 to 1900 were a transitional period in American surgery, and brought us from laudable pus to the conception of aseptic surgery; from rapid, spectacular technique to deliberate and refined methods in operating.

We had been blind followers, and this was the beginning of our independence. Scientific medicine had given us facts, and we began to interpret these facts. Though they did not always agree with our procedure, based on traditions gained from foreign teachers and literature, we began to do our own thinking. The leaders of this renaissance were maturing. They had inquiring minds and they were not yet so sure of themselves that they had become provincial. They argued: "We may not be right. Let us see what our confrères are doing. In this way we may find something to imitate, or we may learn what not to do."

Meanwhile, there were pathfinders who were being watched and criticized. They were going too fast even for some of the most progressive. Senn had written into the history of surgery his initial chapter on the development of intestinal surgery; Fenger had coupled pathology with surgery; Murphy was altering traditions; the Mayos were building, if not better than *they* knew, better than *we* knew. Thus miracles were in the making.

In substance, George said to Harvey: "Let us, as a group, get together and watch one another operate. Let us criticize, talk out in meeting, and each get the standpoint of the other. Let each of us know what all of us know, and let us take our knowledge at first hand from those who are doing things rather than from those who are talking and writing about them."

And thus the Society of Clinical Surgery was organized in July, 1903, an act that gave to the surgery of the world and to the conservation of surgical patients, the greatest impulse since the work of Pasteur and Lister. It taught a group of leaders the best methods current, not only in the United States, but in all civilized countries.

Such advantages could not remain exclusive. Other surgical specialists imitated. One clinic and another were established; they welcomed those who wished to observe the work of others, and became the mecca for aspiring surgeons.

II. Stimulation of Clinical Literature

This was the soil that was being fertilized, a fallow field with possibilities of a great crop.

Your speaker became interested in this progressive movement as he sat one day at a popular clinic, the guest of the Society of Clinical Surgery. What a marvelous spectacle—the earnest interest of these leaders from all of our great clinical centers, their constructive criticisms, and the instructive replies; in the amphitheater the eager faces of a hundred other surgeons not members of this Society, men from the provincial towns of the United States and Canada, who were also welcomed to this clinic. Later, at the informal round table, all fore-gathered to review the work of the morning and to enter into free discussion.

Several years earlier, in 1905, Surgery, Gynecology and Obstetrics was established to record the work of men who were actually doing surgery, a *practical journal* for *practical surgeons;* edited by *active surgeons* rather than by literary writers remotely connected with clinical work; the profits from the journal to be utilized in strengthening its influence, and not put into the pockets of business promoters. This journal had been welcomed and supported by wellnigh every surgeon in the interesting audiences of that day, and this experience with the journal influenced much the silent observer. What did it mean? Was there ever a greater manifestation of interest in surgical work, and were there ever more constructive discussions?

Did it not mean that these men, as practical practitioners, were demonstrating that there existed an unorganized demand for a new form of medical society, to supplement, not to displace, the time honored associations, a clinical rather than a purely academic body; a "show me" rather than a "tell me" society? The leaven had become implanted in the mind of the silent observer, and the leaven became insistent in its development.

A trip had been planned which involved a sea voyage to the Mediterranean. This individual took ship accompanied by an inspiring and brainy woman, rightfully ascribed as his lawful wife. The decks were broad, the leisure ample, and the ship afforded opportunity for miles of deck walking which was stimulated by the implanted leaven.

[1] Delivered at the Convocation of the American College of Surgeons, Boston, October 12, 1928.

III. The Conception

The question was: How could we make accessible to the many aspiring surgeons what was being enjoyed by the exclusive few, and how enable them to see not only a few clinics but to observe the work of the individual surgeons of these privileged groups?

The solution came suddenly like a flash of lightning. The initial problem was visualized, the technique approved, and plans formulated. The blue of the sea reflected no flaws; the soft tropical breeze brought forth no criticisms. The leaven at last had brought forth results, and these results were poured with enthusiasm into the ears of the often critical companion. The blue of the Mediterranean again approved, as reflected in sympathetic eyes; and no trace of criticism came to mar the scene. The highest court had approved. The Clinical Congress of Surgeons was conceived.

IV. The Clinical Congress of Surgeons of North America

This was February of 1910. There and then it was decided that the 3,000 subscribers to Surgery, Gynecology and Obstetrics should be invited to Chicago in November of that year, as guests of the journal, to observe at first hand the work of the leading surgical clinicians of that midwestern city.

On November 7th of 1910, the first day of the two-week session, we waited breathlessly and anxiously for the response. Many acceptances had been received—so many that it seemed too good. It was ominous. The first day 1,100 registered; 1,600 finally. Many were in attendance who did not register.

On November 19th, a notice signed by the late Dr. James B. Eagleson, of Seattle, was bulletined at headquarters which asked any who were interested to attend a meeting for the purpose of making permanent the organization. Several hundred of the visiting surgeons accepted the invitation, and a formal association was perfected, by name "The Clinical Congress of Surgeons of North America." John B. Murphy appeared on the floor, thrilled the audience by a rousing speech of commendation, and nominated Albert J. Ochsner as the first President.

The informal meeting demonstrated beyond a doubt the demand for this new form of organization. Your orator was called to Philadelphia, on December 6, 1910, met a group of Philadelphia's leading surgeons at the residence of John G. Clark, and accepted the invitation to hold the 1911 Congress in that city.

V. Difficulties

The Philadelphia Congress was held in 1911 with a stipulated fee for those who attended, sufficient to pay expenses. Eleven hundred were registered, and the leaders of surgery in the Quaker City furnished a magnificent program of clinics. John G. Clark was chairman of the Committee on Arrangements, Edward Martin was elected President, and New York was selected as the host for 1912.

It had become apparent in these initial meetings that some means should be adopted to limit the attendance to the registered surgeons; some means of limiting accommodations at clinics to ticket holders; some means of enforcing the hospitals to recognize tickets as a requirement for admission; some means of establishing an authority that would include only acceptable clinics at each session of the Congress; some means of determining who, among the clinicians of the city acting as host, should be invited to give clinics. Standards, ethics, and the general acceptability of guests and clinicians were recognized as acute problems.

During the year there had been much discussion of our problem among those of us who were responsible for this movement. Some were sympathetic and others decidedly discouraging as to the wisdom of continuing this ambitious innovation.

VI. Looking to Permanency

Your speaker received many hints from the extensive discussion which, on careful study, offered a solution of the obvious difficulties, and gave promise of one more long advance in progress of organized surgery on our continent. The substance of this plan was dictated to the public stenographer of the Twentieth Century on a journey from Chicago to New York, preliminary to the 1912 meeting.

On arrival in New York, this plan was submitted with feverish enthusiasm to John B. Murphy who was routed from his morning bath to receive the impatient emissary. Dr. Murphy, clothed in a bath towel, reluctantly scanned the improvised plan. As he read, his expression grew more and more sympathetic, and as he finished, he enthusiastically asked the privilege of seconding and supporting the plan when it was submitted at the mass meeting of the Clinical Congress.

The prospectus was then submitted (not without fear and trembling) to our autocratic President, Edward Martin. Meanwhile, the document had been put into the form of a resolution, which provided for the appointment of a committee of

twelve, with power to act, which should proceed toward the perfection of the new organization which was to be closely allied with the Clinical Congress and would aid it in controlling the personnel of its members, its clinicians, and its moral and ethical regulations.

Friday afternoon, November 15, 1912, the plan was presented by your speaker to two thousand of the surgeons in attendance at the Congress. Doctor John B. Murphy seconded the resolution which recommended a plan for the organization of an American College of Surgeons.

President Edward Martin lost no time in urging the importance of the movement, and with a few choice words of warning against imitating all things of pomp and circumstance of the effete past, he commanded a rising vote in favor of the resolution. This vote carried with it the appointment of a committee of twelve on organization, a majority of whom were selected almost exclusively from among the old guard of progressive surgeons who comprised the Society of Clinical Surgery as follows: Edward Martin, Emmet Rixford, John B. Murphy, Rudolph Matas, Albert J. Ochsner, Charles H. Mayo, Frederic J. Cotton, George Emerson Brewer, John M. T. Finney, Walter W. Chipman, George W. Crile, and Franklin H. Martin.

During the succeeding six months, Franklin H. Martin, a member of this committee, visited the leading cities of the United States and Canada. He conferred with groups of surgeons, selected by sub-committees and called together local men of prominence to take part in the discussion. These amplified groups, numbering five hundred and fifty surgeons, were invited to a meeting on organization to be held later in Washington, D. C.

At the appointed time, May 5, 1913, 450 leaders in the surgical profession appeared in Washington to assist in or protest against the establishment of an American College of Surgeons. Under the skillful chairmanship of Edward Martin, enthusiasm was stimulated, criticism modified, opposition discouraged, a constitution and by-laws adopted, officers, a Board of Regents, and a Board of Governors elected, and November 13, 1913, appointed as the date for the first Convocation of the new College.

Again the surgeons of all America honored the group comprising the Society of Clinical Surgery, the old guard, with a majority among the officers and Board of Regents. The original Regents have become the veritable wheel-horses of the College. They were as follows: John M. T. Finney, President; Walter W. Chipman and Rudolph Matas, Vice Presidents; Albert J. Ochsner, Treasurer; Franklin H. Martin, Secretary General; George E. Armstrong, George E. Brewer, Herbert Bruce, Frederic J. Cotton, George W. Crile, William D. Haggard, Edward Martin, Charles H. Mayo, Robert E. McKechnie, John B. Murphy, Harry M. Sherman, and Charles F. Stokes.

To these from time to time other surgeons possessing vision, and executive and administrative ability have been elected to aid in steering our course, among whom, I especially wish to mention Frank F. Simpson, William Crawford Gorgas, Harvey Cushing, William J. Mayo, Alexander Primrose, William C. Braisted, George E. de Schweinitz, J. Bentley Squier, James B. Eagleson, Charles H. Peck, Daniel F. Jones, Frederick W. Parham, Jasper Halpenny, Merritte W. Ireland, Allen B. Kanavel, Arthur A. Law, Frederic A. Besley, Herbert S. Birkett, John B. Deaver, Henry H. Sherk, Lincoln Davis, John G. MacDougall, Ernst A. Sommer, Charles E. Kahlke, Robert G. LeConte, Horace Packard, Charles E. Sawyer, George P. Muller, Frederic N. G. Starr, Robert B. Greenough, John S. McEachern, John G. Clark, George Henry Murphy, George David Stewart, Frank H. Mewburn, Irvin Abell, A. T. Bazin, G. A. B. Addy, C. Jeff Miller, Harvey G. Mudd, Eugene H. Pool, Clarence L. Starr, Charles F. Nassau, Truman W. Brophy, J. Chalmers Da Costa, John Osborn Polak, and Herbert P. H. Galloway.

Particularly do I desire to acknowledge the time-serving work that has been conspicuous for its loyalty and disinterestedness in our Directors, Associate Directors, and Secretaries, including John G. Bowman, M. T. MacEachern, E. I. Salisbury, Allan Craig, Judge Harold M. Stephens, Bowman C. Crowell, A. D. Ballou, Marion T. Farrow, and Eleanor Grimm.

VII. Early Activities

In initiating this new kind of society, there was little justification in the venture, unless something of outstanding value should come from it. The group of men who were in at the beginning were not politicians seeking personal prestige; they were busy surgeons who were occupied in the practice of scientific medicine. What was the idea? Why another society?

The purpose was to organize: 1. A comprehensive association of practical surgical specialists, and do on a large scale what the Society of Clinical Surgery was doing on a smaller scale, viz., enable visiting surgeons to see surgical confrères at work in their respective environments; discuss

with them problems *based on practical surgical experience* rather than listen to literary treatises based on theoretical deductions.

2. A comprehensive association that would conscientiously enroll those surgeons of the American continent as in the opinion of their confrères were competent to do surgery, were morally and ethically reliable, and would support the ideals of our profession; an association which would welcome into its ranks any individual licensed physician whose credentials, under proper scrutiny, measured up to stipulated requirements, and through which the public by dignified means could recognize and obtain the services of such qualified men.

3. A comprehensive association that would with all of its resources oppose financial dickering (commonly known as fee-splitting or the buying and selling of patients), between the medical practitioner and the surgeon, and so far as possible exclude from its ranks all offenders.

4. A comprehensive association that would seek by every legitimate means to protect the public from incompetent, dishonest, and unnecessary surgery; that would assume leadership and co-operation with all resources of organized scientific medicine, toward the improvement of hospitals, laboratories, dispensaries, medical schools—in fact every environment in which surgery and medicine may be taught or practiced.

5. A comprehensive association that would cooperate with the people, obtain for them the benefits of scientific advice, furnish to them the services of preventive medicine, and educate them to distinguish between the reliability of scientific medicine and the false sophistries of quackery.

How well we have succeeded in fifteen years is a matter of history.

There is no doubt that our efforts have been a great factor in placing the science, technique, and administration of surgical practice in a supreme position of efficiency. Eight thousand eight hundred Fellows of the College of Surgeons are now pulling together to raise the practice of surgery to the highest degree of perfection. Many clinical organizations are following in the wake of this great movement. There is no longer provincialism in American medicine. It is unusual for doctors to be satisfied with their own efforts. We are traveling, observing, and learning to practice safe surgery.

The College is the accepted leader in bettering the hospitals of the United States and Canada, and its example has aided the hospitals of Latin America, Australia, New Zealand, and other countries of the civilized world. It has been a revolutionary movement of transcendent value to the public and to the profession.

There is no doubt that clinical surgery has been stimulated in the different localities, and the people aroused to a knowledge of the ideals which motivate the Fellows of the American College of Surgeons, through the sectional meetings of the College, inaugurated in 1920 for the purpose of bringing a miniature Clinical Congress into the states and provinces, and carrying to large groups of laymen and women the story of scientific medicine.

There is no doubt that our practical examination for admission to the College, which requires the filing of 100 case records, has impelled recognition of the value of records, and has been the means of educating our profession to write better case histories, to improve their literary ability, and critically to observe scientific facts.

VIII. These Are Idealistic Activities—What About Their Administration?

After the sessions of this meeting in Boston, in which each department of the College has been reported upon and discussed, it is needless to review them in the brief time at my disposal.

Our program and leadership in the betterment of hospitals is now accepted by the national and international hospital associations, and by their great journals; by the departments of the United States government: the Army, the Navy, the Public Health Service, the Veterans Bureau, and the National Homes for Disabled Volunteer Soldiers. The South- and Central-American republics, Australia and New Zealand have studied and in many places have adopted our standards.

The most convincing evidence of the acceptance of our standards and leadership is the fact that our eleven surveys have stimulated great improvement in hospitals. In 1918, 12.9% of the hospitals with 100 beds and over met our standard; in 1928, 93.1%; 50 to 99 bed hospitals: 41.3% in 1922, and 62.2% in 1928; 25 to 49 bed hospitals, 15.9% in 1924, 18.1% in 1928. Government hospitals have advanced from 90.0% in 1925, to 100% in 1928.

In many instances these surveys, when first instituted, were considered an interference; now they are sought after and welcomed. Any community deems it a tragedy to possess a hospital that is not on the approved list of the American College of Surgeons.

IX. Clinical Research

Clinical Research has been organized as a distinct department, with an Associate Director in charge. It comprises:

a. Committee on the Treatment of Malignant Diseases with Radium and X-Ray, Robert B. Greenough, Chairman;
b. Committee on Bone Sarcoma (historically known as the Ernest Amory Codman Registry), Dallas B. Phemister, Chairman;
c. Board on Traumatic Surgery, Frederic A. Besley, Chairman;
d. Committee on the Treatment of Fractures, Charles L. Scudder, Chairman;
e. Standardization of Clinical Laboratories.

These Committees consist of strong boards of clinical practitioners and administrators who seek to furnish through their activities an annual report of the consensus of opinion of leading clinicians on their respective problems.

X. Research of Literature

Our Literary Research Department is making available to clinicians an organized and authoritative means of obtaining through trained workers what they desire in medical literature—either in the form of an abstract, of a bibliography, or of extensive research of the literature in all languages. Service of this type, accessible to all clinicians, whether members of the College or not, takes that important work out of the hands of unorganized commercial individuals, or unsatisfactorily financed organizations, and offers reliable, censored service at less than actual cost; and the expense is gradually diminishing because of our ability, through proper organization, to accumulate valuable material.

XI. Medical Motion Picture Films

Motion picture films can and will occupy an important place in the teaching of medicine. This fact is conclusively proved by the very great interest which has been manifested in the program of medical motion picture films which the American College of Surgeons is fostering in co-operation with the Motion Picture Producers and Distributors of America, Inc., and the Eastman Kodak Company; a movement which gives greater promise than any other program that the College has undertaken, a movement that will result in the development and distribution of the highest grade of medical motion pictures.

The preliminary survey of films already produced, conducted by the College, reveals an astonishing amount of effort, principally by individuals, with many commendable results. However, there is opportunity for an epoch-making advance in education in general and in medicine in particular; and this opportunity is being utilized by our affiliated organizations.

XII. Fee Splitting

It was a bold stroke when the American College of Surgeons at its initial meeting declared against the division of fees between practitioners of medicine and surgeons. It requires courage to discuss the abominable practice, which reduced to its ultimate terms, is simply a traffic of patients between these two groups; the buying and selling of patients, with the highest bidder the purchaser, regardless of his ability. It requires courage to discuss the subject because in so doing we must acknowledge that there are unworthy men in our own profession. It is a menace, however, that can be eliminated only through frank recognition by the profession, and education of the public.

This vicious practice will cease only when every member of the profession has the courage and the honesty to present his individual bill for services rendered, and when the public will insist upon paying each, the practitioner and the specialist, for his individual service.

One of the qualifications for Fellowship in the College requires each and every candidate to sign a declaration against the practice of the division of fees either directly or indirectly in any manner whatsoever.

Each one of the five or more individual references named by a candidate in support of his application, must state in writing over his signature that to his knowledge and belief the candidate does not practice the division of fees.

Each State of the United States and each Province of Canada has a Credentials Committee, elected by ballot by the Fellows of the College in the respective State or Province. When an applicant's name comes before his respective Credentials Committee, the acceptability of the candidate from the standpoint of division of fees must be voted upon.

The Central Credentials Committee of the College makes a careful scrutiny of the candidate's environment and methods of practice, and especially of the standing of the hospital in which he does his surgery.

Finally any charge against a candidate, or a Fellow of the College, is carefully followed up by the central office, and evidence sought upon which proof may be based. For obvious reasons it is difficult to secure positive proof of fee splitting which would be accredited in court of law. When such proof is obtainable, the Fellow must be given

an opportunity to appear before the Board of Regents and make his defense. Seldom will a guilty man appear. The alternative is acceptance of his resignation or summary dropping of his name.

The most effective safeguard against fee-splitting is the standardized hospital. It is difficult for a Fellow on the staff of an approved hospital to divide fees unknown to the officials of the institution, or at least without their suspicion. When we receive rumors or charges that an individual practicing in one of our accepted hospitals is dividing fees, we inform the authorities of that hospital that such rumors have come to us, that the hospital will be resurveyed, and that the resurvey must satisfy us that the charges are unfounded. Through this procedure we immediately obtain co-operation not only of the hospital authorities, but of every honest member of the staff. Resignations from staffs, for reasons outlined above, are frequently reported.

However, the American College of Surgeons includes in its membership only 8,800 of the 164,000 doctors of medicine in the United States and Canada. Our jurisdiction extends only to our own Fellows, and to 1,919 standardized hospitals. In organizing a protest against the practice of the division of fees, and deliberately accepting the responsibility of attempting to eliminate it from our own organization, we must accept, also, the responsibility of becoming the mark for criticism by those who have reason to resent our exposure of so criminal a practice.

I am in a position to know, however, that fee-splitting is very rare in the ranks of the College of Surgeons, and that our publicity campaign has caused much discomfiture to those outside or within our ranks who continue its practice.

At one of the Credentials Committee meetings in an important state, with 30 men present to consider a long list of candidates, a member of the Committee, rather more belligerent than informed said: "Until you revise your whole plan of selecting candidates, you will fail. Practically every member of the College in this state, excepting myself and one other individual (mentioning him by name), is splitting fees." He got the retort for which he was playing. Practically every other member of the Committee honestly and indignantly resented with emphasis this unjust accusation.

There is but one procedure when loose insinuations are made, and that is to ask: "How do you know?" The College insists on proof, and proof is difficult to obtain unless the accuser acknowledges that he is a party to the transaction.

XIII. Successful Leadership Is Maintained by Making Good

An undertaking cannot be successful without appealing ideals; ideals cannot be realized without a sane program which will make them come true; and a sane program cannot be successfully executed without sound financing and wise administration.

To advance clinical surgery, to pursue a sound program for the improvement of hospitals, to make a drive against unworthy financial dickerings, to assume active interest in the standardization of surgical methods and the elimination of unnecessary operating, to aid literary, clinical, and industrial research—in a word to accept progressive leadership in the teaching and practice of medicine, in educating the lay public in the value of scientific medicine—it was obvious that a business like plan of financing would be necessary.

Our financial arrangement at the beginning was based on the custom current in the old societies; a twenty-five dollar initiation fee and five dollars a year dues. After two years we realized that this would leave our program without financial support. The founders of the College, represented by our Board of Regents, were not satisfied to back another national organization in medicine if it did not possess the financial resources necessary to carry forward reforms that it had undertaken.

At the June, 1914, meeting in Philadelphia, the Regents started a movement that would eventuate in a permanent endowment fund. A new society regardless of its worthy ideals, could not expect to interest outside financiers in an endowment on the basis of paper aspirations. The Regents, at their morning session, sold the project to themselves, and decided to take it before the Fellows at a meeting that afternoon, and ask the support of volunteers.

The desire was to secure one thousand $500 pledges from such members of the College as were willing and able to subscribe. As the interest on $500 would represent the amount of the annual dues, it was suggested that this amount would constitute a life membership contribution. Every dollar pledged to the endowment would be invested in trust securities, and no part of the principal, it was stipulated, should at any time be expended.

One Hundred and Thirteen Thousand Dollars were subscribed at that first meeting, and by December, 1915, the subscriptions totaled $526,000. Later the Regents allocated a portion of the initiation fees to the endowment, and unexpended surpluses from annual dues. The endowment fund today, invested in gilt-edged trust securities,

which yield slightly over five per cent, has reached $802,600.

At the 1916 meeting in Philadelphia, our By-Laws were revised, the initiation fee increased to $100.00, and the annual dues to $25.00.

XIV. A Permanent Site

From the beginning a friendly contest ensued in the selection of a permanent home. Washington, New York, Philadelphia, Chicago and Cleveland were the principal contestants. It was easy to reach a decision, but who would finance the site? Washington, as the capital of the United States, led as the ideal location in the East; Chicago was a close second, because it is the geographical and population center. The untimely death of one of our beloved founders, John B. Murphy, led his lay and professional friends to ask the College if it would accept a permanent site in Chicago, upon which a home for the College would be builded and presented to the institution as a memorial to Doctor Murphy. This plan failed because of the sudden death of two of its principal lay supporters.

The effort, however, had crystallized opinion, and caused the Fellows of the College to vote in favor of Chicago as an acceptable location for the permanent home. This decision resulted from the assumption that a completed home on an acceptable site would accrue to the College without cost.

At a meeting of the Board of Regents in June, 1919, with President William J. Mayo in the chair, the question of site became acute. Chicago had made a promise and on that basis she had received the favorable vote. Chicago must satisfy the Regents that a site in that city was available, or the contest for permanent home would be reopened. The arbitrary Chairman would brook no delay. This was June 25th. If Chicago did not produce by August 15 satisfactory legal evidence that an appropriate site would be presented, the Regents would look elsewhere. The Chicago contingency recognized the futility of argument with the relentless power, the presiding officer, and realized that immediate action was necessary.

Within three days a site was selected which had upon it a stately building that would make a satisfactory administrative headquarters. The President was called upon to approve. "Take that," was the laconic reply. In one month the business men of Chicago had subscribed three-fourths of the purchase price, and members of the profession and Fellows of the College in Chicago the additional one-fourth. On May 1, 1920, the administrative offices of the American College of Surgeons were transferred to the permanent location.

The site also contained a suitable plot of vacant ground upon which the friends of Doctor Murphy asked the privilege to build the belated memorial and proffer it to the College as one of its administrative units. This offer was accepted. The corner stone was laid on October 23, 1923, and on June 10, 1926, the Murphy Memorial building was presented to and accepted by the College. This useful structure contains assembly halls, library, and temporary museum space. It was built at a cost of $500,000, and involved no outlay on the part of the College.

In the meantime the ground value of our property has advanced, and with its buildings it is conservatively appraised at $1,250,000.

XV. Our Budget

Our budget for 1928, divides itself as follows:

Hospital Department	$65,000
State and Provincial Sectional Meetings	20,000
Credentials Committee Meetings	25,000
Clinical Research	25,000
Library	20,000

The funds for this budget come from the dues paid by Fellows of the College.

XVI. Latin-American Activities

As to the financing of Latin-American activities. Our actual surveys in Latin America followed vacation trips that were made in 1920 by Dr. W. J. Mayo and his family, and Mrs. Martin and myself; and in 1921 by Dr. and Mrs. Thomas J. Watkins, Mrs. Martin and myself. Several surveys were made: In 1921 and 1922, by Dr. Francis P. Corrigan, of Cleveland; in 1922, 1924 and 1925 by Dr. Edward I. Salisbury. These surveys, together with expenditures, incident to literature and correspondence, were met by a surplus which accrued from exhibit charges at the annual meetings of the Clinical Congress, funds which belong to the College but which are in no way contributed toward from our investments or the dues of the Fellows. For convenience of book-keeping these funds have a separate ledger account in the College books, as the Regents have always felt that the Clinical Congresses, which are attended at any one time by not more than one-third of the Fellows, should be self-supporting. The Congress is self-supporting, and its surplus is available for expenses of an extraordinary nature, which would not come within our stipulated budget for academic activities.

One cruise was arranged for individual members of the College, their families and friends. This cruise was conducted without one cent of expense

to the College. It was financed by the individuals who participated in it.

XVII. Outside Financial Aid

A new enterprise will not draw financial support from business or philanthropic sources, regardless of the extent of its program and worth of its ideals. It must first make good. Its activities and accomplishments must attract the attention of the public. It must create an impelling sales power before gifts can be successfully solicited, or voluntary contributions offered.

This has been the experience of the College. With the exception of donations from our own Fellows, or appropriations obtained through special friends for specific purposes, until recently we have not attracted business or philanthropic contributions. Within the last two years a change is noted in the attitude of the public. In that period we have received moneys to be used in special work in our departments as follows: From three individual sources, for special hospital activities and research, $15,000, $5,000 and $10,000. The Board on Traumatic Surgery is receiving $20,000 and $500, which we have reason to believe will be duplicated. Our backing and our program are being recognized.

XVIII. Business Methods

Much planning, successful persuasion, and many refusals, polite and occasionally otherwise, have resulted in building our still youthful organization on a sound basis financially.

No organization can be considered on a sound financial foundation if it does not have the backing of a watchful and thrifty administration; and no foundation can be so unstable as a financial one. We may compliment ourselves on our satisfactory financial progress. But as an interested bystander, who has experienced the difficulties of accumulation, I tremble to anticipate what will happen to our $2,000,000 assets if an orgy of administrative mismanagement should ensue even for a brief period.

From the beginning of our work the Regents, with disinterested persistence, have supported the idea that they were administering a public trust. They have held sacred that trust.

It is not always an easy task to instill that same attitude into the minds of half a hundred employes. Associates in our work are selected for their ability in a particular line, for their initiative, for their independence, and for their enterprise and industry. These qualities must be molded so that each may realize that while he is expected to perform a specific task, he must also fit into and co-operate with the comprehensive program which involves the labors of several other individuals who are responsible for different tasks in the same organization. In other words, an *esprit de corps* must be developed which makes each one loyal to the entire program of work in hand.

Furthermore, it is incumbent on each department to live within its stipulated budget. It is indeed gratifying to find one of these enthusiastic individuals exerting every effort to remain within the financial bounds that he himself has helped to arrange. It indicates commendable enterprise. However, year by year he plays the game in the hope that his important work will draw a larger portion of the budget and thus make possible even greater accomplishments the succeeding year.

To get the very best from our individual associates, it is necessary for each to regard the whole. An uncensored, undiplomatic letter, written by an indignant associate to a Fellow who has been accused of a misdemeanor, may involve unpleasant consequences. To be cautious and discreet are among the chief injunctions to every one engaged in our activities.

From the beginning the management has insisted upon conducting the routine administration of the College on the strict principles of business. While ours is an educational institution, each one of us is made to realize that he is dealing with trust funds. It may be old fashioned, but if a telegram can express its meaning in ten words, eleven words are not allowed. Nor is a telegram sent in place of a letter if the letter will accomplish the same end.

Time, too, is considered a financial asset. The loss of half an hour by a careless or indifferent aid, when multiplied by forty, the number in service, would result in the loss of twenty hours, three and one-half days' work. The careless one is not allowed to go uncensured in this breech of fair play. And it is gratifying to testify that our great family is in entire sympathy with these reasonable requirements.

XIX. Requirements for Fellowship

Important as are these administrative regulations, the most difficult policy to establish was one that would enable us to select for Fellowship only the qualified surgeons and surgical specialists. This involved a study of measures adopted and in use by the time honored Colleges of Surgeons of England, Ireland and Edinburgh. It was found that almost without exception their requirements and tests were formulated before modern surgery came into existence. They are similar to those

which are now exacted of internes and hospital aids to ascertain the candidate's knowledge of academic facts instead of his practical ability to apply such knowledge toward the accomplishment of deeds.

After thorough and careful study of the whole problem, there was no reason why we should begin by adapting obsolete plans to a 20th century program.

What requirements, then, should the medical practitioner meet that we may recommend him to the public as a reliable surgeon?

First: He must have graduated from a Class "A" medical college (or its equivalent); and he must have served at least one year as interne in a creditable hospital and two years as surgical assistant, or he shall give evidence of apprenticeship of equivalent value.

Second: Five to eight years after graduation in medicine, devoted to special training and to practice, are normally the time-requirement for eligibility to Fellowship, so the candidate may prove that he has the proper temperament, and is mentally and mechanically adapted to do surgery.

Third: The moral and ethical fitness of the candidate as a physician and as a citizen shall be determined by reports of surgeons whose names are submitted by the candidate himself, and by such other reports and data as the Credentials Committee and the administration of the College may obtain.

Fourth: The professional activity of the candidate shall be restricted to study, diagnosis, and operative work in general surgery or in special fields of surgery. His specialization in surgery or one of its specialties must be not less than 85% in communities of more than 50,000 inhabitants, and 50% in smaller communities.

Fifth: He shall do his work in a hospital or institution that will give him the benefit of scientific facilities and the aid of competent assistants, nurses, and associates.

Sixth: He shall make formal application for Fellowship, which will record full data regarding his educational opportunities, his medical training and post graduate work, and his literary efforts; and he shall give the names of not less than five personal references.

Seventh: This information and the replies from his references are referred for careful scrutiny by his State or Provincial Committee on Credentials, which is a committee of Fellows of the College ranging in number from eighteen to thirty-six. Full information is sought, and each member of the committee is required to vote to accept, postpone, or reject the applicant. Candidates are considered with such care that not more than one of every four is accepted at any one meeting.

Eighth: Not until the candidate is accepted by his State or Provincial Committee is he required to file with a committee of competent surgical specialists a sufficient number of case records of major operations which he has performed himself that the committee may definitely determine his surgical judgment, his diagnostic accuracy, his technical skill, acceptable environment, his dependence on laboratory findings, his acceptance of consultations, and his immediate and remote results. These records are carefully scrutinized by a committee of practical surgeons, teachers in the four Class A medical schools of Chicago. This examination is thoroughly and consistently conducted. Great care is exercised, and the standards of the examiners are very high. From 25% to 51% of the records are not accepted as sufficient evidence of qualifications for membership.

This careful surveillance, from the filing of the original application until the routine of investigation is successfully completed, consumes from two to four years of time. The applicant's record is finally submitted to the officials of the College for consideration, and as a last act to the Board of Regents.

We are proud to submit this program as one that will reveal the qualifications of a surgical practitioner, and when successfully negotiated the candidate may be recognized as a real surgeon, spiritually and morally worthy of Fellowship in the American College of Surgeons.

Briefly, these are the qualifications that have been met by this fine group of men who have been received into the College this evening, for which occasion you have honored us with your presence. The majority of our candidates have been in practice since graduation from medical school, much longer than the required seven years.

We believe that our requirements possess advantages over the purely academic. Imagine asking William Mayo or Edward Martin to submit to an academic examination to prove their ability to qualify as surgeons! Not only would it be difficult for them to pass such an examination, even after months of cramming, but in the meantime the world would lose their services as practical operators.

XX. Junior Candidate Group

The Junior Candidate Group forges another strong link in our propaganda against unworthy financial practices. Through it, the College purposes to accept these candidates, when qualified, and place them on a probationary list (unpub-

lished) as early as two years after graduation. They are required to fill out and sign the same application blank and anti-fee-splitting pledge as is required of all Fellows of the College. Annually their names, if approved, are reconsidered by the respective State or Provincial Committee on Credentials.

Seven years after graduation, if they desire to apply for regular Fellowship, they must submit another application, again sign the anti-fee-splitting pledge, be reconsidered by the respective State or Provincial Committee on Credentials, and if approved submit the necessary case histories.

The Junior Candidate group furnishes a young surgeon a tie of great importance in the formative days of his career.

XXI. Appreciation of Our Efforts

In these short, but strenuous years, we have been rewarded by the appreciation of organizations, and of many loyal and eminent men of vision and accomplishment. The Royal College of Surgeons of England honored us at our first Convocation by sending to us its distinguished President, the nephew of Lord Lister—Sir Rickman Godlee. In appreciation of our efforts in the Great War (for which 90% of our distinguished Fellows enrolled for service to support the efforts of our allies), the Consulting Surgeons of the Armies of Great Britain presented to the College the Great Mace, which now and for all time to come will lead our ceremonial processions.

Of transcendent importance, our ideals and standards have been accepted by 1,919 hospitals of the United States, Canada, Central and South America, Australia and New Zealand. These ideals and standards are enthusiastically welcomed by surgeons, internists, and specialists; and they have commanded also the recognition of medical schools, medical associations, and nurses. Of greatest importance, they have secured the recognition and following of the great lay public.

XXII. The Heritage

This is the heritage that our new Fellows receive from the old. It is the gift of the Old Guard to the New Guard; this New Guard—of which you who have but just now received your Fellowship are a part—must begin to assume the obligations that were so well maintained by the Old Guard, who sit about me, and who have honored you and me by their presence on this fifteenth anniversary. They are still reluctant to release their responsibilities until they are convinced that younger minds have caught the vision, appreciate their opportunities, and are willing to labor—and fight if necessary—for the honor of the American College of Surgeons.