

# 7. The First American Specialty Boards

*It is the very worst thing that can happen to the profession and patients if a man does not master his own specialty.*

JACQUES HOLINGER  
TO THE ACADEMY, 1908

## PART 1: TABLEAUS

### THE HISTORICAL POINT IN TIME

**T**HE YEAR IS 1916—it is the year James Joyce made literary history with *A Portrait of the Artist as a Young Man*, the year Picasso painted *Abstraction*, the year “Twelfth Street Rag” and “Poor Butterfly” were added to the repertoire of American musical favorites, the year the first woman was elected to the US House of Representatives, the year Rasputin was murdered. The day is the 13th of December—it is four months before the United States declares war on Germany marking its entry into the First World War; it is three months before revolution begins in Russia altering world history. It is only hours before a handful of physicians will gather at the University of Tennessee College of Medicine in Memphis to take the first American Board examination, and Wendell Reber, an Academy representative to the newly formed American Board for Ophthalmic Examinations, is addressing the Academy:

We are ready to have the first examination this evening at 8 o'clock—a written examination, and the clinical examination will be conducted throughout tomorrow. It is only fair, right and proper. There is no desire to ask any catch questions, merely a desire to test the ability of the candidates. That this should be done you have shown by the way you have supported the committee in the past. <sup>62(pp10,11)</sup>

Certainly in the cosmos of American medicine, in the unfolding of American specialty practice, this event marked the beginning of evolutionary changes. The American Board for Ophthalmic Examinations, the collective product of the Academy, the American Ophthalmological Society, and the Section on Ophthalmology of the AMA, stimulated motivation and means for elevating the quality of those practicing the specialties and, therefore, the quality of care delivered. The influence of the Board traversed the entire circumference of American specialism and was a prime mover toward the highly sophisticated medical specialization that we have in this country today.

## THE MEDICAL TIME IN POINT

The work that led to formation of the Boards in ophthalmology and otolaryngology, both labors in which the Academy played an intrinsic role, started in 1913. The original intent of this work was to standardize graduate instruction and establish uniform educational criteria for those aspiring to specialty practice.

Although certainly the end viewed by the ophthalmologists was to upgrade and standardize training for the specialty, their creation of an ophthalmic examining board was a pragmatic solution, the mechanism of which worked in reverse, that is, setting a standard for candidates to receive the distinction of certification, thereby forcing men to obtain proper training, and in turn making the demand for this training such that it was felt by the institutions which would eventually provide it. It did, indeed, turn out to be a most effective incentive. Within the short span of three years, the ophthalmologists had grappled with the problem of amplifying specialty training and deployed their immediate answer—the American Board for Ophthalmic Examinations.<sup>69</sup>

The otolaryngologists also began groping for answers in 1913, but they spent much time debating alternative plans for effecting adequate training programs and prevaricating about the substance of such programs, and their Board was not established until 1924 (the otolaryngology Board was the second American specialty board).

To understand the genesis of these boards in its full implication and ramification, it is essential to understand in the context of the times something of the climate of specialty practice and how one qualified oneself for such.

### Delayed Specialty Training

In the late 19th and early 20th century, a general disposition or dogma held that a man should practice general medicine before confin-

ing himself to a specialty. This prejudice against "early specialization" was grounded in the belief that a man should be thoroughly conversant with all aspects of general medicine before taking up a specialty, and the opinion originated, rather understandably, at a time when medical teaching was so poor that the physician learned a large part of his art in on-the-job training. To concentrate early on a specialty was to abridge one's knowledge of fundamental medicine. The idea also dated to a time when the radius of scientific knowledge and development in the specialties was limited. As the perimeters of knowledge expanded, so did the number of specialists, but the bias of "general practice first" was rather persistent.<sup>70</sup> A scan of early Academy members shows many who defied this notion and embarked on specialty training immediately after their medical studies, but the crossover from general practice to specialty practice was common.

### Technique of Training

Whether a man was fresh from medical school or seasoned with a few years in general practice, the available supply of education for a specialty was limited and the route circuitous (often requiring a combination of available resources), and this coupled with the fact that specialty training and practice were regulated by no more than the individual conscience, made for a large number of men wearing the panoply of the specialist with virtually no training at all. Given the lack of adequate graduate training programs and the contingent lack of an established curriculum of study, the man deciding to embrace a specialty had essentially three educational options, and his pursuant mastery was directly correlated with the option selected.

Probably the best training was achieved by going abroad to study in the medical centers and clinics of Europe. Next in line would fall a preceptorship with an experienced practitioner of the specialty, although the type and degree

of training attained were subject to circumstantial elements, such as the depth of guidance and instruction by the preceptor and the breadth of effort by the trainee. Last in line, and diametrically opposite the first two in quality, was a short stint at one of the postgraduate schools. These schools offered no training in the basic science of a specialty but rather prepared their students by giving them smidgen familiarity with the tools of the trade and dispensed them off with a diploma, the mantle of specialism, and a thimbleful of knowledge and skill after a modicum training period of sometimes six weeks' duration.

Naturally, those interested in actually becoming a specialist chose to bridge the gap between general medicine training programs and specialty practice either by going abroad to study or by obtaining a preceptorship, or maximally, by employing a combination of the two. Those eager to assume the countenance of the specialist but unable or unwilling to consecrate themselves to the more lengthy preparation chose the shortcut of the postgraduate school. Although the first two methods were satisfactory, they did not provide any assured consistency of training among those who utilized them. Without fixed standards to direct and control the time, content, and quality of training, all postgraduate study was subject to the vicissitudes of individual situation and discipline.

In respect to the third method, the postgraduate school was not a deliberately contemplated pretext to specialty training; it had served a respectable purpose in providing rudimentary knowledge and craft in special areas at a time when specialism was still in a rudimentary stage of definition and development. Its continued existence, however, hinged more on pragmatism than on principle. The long-standing general practitioner who elected to adopt a specialty often did so under this guise (these men are to be distinguished from men who took up general practice for a short-

term period out of deference to medical opinion and as a prelude to specialty training).

There was a fourth method of obtaining training, that of procuring a residency in one of the eye, ear, nose, and throat hospitals in this country, but the positions were so few that this was a remote possibility for the vast majority of men, and it was the conditions affecting the majority that fired the atmosphere in which the first Boards were produced.

### Need of American Training

Specialty knowledge and practice in the United States were heavily dependent on the buttress of European research and training—if the student of a specialty did not study in Europe, he learned from teachers who had—and the danger inherent to such dependency became actual when the First World War dislodged this support. The outbreak of war in 1914 agitated anew the imperative to fortify American medicine with its own citadels of training and research. The sentiments of the entire medical profession were echoed by C. J. Blake, a Boston physician, in his welcoming address to the Academy's 1914 meeting.

For more than fifty years we Americans have been supplementing our medical education by visiting the clinics of the medical schools of the continent, and especially is this true in specialized lines. We have brought home a rich food. We have garnered it and are applying it to the education of our brethren in this country who are not able to do what we have done. . . .

. . . suddenly there has come to us a loss of the opportunity . . . for study abroad, and it is the duty of our profession to offer in this country an opportunity for a substitute education.<sup>67(pp3,4)</sup>

To provide the opportunity for specialty education in America, thereby to pattern and govern the quality of it, and therefrom to set norms for training of the qualified which would exert constraints on the practice of the unqualified—these objectives were the seed and the harvest of national specialty boards.

## THE FIRST-PERSON STORY

With the foregoing as background to the setting of American medical specialism, the most interesting vantage point is supplied by the following panorama of extracts from the counsels of men whose names epitomize progress in the specialties. A graphic documentary of the conditions which led to formation of the Boards emerges from listening to the problems as phrased by the men who sought solutions. All the quotations except the first are extracted from reports and discussions at Academy meetings which preceded and prodced Wendell Reber's 1913 call to action. The first excerpt used to tell this story says something about medical training around the turn of the century, and the article from which it is taken, entitled "Towards Standards for Licensure," appeared in the *Journal of the American Medical Association* in June 1896, two months after the founding meeting of the Academy.

### JAMA—June 13, 1896

Twenty-three States now require licensing examinations. Of these examinations, sixteen are before a single board; four before two boards, allopathic and homeopathic; three before three boards, allopathic, homeopathic and eclectic. In eleven states candidates for examination must be graduates of medical schools; in three of these eleven States they must have studied medicine four years; in two States they must have attended at least three courses of medical lectures, though a diploma is not required. . . . In six States applicants must have a competent preliminary education, though the provision is indefinite except in the New York law. . . . In ten States the licensing examination is the only test of fitness for practice, plainly a much more unsafe standard than indorsement of diplomas from accredited schools without a licensing examination.

The laws of thirteen States and three Territories demand either approval of medical

diploma or examination by State or other duly qualified boards.

We do not contend that many State medical laws are satisfactory. Indeed with few exceptions they are far from perfect. But we do assert positively that the advance in this country since 1888 is without a parallel.<sup>71</sup>

### Edward Jackson—1904

To-day there are more than two thousand [specialists in eye, ear, nose, and throat] within the borders of our country. . . . The specialist requires a special literature, . . . special societies, and primarily . . . special education. . . . this special training is required by a large and rapidly increasing body of physicians, [and] the institutions that furnish medical education must take upon themselves the task of meeting the demands of the time. . . .

. . . It should be understood that the custom of teaching medical students a fair amount of internal medicine and general surgery, and the sending them out to adopt what line of practice they please, and qualify themselves for it as best they can, is . . . disastrous. . . .

. . . It is not possible that special preparation for ophthalmic practice should remain dependent upon individual initiative. It is not desirable that it should be left to brief postgraduate courses, or to the so-called ophthalmic colleges. There is a great and pressing need that stable, conservative institutions of learning of the highest type should offer a formal course fitting their graduates for ophthalmic practice.<sup>72</sup>

### George E. Shambaugh—1908

To meet the increasing demand for trained specialists there sprang up in our larger centers of population the so-called postgraduate medical schools. These schools extended practically the only opportunity for training in the

specialties. . . . Specialization of to-day has outgrown the postgraduate medical school. . . .

The time was, in the earlier days of specialization, before much had been accomplished in the development of the special fields, when it was customary for the general practitioner without any special preparation to limit his work to this or that specialty, and from that time he was recognized as a specialist. It was under these conditions that the postgraduate school accomplished its best work. These men would get away from their work for a few weeks, and at the postgraduate school they would acquaint themselves with the use of the instruments necessary for the examination of their cases, and returning to their practices they gradually developed, if they were studious and persistent, as the specialty itself developed and expanded.

. . . development of the specialties has in recent years carried the work in these fields so far beyond the scope of the work done by the general practitioner, or the general surgeon, as to require at least several years of close painstaking study in order to give one a preparation adequate to take up the real work of the specialist. It is still not uncommon to-day to see the general practitioner drop his general work, for which his medical course has prepared him, and limit his practice to this or that special field, with no further preparation than a few weeks' attendance in the postgraduate school, or a few months' trip abroad. . . .

. . . a practitioner can become a specialist over night by permitting our postgraduate school to issue at the end of a few weeks' attendance a certificate. . . .

. . . a general practitioner can not be transformed into a specialist in six weeks or six months, but . . . at least two or three years' painstaking study is necessary to adequately prepare a physician for such work. . . .

. . . the time is ripe for a revolutionary change in our attitude toward the preparation of the specialist. It should be recognized that one of the most urgent problems in medical education to-day is the establishing of courses of instruction which will provide adequate preparation for the physicians entering the practice of the special fields. . . . such courses should be as much in the fundamental sciences as in the clinical study. . . . It is only after fundamental sciences have been mastered that one is properly prepared to take up intelligently the clinical study of the subject. The method . . . in our postgraduate schools, of attempting to teach the man preparing for a specialty the clinical aspect of the subject before he has been thoroughly grounded in the fundamental sciences of the subject, is as absurd as it would be to attempt to teach clinical medicine or clinical surgery without first requiring thorough training in general physiology and general anatomy. . . .

To acquire the knowledge of the special anatomy, the special physiology, pathology and embryology of an organ like the ear, or the eye . . . would require at least one whole year. Another whole year should be the minimum devoted to clinical study before one should be allowed to practice in these specialties.

We have at present no provision for work of this kind.<sup>73</sup>

#### Casey Wood—1908

It can not . . . be too strongly insisted upon that an earnest investigation of the elements of ocular physiology, anatomy and pathology should precede or at least run parallel with the clinical study of ophthalmology. . . .

. . . I see no reason why any one of our undergraduate schools should not enter the field of postgraduate teaching. The adoption of such a plan would . . . elevate the standard of postgraduate instruction . . . and would soon make it unnecessary as well as undesirable for

our American students to go abroad, as they now do, for any considerable portion of their instruction in matters pertaining to diseases of the eye.<sup>74</sup>

#### Derrick Vail—1908

I hope to see the time when ophthalmology will be taught in this country as it should be taught. That day will come when we, as oculists, demand that a certain amount of preliminary education and training be enforced before a man may be licensed to practice ophthalmology. It should be no longer possible for a man to be called an oculist by himself or by the laity, after he has spent a month or six weeks in some postgraduate school or after serving as assistant for six months or a year in some oculist's office. It is a blot on our fair escutcheon that any man be so regarded after such short courses of attendance in any postgraduate school or even after six months' service without the proper preliminary training. When we require students to qualify by years of study in general medicine or by a year or two of experience as an interne in a general hospital and then, after a sufficiently long time of service in an ophthalmic institution in America or abroad, he should be permitted to appear before a proper examining board, similar to any State Board of Examination and Registration, for examination and if he is found competent let him then be permitted and licensed to practice ophthalmology.<sup>75</sup>

#### Edward Jackson—1912

The time has come when the specialization that has actually occurred in medical practice must be recognized in medical education. . . .

. . . laboratory work, clinical work, reading and other methods for the study of ophthalmology should be carefully systematized and correlated by standard educational institutions. The school of ophthalmology must be a department in the university. . . .

The service of the community, the standing of ophthalmologists as a definite class of professional advisers, and their ability to secure the proper recognition even in the ranks of the medical profession, have suffered greatly from the lack of provision for such supervised systematic study.<sup>76</sup>

EDWARD B. HECKEL, Pittsburgh: We owe a debt of gratitude to Dr Jackson for the interest he has and is taking in this subject. I cannot but believe that he is gradually and surely developing into a Moses who will lead us out of this wilderness. . . .<sup>76(p195)</sup>

#### Linn Emerson—1912

The general practitioner must be licensed as such by the state before he may practice, but no such public safeguard restricts the specialist. Any person who chooses may call himself a specialist. . . .

I am a firm believer in the most rigid preparation: the ideal preparation in a collegiate course leading to a degree, followed by the four years in medical college, the year or two years in a general hospital, and then the special line, followed with all the earnestness and enthusiasm that a well-trained mind can bring to bear on it.<sup>77</sup>

GEORGE F. KEIPER, La Fayette, Ind: One question I desire to bring before you is as to how we shall judge whether a man is a real specialist or not. . . .<sup>77(p205)</sup>

MAX A. GOLDSTEIN, St. Louis: . . . National and state laws should be framed in which the qualifications of the specialist may be prescribed, time of service in general practice recognized, special examinations passed, and other details arranged; such laws should receive the unanimous endorsement of all of our national special societies, and an endeavor made by means of such legislation to regulate the practice of the specialties, by properly qualified and licensed confrères. . . .

I would suggest that a committee be named by representatives of each and every society of specialists; this committee to formulate and outline some plan of legislation, and to report back to their respective societies for further instructions. . . .<sup>77(p206)</sup>

EDWARD JACKSON, Denver: . . . Until the medical profession recognizes specialization within its ranks no

legal recognition will be very effective. This was discussed in the Hospital Section of the A. M. A. at Atlantic City. One suggestion was that the American Surgical Association should appoint a board of examiners and offer a license, much on the plan of the Royal Academies in Great Britain, recognizing certain men as worthy of the special diploma.<sup>77(p208)</sup>

### Wendell Reber—1913

I do not know whether a committee has been formed from our Academy as from the American Ophthalmological Society, to confer on postgraduate instruction. If not, we certainly ought to form a committee. . . . as undergraduate medical education has been regulated, postgraduate will soon be regulated. . . . our committee should strive to arrive at what it thinks should be the general medical training of any young man when he enters on the study of ophthalmology as a science, and then set down a standard uniform requirement for any one to be admitted to the practice of ophthalmology. . . .<sup>70(pp303,304)</sup>

I did not have as much opportunity to confer with others as I had hoped, but I present my resolution now in this shape:

RESOLVED that the American Academy of Ophthalmology and Oto-Laryngology, realizing that standardization of postgraduate medical teaching in Ophthalmology and Oto-Laryngology is much needed,

feels that definite action in this direction should be taken.

RESOLVED further that it is the sense of this meeting that two committees be appointed by the chair to confer with similarly appointed committees from the American Ophthalmological Society and the Section of Ophthalmology of the American Medical Association on the one hand, and similar committees from the Oto-Laryngological societies. The end in view will be to induce the various post graduate institutions of the United States to adopt some manner of uniform curriculum and uniform requirements for admission to Ophthalmic and Oto-Laryngologic practice; said committees to report back to the Council and Academy at the Boston meeting [1914 annual meeting].<sup>47(pp24,25)</sup>

Dr Reber's resolution was adopted, and President John W. Murphy appointed him chairman of the Committee on Education in Ophthalmology, the other two members being Edward Jackson and Walter B. Lancaster. William L. Ballenger was designated chairman of the Committee on Education in Oto-Laryngology, with his co-workers being Samuel Iglauer and John M. Ingersoll.<sup>47(p25)</sup> Chairmen Reber and Ballenger were both to die before they saw the full fruits of this endeavor; however, Dr Reber, who was instrumental in forming the American Board for Ophthalmic Examinations, lived to see the first examination given, and Dr Ballenger was active in working through the initial stages which led to the otolaryngology Board.

## PART 2: OPHTHALMOLOGISTS EXPEDITE PLAN: AMERICAN BOARD FOR OPHTHALMIC EXAMINATIONS

On Oct 19, 1914, at the Academy meeting in Boston, Wendell Reber read to the Academy a report which introduced the concept of an examining board and described its functions (Fig 19). He portrayed the report as "the result of numerous conferences" and as "close to that of the American Ophthalmological Society and the Section of the American Medical Society."<sup>67(p7)</sup> The document laid buried for years in Academy archives, and interestingly, it credits Walter B. Lancaster with conceiving the plan of an examining board. This contradicts the general belief that the plan originated with Edward Jackson.

In working out the role and province of a board for examinations, a key proposal discarded was that of granting a special degree, and Dr Reber explained:

We have gone carefully over the question of a degree, and this has been argued for a year, pro and con. The matter of some sort of a degree for advanced medical work has been considered by President Lowell and others of Harvard. The degree of Doctor of Medical Science, to be qualified by what was necessary to express his qualification.

The committee feels that the function of the board should be to examine and then certify, and not to confer degrees. We all have our degree, of which we are proud.<sup>67(p7)</sup>

Immediately after Dr Reber narrated the report of the Committee on Education in Ophthalmology, the Academy membership unanimously endorsed it and suggested that the joint conference with similar committees, as recommended in the last handwritten paragraph, be held following the meeting. Representatives from the Academy, the American Ophthalmological Society, and the Section on Ophthalmology of the AMA did meet in Boston after the Academy's 1914 meeting, and Dr Reber recorded that "a temporary organization was effected."<sup>57(p'a')</sup>

Progress toward an ophthalmic examining board then proceeded quite rapidly as the general committee of the three societies began tailoring the details into final form.

By the time of the Academy's 1915 meeting, a joint report from the general committee had been issued and published in some ophthalmic journals. The report distributed to members at the meeting was probably identical to the following account published in the 1915 *Transactions of the American Ophthalmological Society*:

During the past year the American Ophthalmological Society, the Section on Ophthalmology of the American Medical Association, and the American Academy of Ophthalmology and Oto-Laryngology have considered and adopted the reports of their respective committees recommending that graduate courses in ophthalmology representing at least two years of work subsequent to taking the degree of Doctor of Medicine be established in medical schools of the first class; and that such work be recognized by conferring an appropriate degree upon those who have successfully completed it.

It seems clear that there is unanimous agreement as to the need for systematized and standardized training of those who are to practise ophthalmology. At least five of the medical departments of important American universities have now arranged for such courses leading up to special degrees. But already it is clear that the number of graduate students who will take the complete course leading to such a degree will, in the near future, be small. Even in universities capable of furnishing facilities adequate for the training of large numbers the great majority will not meet the requirements for the higher degree.

It is desirable that the standard of attainment for which university degrees are given should be kept fully up to the present standard of our best universities. As matters now stand, therefore, a large majority of those entering upon the practice of ophthalmology will not be reached, or directly influenced, by these standards. It is extremely desirable that all who take up ophthalmic practice as a specialty should be induced to pursue systematic courses and to show proficiency therein.

Professional opinion, particularly the opinion of those who have already established themselves in



Revised Report 1914

The present chaotic state of post-graduate teaching of ophthalmology in the United States is now too widely admitted to justify any extended discussion of the subject in this report.

The present trend of sentiment indicates plainly that two years of systematic postgraduate study should be the prime requisite for any ~~recognition~~ recognition of that degree of skill and fitness for ophthalmic practice that would justify special recognition of some kind. Just what form this "special recognition" should take will be dealt with further on.

This is not the time or place to enter upon a detailed curriculum but your committee feels that the following essentials must be embraced in a systematic graded course:-

1. A practical anatomical course on the eye and its appendages, the accessory sinuses, and the regional anatomy of the brain.
2. The anatomy and histology of the eye on a comprehensive basis.
3. Work in physical and physiologic optics supplemented by laboratory and clinical study of the refraction and accommodation of the eye and the principles governing the various instruments of precision used in ophthalmic practice.
4. A course in <sup>the</sup> pathology and bacteriology of the eye ~~including the theory of surgery and its therapy.~~
5. A course in ophthalmic surgery which should cover practice on animals eyes and the cadaver and also if possible operations on living animals.
6. A course on motor anomalies of the eyes which should be both didactic and clinical.
7. A didactic course on external diseases of the eye.
8. A didactic course on ophthalmoscopic diseases of the eye.
9. A course on ophthalmic-neurology.
10. A course of lectures on color theories, color vision and testing modern illumination and the hygiene of the eye.
11. Clinical work for not less than one year which should include all the departments above mentioned as well as history taking and ocular therapeutics, ~~including vaccine & serum therapy.~~

To test the fitness of candidates who shall have met the requirements above set forth and to properly certify them to the medical profession and the community at large, your committee would urge the formation of a Federated Board of Ophthalmic Examiners to be composed of nine members, three to be named by each of the national ophthalmic societies, namely, The American Ophthalmologic Society, The Section on

Ophthalmology of the American Medical Association and the American Association of Ophthalmologists and Otolaryngologists, as proposed by Dr. Lancaster last year.

[The bottom part of this page is mutilated but is discernible in the original. The entire last paragraph, including the mutilated portion, reads as follows: "To test the fitness of candidates who shall have met the requirements above set forth and to properly certify them to the medical profession and the community at large, your committee would urge the formation of a Federated Board of Ophthalmic Examiners to be composed of nine members, three to be named by each of the national ophthalmic societies, namely, The American Ophthalmologic Society, The Section on Ophthalmology of the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology, as proposed by Dr. Lancaster last year." The last phrase, "as proposed by Dr. Lancaster last year," is penned in, obviously to replace the sentence crossed out, beginning on this page and continuing on page two, which reads: "Your committee is indebted for this suggestion to one of its members, Dr. Walter Lancaster who made it last October during the homeward journey from the Chattanooga meeting."]

~~submitted for this suggestion to one of its members, Dr. Walter Lancaster~~  
~~at the October meeting of the Academy, January 1914, that~~  
~~language meeting.~~

The Examining Board should have complete charge of the examination of candidates who have prepared for special recognition.

Your committee is unanimous in the belief that all interests will be best subserved by the granting of a certificate by the Board rather than any degree. This will leave the schools or universities doing postgraduate ~~work~~ teaching the privilege of granting any degree that in their judgment may seem fit to meet the peculiar needs of the case. At present no ~~idea~~<sup>degree</sup> has been brought forward that meets with anything like general acceptance.

It will be peculiarly within the functions of such an Examining Board to allot appropriate credits to those who have worked or studied in postgraduate schools, to those who have worked in recognized ophthalmic clinics, and to those who have studied in European institutions, also to provide the details for allotting accumulated credits until they shall have reached a total of 2 years.

Your committee is unanimous in its agreement with the Committee of the American Ophthalmological Society and that of the Section on Ophthalmology of the American Medical Association that an Examining Committee of the kind described is thoroughly practicable and offers the best means for ensuring a comparatively thorough preparation on the part of those who offer themselves to the medical profession and the public as skilled ophthalmologists. The certificate of such a Federated Board "backed by the influence of these important associations while conferring no academic degree, would surely have great weight with the professions and public, and would soon come to be sought by most of those desiring to enter the practice of ophthalmology."

*Your committee finally recommends a joint Conference with the similarly constituted Committee from the American Ophthalmological Society and the Section on Ophthalmology of the American Medical Association.*

Edward Jackson  
Walter B. Lancaster  
Wendell Reber  
Chairman

Fig 19.—First report of Academy's Committee on Education, bearing personal signatures of Drs Reber, Jackson, and Lancaster. There is no way to determine accuracy of credit assigned to Walter B. Lancaster for suggesting an examining board. In their "History of the American Board of Ophthalmology," Drs Cordes and Rucker cite report given in June 1914 to Section on Ophthalmology of AMA as "first mention of a conjoint board with representatives from the three national eye societies."<sup>69(p249)</sup> Edward Jackson, to whom this idea is usually attributed, was chairman of committee from Section on Ophthalmology and also member of similarly directed committee from American Ophthalmological Society. If Dr Lancaster proposed plan immediately after Academy's 1913 meeting at which Committee on Education was appointed, Dr Jackson's committee would have presented it to Section on Ophthalmology before it was presented to Academy at its October 1914 meeting. Whether it was Dr Lancaster or Dr Jackson who first raised concept of an examining board, the larger truth is that the idea was culled from Royal Colleges of Great Britain.

ophthalmic practice, can bring about the desired change to a large extent, without assistance from legal enactments and without the necessity for establishing

new educational institutions. It is only necessary to bring into existence a competent body to outline the proper course of study to be pursued; to examine and

pass judgment upon existing institutions that offer opportunities for such study, and when individual students have proved that they have profited from such opportunities, and have prepared for ophthalmic practice, to give them the advantages of a certificate to that effect.

To accomplish this purpose, in which we believe the ophthalmologists of America are fully united, we make the following recommendations, unanimously agreed to by the joint committees representing the three organizations above named:

1. That, by the conjoint action of the American Ophthalmological Society, the Section on Ophthalmology of the American Medical Association, and the American Academy of Ophthalmology and Oto-Laryngology, a Board be established to arrange, control, and supervise examinations, to test the preparation of those who design to enter upon the special or exclusive practice of ophthalmology.

2. That this Board consist of nine members: three to be chosen by each of the above-named organizations, in the same manner as their presiding officers are named. At the first election each organization shall choose three members, one for three years, one for two years, and one for one year; and thereafter one each year to serve for a term of three years. Vacancies shall be filled for the unexpired term by the Society from which the preceding member has been chosen. No member of the Board shall serve more than six years continuously.

3. Members of the Board shall serve without compensation, but shall be reimbursed for actual expenses while engaged in the work of the Board, provided all other necessary expenses of the Board and its appointees have been properly provided for.

4. The Board shall appoint from its own membership, and from the medical profession outside its membership, a sufficient number of learned and skilled examiners who shall conduct the said examinations and report thereon to the Board.

5. The examinations may be held in any city of the United States where good facilities may be obtained for conducting clinical and practical examinations.

6. The Board shall fix requirements to be met by all candidates for examination, which shall include the successful completion of a course in medicine in a medical school of recognized good standing, at least two years before the examination; adequate study of ophthalmology and allied subjects; and payment of an examination fee to be fixed by the Board. It shall be authorized to prepare lists of medical schools, hospitals, and private instructors recognized as competent to give the required instruction in ophthalmology.

7. Each candidate whom the examiners report as having successfully passed the required examination

shall receive by the authority of the Board a certificate or diploma setting forth this fact, but conferring on the recipient no academic degree.

8. The American Ophthalmological Society and the American Academy of Ophthalmology and Oto-Laryngology shall from the year 1920 require every candidate for membership in those bodies to possess the certificate above mentioned, unless the applicant shall possess a degree in ophthalmology conferred by a university recognized by them as competent to prepare its students for such a degree. The Section on Ophthalmology of the American Medical Association, in so far as it is empowered to adopt its own rules, shall, from the year 1920, require that its officers and those members accorded places on its program shall possess the certificate in question or its equivalent; and shall request that in the directory published by the Association the holder of such certificates be especially recognized.<sup>78</sup>

Having submitted the foregoing specific plan and objectives for a joint examining board, the Academy's committee of Drs Reber, Jackson, and Lancaster (Fig 20) addressed a separate notice to the members outlining what action should be taken. Their recommendations are in Dr Reber's handwriting on a piece of letter-size stationery:

Oct. 6, 1915

To the American Academy of Ophthalmology and Oto-Laryngology

Fellows:—

It is of interest to note that the idea of an advanced standard for ophthalmic practice along with a general plan for obtaining the same which was first formally promulgated in this Academy has been adopted by our sister organizations namely The American Ophthalmological Society—and the Section on Ophthalmology of the American Medical Assn in accordance with the recommendations made by your Committee at the meeting in Boston last October (1914). The advisability of an advanced standard seems therefore to have taken real form. In view of the fact that the two sister organizations have finally committed themselves to the idea of a Joint Board on Examination to determine fitness for ophthalmic practice, your committee would now recommend that adoption of the joint report as formulated by the Joint Committee from the three societies namely The American Ophthalmological Society, the Section on Ophthalmology of the American Medical Association and the American Academy of Ophthalmology. They would also further recommend that in accordance with the provisions of that report that the Council nominate and the Academy elect 3 of its members to serve as members of the Joint

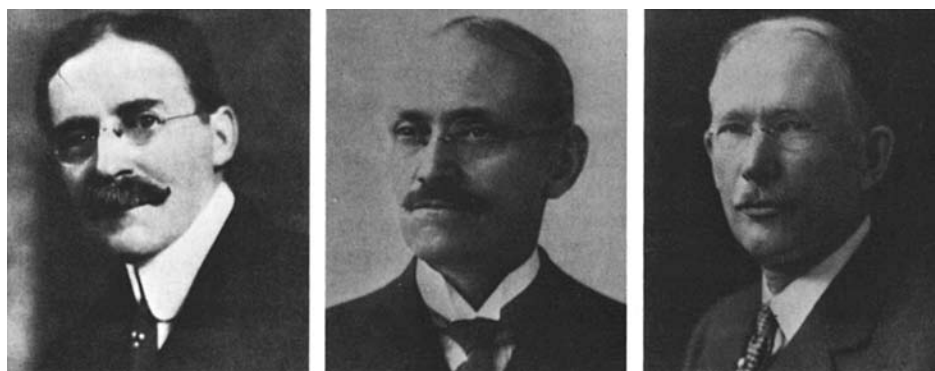


Fig 20.—Academy Committee on Education in Ophthalmology. Left, Wendell Reber, Philadelphia, chairman. Center, Edward Jackson, Denver. Right, Walter B. Lancaster, Boston.

Board of Examiners to determine fitness for ophthalmic practice, one to serve for 3 years, one to serve for 2 years and one to serve for 1 year.

[Signatures]  
Edward Jackson  
Walter B. Lancaster

Respectfully submitted  
Wendell Reber, Chairman<sup>79</sup>

To urge appropriate action and dispel any possible apprehension on the part of members, Dr Reber clarified that the board proposed would

conduct examinations of those who feel qualified for these examinations, which will be very like the examinations of England. Men are not obliged to take these examinations. . . . This committee will be ready to conduct examinations for candidates who have had two years of preparation and who choose to come up for a certificate.<sup>57(p'd')</sup>

Academy members supported creation of a permanent joint board and elected as their "committee" of representatives to implement and staff the board, Wendell Reber, for a term of three years, Walter B. Lancaster, for a term of two years, and Frank C. Todd, of Minneapolis, for a term of one year.<sup>57(p'e')</sup> Edward Jackson had already been appointed to represent the Section on Ophthalmology of the AMA on the proposed board; he was named the first chairman of the ophthalmology Board.

Throughout the next seven months, the representatives from the three societies met

several times, and in May of 1916 in Washington, DC, the American Board for Ophthalmic Examinations was formally organized.<sup>62(p11)</sup> Seven months later, on Dec 13 and 14, 1916, the first Board examination—rather a trial run "that the examiners might get fitted into their work"<sup>62(p11)</sup> as Edward Jackson put it—was given in Memphis following the Academy's annual meeting. In a progress report on the morning of Dec 13, Dr Jackson said, "I believe there are 13 applicants in this first examination,"<sup>62(p12)</sup> but there are discrepant records on this figure.

The first regular examination was held in New York on June 7 and 8, 1917, and another examination was held at the Singer Memorial Research Laboratory in Pittsburgh on Oct 27, 1917, just preceding the Academy's 22nd annual meeting. At the meeting, Dr Jackson announced that from the three examinations "120 have been awarded the certificate of the Board."<sup>80</sup> This number requires some qualification, since less than a third of those so distinguished actually took and passed the examination and the balance were awarded the certificate on their merit. "Past achievements will be given full credit,"<sup>62(p12)</sup> said Wendell Reber at the outset in 1916, and the policy of certifying, without examination, those of proven standing and ability was to continue for many years. Dr Reber had, in fact, taken care to inform Academy members of this policy:

One phase that should be put before us, a great many of the mature and better seasoned members of the Academy will feel they would like to take this examination. It is an extremely important thing they should know that their record and achievement in the past will count for more than half of the final credits. The young man will have to prove his fitness by examination, as he has no record. But any man who can show what he has done, in teaching, or in laboratory work or in practice—all these things should and will count. There is no reason that any member of the academy should present himself for this examination.<sup>62(pp12,13)</sup>

**A**lthough certification was not required of those already members of the Academy, all applicants for membership after Jan 1, 1921, were required to be certified by the Board<sup>58(p367)</sup> or to possess a degree in the specialty from a recognized university program<sup>59(p439)</sup> (in accordance with the agreement in item 8 of the joint report). Since no otolaryngology board had been established by the time of the 1920 meeting, the Academy appointed its own examining committee in otolaryngology to ensure that the qualification was activated with parallel effectiveness.

Academy adoption of Board certification as a constitutional requisite for membership is not recorded in Academy minutes but is mentioned in the 1921 minutes of the American Ophthalmological Society.<sup>81</sup> Also in this year, John M. Ingersoll, a member of the Academy's otolaryngology examining committee, proposed amending the phraseology in the constitution so that it did not specify a certificate since the otolaryngology committee issued no certificate.<sup>59(pp439,440)</sup> In 1924, after temporary organization of the otolaryngology Board had been achieved, this addition to the constitution read:

An applicant for membership must be approved by the American Board for Ophthalmic Examinations, or by the National Board of Examiners in Oto-Laryngology. When, however, an applicant for FELLOWSHIP fails to pass the examinations of the American Board for Ophthalmic Examinations or of the National Board of

Examiners in Oto-Laryngology, he shall not be eligible for election until he has passed the Board before which he failed. If an applicant shall fail to qualify for FELLOWSHIP within three years after his application has been filed with the Secretary, he must reapply for FELLOWSHIP in order to be continued on the list of applicants.<sup>68(pp473,474)</sup>

Of the Academy's original representatives to the Board, two were claimed by death before they could serve out their terms. Wendell Reber died shortly after the Memphis examination in December of 1916, and William H. Wilder, of Chicago, was appointed to fill the vacancy. Frank C. Todd, elected for a one-year term in 1915 and reelected in 1916 (also serving as the first secretary of the Board) died in July of 1918 and was replaced by John R. Newcomb, of Indianapolis. Only Walter B. Lancaster served out a full two terms for the Academy, and in January of 1921, after having filled the maximum term of continuous service permitted by the Board, he was replaced as Academy representative by Allen Greenwood, of Boston. A complete listing of Academy representatives to the American Board of Ophthalmology appears in Table 4.

The prototype of the ophthalmologists' board of examiners has been multiplied and diversified until such bodies are an integral part of American specialty medicine. But the heritage of this plan stretches considerably farther than the continued vigil maintained over training and competence of specialists. The American Board for Ophthalmic Examinations was created as an influence, unsupported by power to enact or enforce, in the vacuum of American training for, or restraints on, the practice of specialty medicine. As its designers hoped it would, it helped both to measure the need and to convolve forceful pressures to fill it. The often forgotten legacy from this Board is that it prodded a renovation in the standards for training and mastery of the specialist, which standards it now reinforces and supervises.

### PART 3: AMERICAN BOARD OF OTOLARYNGOLOGY

Within the Academy, and indeed within the context of actual fact, there is an intimate historical relationship between the ophthalmic and otolaryngologic examining boards. For the Academy, the work leading to their creation began as two sides of the same coin, embarked in 1913 by Wendell Reber's resolution that a committee for each specialty be assigned to study the problem of ungoverned specialty education and to collaborate with similarly directed committees of other societies in procuring reform.<sup>47(pp24,25)</sup> Thus the Academy committees on education in ophthalmology and otolaryngology were dedicated to the same task—it was their means of achievement which was to differ considerably for a few years.

Although the Boards of ophthalmology and of otolaryngology were formed through the conjoint efforts of the Academy committees and those of allied societies and were separate entities throughout their developmental stages, the Academy viewed its two committees on education as separate but equal groups working toward a parallel goal, and their progress was considered and compared accordingly. This collateral perspective was inevitable, for of the seven societies that contributed to formation of these Boards, only the Academy represented both ophthalmology and otolaryngology, and therefore, the decisions of both groups affected the Academy as a whole.

The most decisive register of this effect was the requirement, set forth in the joint report of the ophthalmology committees and adopted by the Academy in 1915, that possession of a certificate from the proposed American Board for Ophthalmic Examinations or of a degree in the specialty from a university program would be required for Academy membership after 1920.<sup>78,57(p''b'')</sup> This stipulated a high standard for entrance of ophthalmologists while making no such qualification for otolaryngologists. It

introduced a lopsided element in regard to candidates that could not be allowed. Moreover, it raised the distinct possibility that candidates might come into the Academy under the flag of otolaryngology in order to avoid the ophthalmic examination. The new standard demanded of ophthalmologists made the Academy an insistent voice in pressing for creation of a similar board in otolaryngology.

Unlike the ophthalmologists, the otolaryngology committee set out to fulfill more to the letter the objective outlined in Wendell Reber's resolution, that is, "To induce the various post graduate institutions of the United States to adopt some manner of uniform curriculum and uniform requirements for admission to Ophthalmic and Oto-Laryngologic practice. . . ."<sup>47(p25)</sup> Concentrating on the basic problem, the otolaryngologists settled on a line of direct attack which included defining a proper curriculum that would lead to a degree, then bringing about opportunity for such instruction, and finally, securing legislation that would make completion of the specified graduate preparation necessary for admission to practice.

The task posited initially by the otolaryngologists was formidable. Ultimately, five otolaryngology societies became involved in the endeavor, and it was an arduous process to reach concord among the various factions on what constituted proper training. In respect to provision for the training, university organization of courses, laboratories, and clinical facilities for graduate work in medical specialties was hardly in the ground-breaking stage, and in fact, undergraduate medical education was still the prime issue (Abraham Flexner's pilgrimage to medical schools to assess medical education in this country lasted from 1909 to 1912, and the decade following saw substantial reforms in medical education<sup>82</sup>).

The prospect for enactment of legislation regulating specialty practice was both remote and fraught with overtones, and the idea faded with time.

The otolaryngologists' primary goal of systematic graduate specialty training within the framework of the university medical school was also the long-range goal of the ophthalmologists who continued to work for it. The ophthalmologists, however, chose an immediate plan that they could activate independently. Their invention of an examining board to certify competency was, by comparison, an oblique but adroit thrust at the problem, since this board could construe standards unilaterally and employ them to maneuver professional and public opinion.

Prior to appointment of the Academy's Committee on Education in Otolaryngology, a committee had been launched by the American Laryngological, Rhinological and Otological Society to study the teaching of otolaryngology in both undergraduate and postgraduate schools. This committee of three—D. J. Gibb Wishart, of Toronto, and S. MacCuen Smith and Charles W. Richardson, both of Philadelphia—delivered a lengthy report in which they (1) outlined an eight-point program for adequate otolaryngologic instruction within the general medical curriculum, (2) deplored the inadequate and unregulated training of the specialist, (3) proposed what they deemed to be a desirable specialty training program, (4) advocated legal measures which would require fulfillment of such program for specialty practice, and (5) called on other societies of otolaryngologists to join with them in fixing a standard of training necessary to qualify for the practice of otolaryngology.<sup>83</sup> Their report was published in the *Laryngoscope* the same month the Academy committee was appointed, and judging from what followed, we must assume it had a great impact on the direction taken. A few excerpts from the report convey the mood

in which the otolaryngologists began their work.

Up to the present, on this continent, there is no recognized portal to the specialty. On the other hand the gates may be said to be many, and yet, *mirabile dictu*, our towns and villages and even our cities are filled with "specialists" who have entered by no gate whatever, but have simply "climbed over the wall" and are to some extent, at least, to be considered merely as "thieves and robbers."

The house-surgeon attached for three months to the oto-laryngological service of a hospital, the general practitioner who derives his knowledge of the subject from a six weeks' course in a post-graduate school, and the man who takes a run to Europe immediately after graduation, alike think themselves worthy to be ranked as specialists. . . .

It is time we had done with this farcical sort of preparation, if our specialty, worthy as it is of the best, is not to be dragged in the mire as a result of the ignorance of anatomy, diagnosis, and technic displayed by a very large proportion of the rank and file of those who now style themselves "specialists in diseases of the ear, nose and throat."

We all know the facts, and we deplore them. Now what can be done to face and overcome the difficulties of the situation? *We must first decide what constitutes the standard of proper training, then provide for its acquirement, and finally bring such influence to bear upon state legislatures as to secure the legal enactment that only specialists provided with this training may practice as such* [italics added].

. . . not less than two years should be devoted to preparation for practice as a specialist, this should, however, be preceded by one or more years spent in general practice, or better as house-man in the medical and surgical services of a good hospital, at least half the time being devoted to surgery. The specialist course itself must embrace highly specialized studies in the anatomy, physiology, embryology, pathology, physics and therapeutics, which bear upon the subject, operations on the cadaver, etc.

The time required for this course will occupy at least six months. In addition the candidates must subsequently serve as resident assistants in a special hospital or in a similar position in the special service of a large general hospital, for a period of not less than eighteen months, and to provide sufficiency of experience the special clinic should work daily and should have at least fifteen beds assigned to its use. In this connection it is well to insist that during the last six months of his service, the candidate shall act as a senior assistant in the major operations, and personally perform those less important.



Where shall such training be provided? Without doubt the scientific part must be placed solely under the control of the universities, for these are the proper bodies to provide post-graduate instruction. . . .

To add a fitting coping stone to the structure whose erection we are considering, the candidate should finally be compelled to present himself to one of the universities supplying the post-graduate instruction indicated above for examination on the work embraced in the entire course, and the successful candidate should be given a degree—that of Ph.D. (otolaryngology) has been suggested in various quarters. . . .

The final step, that of securing legislative measures, would of necessity be difficult to attain, but public opinion will ere long demand that we be protected from the incompetent specialist. . . .<sup>83</sup>

It was the Academy's committee chairman William Ballenger who objected to this approach and who proposed a plan similar in spirit to that which the ophthalmologists were considering. On Oct 3, 1914, Dr Ballenger wrote to Samuel Iglauer setting down his suggestions so they could formulate a report for presentation at the Academy's annual meeting two weeks hence.

"I should state in the beginning," said Dr Ballenger, "that I believe that the best results can be obtained by offering an honorary Fellowship degree, than can be obtained by legislation, in which a special course of study is made a requirement."<sup>84</sup> Noting that it would be "exceedingly difficult to get adequate legislation," Dr Ballenger advised that to

elevate the standard of medical education, I propose the following plan:

The establishment of a National Academy of Surgery without a teaching faculty. Its faculty shall have the powers to outline a course of training, educational and clinical, and the power to grant a Fellowship degree upon satisfactory evidence that these requirements have been fully met. In other words the faculty of this American Academy of Surgery shall be a degree granting faculty only.

Furthermore, this Academy of Surgery shall have no other function. It shall be contrary to its constitution and by-laws for it, as a body, to take part in, or to express its opinion on any subject beyond the affairs pertaining to the conduct of its business, and conferring Fellowship degrees upon candidates for such degree, and conferring the same degree upon such Surgeons as

have been in practice ten or more years, who have by their work attained such proficiency as to satisfy the Faculty of the Academy [of Surgery] that they are worthy of the degree without examination. The degree shall in each instance be the same. There will be no marks of distinction between the Fellows, whether he be a founder, a licentiate by examination, or a licentiate by reason of his eminence. . . .

Another factor of great importance is the influence the Academy of Surgeons will have upon the curriculum of the Medical Schools. The candidates for the Fellowship degree in the Academy of Surgeons will naturally apply to the various Universities and Medical Schools for the courses of instruction required to obtain the Fellowship Degree, and will (under present conditions) be told that such courses are not given. Year by year the demand for these courses will be made, and finally, the demand will be recognized and the courses established. In other words the Academy [of Surgery] not being a teaching body, but only a degree conferring body, has created a demand for advanced training in Ophthalmology and Otolaryngology (and other Surgical specialties), to which the various high grade medical colleges respond.<sup>84</sup>

In closing his letter, Dr Ballenger reiterated the achievements that could be fostered by creation of an academy of surgery, the most important of which being: "It has stimulated the beginner to fulfil [sic] the requirements for Fellowship before he engages in the practice of his chosen specialty. This is the primary object of the Academy."<sup>84</sup>

On Oct 13, 1914, Samuel Iglauer answered Dr Ballenger: "I have considered your recommendation very thoroughly. I regret that I cannot agree with you in recommending the establishment of a National Academy of Surgery, at least not at the the present time." Instead, Dr Iglauer favored what the other societies were recommending. "To my mind," he countered, "there is no objection in a medical organization trying to influence legislation for the public good. In fact all legislation regulating medicine has originated in the Medical profession itself."<sup>85</sup>

Drs Ballenger and Iglauer forwarded their correspondence to the committee's third member, J. M Ingersoll, who read both position statements at the Academy's 1914 meeting in their absence. Dr Ingersoll aligned himself with



Dr Iglauer in disagreeing with the proposal of an academy of surgery with the sole function of conferring degrees on qualified candidates. He suggested, as had Dr Iglauer, that the new American College of Surgeons (founded in 1913) might take up this work and accomplish the same end.<sup>67(p10)</sup> Drs Iglauer and Ingersoll pointedly endorsed the postgraduate course which had been sketched in the most general terms the previous year by the committee from the American Laryngological, Rhinological and Otological Society.<sup>83</sup> Their endorsement represented more their bearings on the problem than any concrete program of study.

Incorporated in the Academy motion which accepted Dr Ingersoll's varied report was the proviso that the otolaryngology committee confer with its counterpart in ophthalmology. The ophthalmologists had just presented their initial draft for a "Federated Board of Ophthalmic Examiners" to conduct examinations of, and grant certificates to, qualified candidates (Fig 19). During the succeeding year no consultations were initiated—the ophthalmologists were engaged in drawing up final plans for their proposed board, and the otolaryngology committee was rendered inactive by the illness of its leader. Dr Ballenger died shortly after the Academy's 1915 meeting. Judging from his past ability to girth a problem and persuade an expedient answer, it is probable that had he lived, the otolaryngologists would have formulated and enacted a definite plan with far greater rapidity than they actually did.

Because the general committee of the ophthalmology societies had by 1915 issued their definitive report for a joint examining board<sup>78</sup> and were requesting appointment of three representatives from each of the sponsoring societies, the Academy appointed the otolaryngology committee along the same lines: Dr Ingersoll was appointed for a term of three years; Dr Iglauer, for two years; and Burt R. Shurly, of Detroit (who replaced Dr Ballenger), for a term of one year. Mentioning that "the

ophthalmological section has set the pace,"<sup>57(p'a')</sup> President Joseph Beck urged the otolaryngology committee to have a general report ready by the 1916 meeting. "It is especially important now," said Dr Beck, "since we know that America is bound to become the center of medical education. We must be prepared in this, one of the largest bodies in the world of teachers and specialists."<sup>57(p'b')</sup>

The otolaryngologists continued to channel their efforts toward working out a satisfactory course of postgraduate instruction leading to a degree. At the Academy's 1916 meeting, Dr Ingersoll said that his committee had been working with similar committees of allied societies and he delivered the following tentative report:

That all Class A Universities and Colleges in the United States and Canada be invited to adopt a plan of post graduate instruction in Ophthalmology and Otolaryngology to cover a period of one or two years, at the end of which time a special degree shall be given after satisfactory examination.

That the following subjects be studied: Anatomy of the head and neck, including eye, ear, nose and throat; embryology and histology, physiology, hygiene and public health, pathology and bacteriology, neurology, physics, dispensary work and clinical conference, operative work on the cadaver.

That the student shall be given an opportunity to do a certain number of operations upon the living.

That an opportunity for research work shall be provided and the preparation of a suitable thesis shall be required.

The Committee realizes that it is impossible to realize this standard immediately, but we hope that a similar high standard may be reached in the near future.<sup>62(pp4,5)</sup>

Dr Ingersoll's report represented nothing definite, and inasmuch as the ophthalmologists had formally created the American Board for Ophthalmic Examinations and were ready to give the first Board examination after the Academy's 1916 meeting, members were concerned about the lack of concrete plans for otolaryngologists.

Joseph Beck criticized, "The ophthalmologists of this Academy have preceded us, or rather, gone ahead and begun the work,

whereas we have not begun yet. I think the committee is too small. It has not done enough and there is not enough cooperation with the other societies. . . . It is an important thing for us to take the initiative, and we have five other societies from which members may be appointed. This Academy will be benefitted and it will give a standing to every member if it is known that he has passed this board."<sup>62(pp7,8)</sup>

Dr Ingersoll rebutted, "The various special societies have an interlocking directorate. The whole plan has been to have one or two members of each of the special societies on the educational committee, so the program can be worked out in unison so that they might all get together in their various committees. I think Dr Shurly, a member of this society, is also on the committee of the A. M. A., and I am on the committee of this society and also of the Triological. The committee is doing all it can to bring about a standard which will produce the effect we want."<sup>62(p8)</sup>

Pursuant to this disagreement a new otolaryngology committee was appointed "in view of the inactivity of some of the members."<sup>62(p9)</sup> Dr Ingersoll was retained, and his new co-workers were Joseph C. Beck and Thomas E. Carmody.<sup>62(p15)</sup>

**T**he vexatious issue uppermost in the minds of Academy leaders in 1916 was the future dichotomy in membership requirements for ophthalmologists and otolaryngologists. Faced with this dilemma and with an acute consciousness of "fitness for practice" brought about by inauguration of the ophthalmology Board, an Academy committee introduced an amendment to Article III of the constitution regarding membership. Because the otolaryngologists were unprotected by examination for entrance into the Academy, and because even the ophthalmologists were not requiring passage of an examination until after 1920, it was proposed—in an effort to make requirements equal and to guard against a sudden inrush of candidates prior to 1920—"that in addi-

tion to the present requirements in the Academy the standard for admission be also based upon the clinical qualification of the applicant; this to be determined by appearing before sectional committees as appointed by the Council."<sup>62(pp8,9)</sup> The amendment should have been voted on the following year at the Academy's 1917 meeting. However, it must have been forgotten in the upheaval of war, because it was never mentioned again. Eventually, the intent of this proposal was vested in an Academy examining committee in otolaryngology that served not only to equalize membership requirements but also to hasten creation of the otolaryngology Board.

Disrupted by the war, the otolaryngology committee gave no progress report at the 1917 or 1918 meetings. A brief account submitted in 1917 and published in the *TRANSACTIONS* indicates the Academy's revised committee of Drs Ingersoll, Beck, and Carmody was persevering along with the other otolaryngological societies in the effort to outline a standard curriculum of training and offer a special degree.

The general committee representing The American Laryngological, The American Otological, The American Laryngological, Rhinological and Otological, and The Academy of Ophthalmology and Oto-Laryngology has had several meetings during the past year.

The committee recommends the obtaining of a special degree from the post graduate department of leading universities by all those who desire to enter the specialty of oto-laryngology.

This degree is to be obtained after examination conducted by the University.

It will be open to all:

1. Who have acted as interns in a standard hospital in either medicine or surgery, or both, or have passed a term of years in practice.
2. Who have also subsequently served as intern in the oto-laryngological department of a standard hospital for the period of eighteen months.
3. Who have subsequently pursued a curriculum of study as laid down by the University in which the candidate is seeking his post graduate degree. This course to be of not less than six months.

Dr. Wishart, chairman of the general committee [D. J. Gibb Wishart was one of the three men who drafted

the 1913 report advocating a special degree], also recommends that the committee in each society be continued without change in order that the men who are familiar with the work may go on with it.<sup>86</sup>

Two years later, in 1919, the general committee of the otolaryngology societies began to put meat on the bones of their plan for a standard two-year curriculum to be given in a class A university,\* and a final report was issued in 1920. Since work along this line was bypassing the Academy's most immediate need of an entrance requirement for otolaryngologists, the Academy committee proposed

that after 1920 the Oto-Laryngologic Sections require for admission the successful passing of an examination similar to that required by the Ophthalmologic Section, which also makes the candidate eligible for the American College of Surgeons as to professional qualifications.

Examinations to consist of written examinations on Anatomy, Histology, Embryology, Physiology and Pathology.

Oral Examinations, practical clinical methods of diagnosis, recognition of microscopic slides from pathologic specimens, therapeutics and relation to general diseases.

The candidate is to present at least twenty-five case reports.

Further details may be worked out by the examiners elected by the Society.

We further recommend that the Society elect a board of three (at least) Examiners.<sup>30(p412)</sup>

The members hastily adopted the idea of a specially appointed board of examiners to ratify otolaryngology candidates, but again the committee was unable to meet and reach harmony regarding this type of examination<sup>58(pp369,381)</sup> (behind this quandary lurked the fear that the requirement of board approval would inhibit

membership growth). By the time of the Academy's 1920 meeting, the issue was pressing, since the requirement of certification by the ophthalmology Board or possession of a specialty degree from a recognized university program was to become effective Jan 1, 1921.<sup>58(p367)</sup> There was no longer time to defer a solution, and the Council stepped in and unanimously voted that the Academy should elect "an Oto-Laryngologic Board to pass on all members." "This board," instructed the Council, "shall conduct examinations for membership in this Academy. One examination shall be held just preceding our annual meetings. This board shall act until such time as its functions shall be taken over by the American Board of Examiners in Oto-Laryngology, or until discharged by this Academy."<sup>58(pp377,378)</sup>

Elected to serve on the board were Joseph C. Beck, as chairman, John M. Ingersoll, Thomas E. Carmody, Ross H. Skillern, Harris P. Mosher, and Robert C. Lynch (Fig 21).<sup>58(p378)</sup>

**T**he Committee on Examinations in Otolaryngology, as the board of examiners was called, conducted three examinations at the 1921 meeting, one before the meeting at which there were 18 candidates, and two during the meeting. The last of these three examinations was given for those who wished to apply for membership the following year but who might be unable to attend the meeting.<sup>59(pp435,448)</sup>

In keeping with the existing policy of the American Board for Ophthalmic Examinations, the otolaryngology examining committee gave credit for past experience and recognized ability. Candidates were grouped into three classes: (1) those who had been in practice between one and two years; (2) those who had been in practice from two to five years; and (3) those who had been in practice for more than five years. The first group was given both oral and written examinations; the second group was given an oral examination; and the third

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\*After investigation, the AMA's Council on Medical Education and Hospitals had rated medical schools in respect to faculty, student body, administration and supervision, and facilities. A scale of 100 points was used to form an A, B, and C classification. Class A schools were those which met at least 70% of the essentials and were considered the acceptable medical schools. For more information, see "Standards of the Council on Medical Education and Hospitals of the American Medical Association" (*JAMA* 77:541, 1921).



Fig 21.—Academy Committee on Examinations in Oto-Laryngology. Top, left to right: Joseph C. Beck, Chicago, chairman; Thomas E. Carmody, Denver; and John M. Ingersoll, Cleveland. These three men represented Academy on general committee of otolaryngology societies. Bottom, left to right: Harris P. Mosher, Boston; Ross H. Skillern, Philadelphia; and William P. Wherry, Omaha. (Dr Wherry was not member of Academy's examining board but was appointed in 1924, along with Dr Carmody, as Academy representative to found American Board of Otolaryngology.) Not pictured is Robert C. Lynch, New Orleans, who served on Academy's examining board in 1921 and 1922.

group was exempt from both the written and oral examinations and from the presentation of case records.<sup>39(p16),59(p435)</sup>

Creation of a committee for the limited purpose of examining candidates for Academy membership was accompanied by specific urging that the otolaryngologists collaborate with allied societies to organize a national board that would be on equal footing with the ophthalmic Board. In 1921, asked what progress had been made, Joseph Beck replied:

It was the intention when the Council appointed this Board, that we should get together with these other gentlemen [representatives of other otolaryngology societies], but that takes time. We have had to wait on them. Every member of our Board is a member of all the national societies, and yet it takes time to develop this. But we hope in the end to have the same kind of a board that the ophthalmologists have. The College of Surgeons is very anxious that we should have such an

oto-laryngologic board, and the Academy is getting a great deal of credit for the effort.<sup>59(p436)</sup>

The sheer number of societies and opinions which had to converge in the founding of an otolaryngologic board was encumbering its organization and was, indeed from the beginning, the greatest barrier to arrival of a definite plan. By this time, however, spreading interest by the medical profession in the education of the specialist was bringing attention to the need and the duty to provide graduate instruction in medical specialties. This attention was bringing material results and credible signs that programs for specialty training, the goal of the otolaryngologists, might be established. These developments were a further source of input into the deliberations of the otolaryngologists.

Although never clearly delineated, the reluctance of some otolaryngologists to create a

national examining board was due to the belief that this was not the safest means of assuring competency and that such a standard might be used as a substitute to the training program they envisioned. They remained committed to a systematic course of study, leading to a degree, as the best guarantee of fitness. Prospects for this were improving by the early 1920s, and since conditions were somewhat altered from those described in part 1 of this chapter, it is necessary to take a look at what was happening in graduate medical education, both generally and as it relates to otolaryngology.

Concern with specialty training came into focus as the natural extension of an energetic and productive inquiry into medical education in this country, and the vast improvements accruing in undergraduate medical education made possible progress in graduate study. At the turn of the century, most medical schools were operated independently and often for profit; they felt no obligation beyond general medical training. Beginning in 1909 when Abraham Flexner turned the spotlight of thorough investigation on medical education, there was unrelenting demand from medical leaders, notably the AMA's Council on Medical Education and Hospitals, that the management of medical education be placed under the university. By the mid 1920s, the number of medical schools in the country had decreased almost by half to about 80 (70 rated as class A), and 63 were part of a university.<sup>82,87</sup> With expansion of university-connected medical schools, equipped with the faculty, facilities, and laboratories for teaching and research, came growing potential for development of controlled graduate work in medical specialties.

Harvard led the way with organization of a graduate division under the medical school in 1912, followed by the universities of California and Minnesota in 1914, and by 1921, the universities of Alabama, Columbia, Pennsylvania, and Tulane had been added to the list. These seven university offerings were out of a total of

18 graduate medical schools in the country. Of the 11 independent schools, four specified the availability of training in otolaryngology, although the others may have offered it in some form.

Even in the university-affiliated graduate schools, most of the course offerings in otolaryngology lasted only eight to nine months, and the number of students that could be accommodated was exceedingly small. The University of Minnesota (to which the facilities and resources of the Mayo Foundation were added in 1915) probably had the largest number of training positions available in the specialty, furnishing a nine-month course in otolaryngology limited to ten students, two teaching fellowships in otolaryngology, additional fellowships at the Mayo Foundation, and a three-year course leading to a PhD for which about five candidates could be accepted annually.<sup>88</sup>

In addition to the seven universities that had actually organized graduate medical schools, there were many universities announcing opportunities for some advanced work in specialties by 1921.<sup>89</sup> There was enormous variation in the purpose, length, and content of the training, but most of it did not attempt or purport to form any comprehensive basis for specialty practice. Opportunities were being provided under the graduate school of the university, through assistantships, residencies, assistant residencies, fellowships, short courses, and sometimes through the personal assumption of responsibility by individual men who used the facilities at their disposal to create the needed programs.

One such program giving fundamental training in otolaryngology was established at Rush Medical College in Chicago. Calling it an "experiment in graduate training," George E. Shambaugh in 1922 described that eight students could be accepted yearly and that these students were grounded in thorough history taking, examination, methods of testing,

diagnosis, treatment, and finally, operative technique (one of the worst aspects of the postgraduate schools was the emphasis on operative technique without proper training in diagnosis or in the indications for surgical treatment; the consequence was a considerable amount of unwarranted surgery). After completion of this one-year course, students were advised to seek the position of intern in a special hospital or of resident in otolaryngology in a general hospital.

In reporting on the program, Dr Shambaugh put in good perspective most of what was being offered as graduate training. "We repeat," he said, "that special courses, clinics, etc., such as are provided in postgraduate schools and in some of our university medical schools, are suitable as advanced work for those who have had the first year of fundamental training, or as review courses for those already established in special practice. They should not be offered as a substitute for the training we are advocating in this report."<sup>90</sup>

While not providing in any but a few instances for extensive preparation of the specialist, the opportunities being offered by universities were small beginnings and represented a dawning recognition that they could not abrogate their responsibility to furnish graduate instruction in the various branches of medicine. This recognition in itself was a tremendous advance over a few years previous.

**G**enuine occupation with the cause of specialty education took a decidedly upward turn in 1916—the first formal gauging of competence in a specialty was introduced by the American Board for Ophthalmic Examinations, and the first survey of the status of graduate medical education was made by the AMA's Council on Medical Education and Hospitals. Out of 20 institutions then listed as providing graduate instruction, the AMA Council found that none published detailed

enough information on their courses for a prospective candidate to judge whether or not any systematic graded instruction was offered; that few limited their courses solely to physicians; that seldom were records kept on the entering student's professional background, the courses in which he enrolled, the progress of his work, and the level of proficiency he attained; that facilities were woefully meager; and that certificates or diplomas were handed out indiscriminately without regard to period of study or criteria of competence.<sup>87</sup>

These dismal conditions led to a second inspection during the 1919–1920 academic year conducted by an AMA Special Committee on Graduate Medical Education.<sup>87,91</sup> This survey showed that the organization of facilities and courses was improving in some schools and that there was a real need for setting guidelines that would help institutions develop a proper course of study for the various specialties. Following this inspection the AMA Council on Medical Education and Hospitals appointed 15 specialty subcommittees, including one in otolaryngology, to recommend the minimum length of study and course content necessary for proficiency.<sup>87,91,92</sup>

Just preceding the AMA charge in 1920 for a subcommittee to outline a course in otolaryngology, the general committee of the otolaryngology societies completed their definitive report. The report, which detailed an approximately two-year period of training, was published and sent to universities, hospitals, and journals.

As a preliminary to specialty training, the committee recommended a term of four years in general practice or one year spent as intern in a class A hospital. The first six to nine months of specialty training were to be spent in the postgraduate department of a university, and the following curriculum was specified: anatomy of the head, neck, and chest, embryology and histology (100 credit hours);

pathology and bacteriology (100 credit hours); operative work on the cadaver (100 credit hours); physics (32 credit hours); physiology (30 credit hours); neurology (20 credit hours); hygiene and public health (10 credit hours); and additional courses providing general knowledge of radiology, diseases of the teeth and mouth, and surgical technique. After completion of this fundamental training, at least 16 months were to be spent as intern in a special hospital or in a general hospital with an adequate otolaryngology service. The committee stood ready to assist those desiring proper training by continuing their effort to secure from the graduate department of universities a uniform course and a suitable degree recognizing completion of the course.<sup>92</sup>

A year later, in 1921, the AMA subcommittee delivered their report. They recommended that candidates for specialty training be graduates of class A medical schools and have served one year as intern in an approved general hospital. They called for a minimum training period of 1½ years, the first year of which was to be spent in one place acquiring fundamental training, with half of each day devoted to clinical study and the other half to the basic sciences. Subsequently, the candidate was to serve as intern in a special hospital or resident in otolaryngology in a general hospital. If a candidate was unable to obtain such a position, they stipulated that the last six months could be spent in the institution providing the basic training, in other centers where special training was available, or in the capacity of assistant to an established specialist. To recognize fulfillment of the requirements, they advocated a certificate be granted by the institution where the first year's work was taken. Lastly, they suggested that existing post-graduate courses and clinics be upgraded as review work for those practicing the specialty and for those who had completed the training outlined.<sup>92</sup>

Representatives from the general committee of the otolaryngology societies and the AMA met in May 1921, and D. J. Gibb Wishart recorded that a joint resolution was prepared which "embraced most of the points brought forward in the two reports."<sup>92</sup> He noted that the resolution had been adopted by three of the specialty societies and was being sent on to the AMA. The question of training, however, did not appear a closed issue the following year when a number of opinions on the length and type of study surfaced in the AMA Section on Laryngology, Otology and Rhinology, after George Shambaugh described the graduate program effected at Rush Medical College.<sup>90</sup>

Academy minutes contain no record that any joint resolution on training was presented or that any specific program was sanctioned. To Academy leaders, debate over curriculum did not stand in the way of the societies uniting in a common standard, and the Academy's examining board in otolaryngology was seen as a prelude to cooperative effort among the societies to establish a national board. But the otolaryngologists were reticent. In 1922, Joseph Beck, chairman of the Academy's board and representative to the general committee, spoke pointedly of the problem in reaching a consensus but gave a favorable outlook:

The Oto-Laryngology Section does not want to stand one iota lower than the Ophthalmic Board. However, we have a different condition to contend with, in that we have five national societies instead of three—the American Otological, the American Laryngological, the Triological, the Section on Laryngology of the American Medical Association, and this Academy,—so it is a little more difficult. But the Committee has discussed arranging a mode of procedure, whereby we hope to have such a Board as the excellent American Board for Ophthalmic Examinations.<sup>60(p502)</sup>

**A**lthough there is no explicit explanation of what finally turned the tide of opinion in favor of a national board, it may have been that steady progress in specialty education put the rationale for a board in new perspective. After a third inspection of graduate medical schools

during the 1922–1923 academic year, the AMA Special Committee on Graduate Medical Education drew up a set of principles regarding the components of a satisfactory graduate school and recommended a classification of schools.<sup>91</sup> These principles and a list of 15 acceptable schools were submitted to the AMA House of Delegates and approved in June 1923 (by March 1924, seven other schools had been added to the approved list, making a total of 22 institutions providing standardized courses of instruction).<sup>87</sup> From the beginning, the otolaryngologists had sought development of uniform courses that would be required preparation for practice, and they were hesitant to create any other standard, such as a national board, by which one could be certified as competent. As programs for, and regulation of, advanced training began to materialize, resistance to a certifying board probably gave way to the view that such a body would function as a further safeguard and measure of competence and would serve notice that the national societies were accepting only qualified candidates.

The Academy's Committee on Examinations in Oto-Laryngology was another pivotal factor in demonstrating how effectively a national board could encourage those entering the specialty to obtain proper training. In 1924, the national societies conformed to the plan of a national board. To inaugurate a board, each of the five societies appointed two representatives. Four of the designated representatives—Drs Beck, Carmody, Mosher, and Skillern (all members of the Academy's board)—met to arrange details preparatory to permanent founding of the board.<sup>93(p449)</sup> At the Academy's September 1924 meeting, Dr Skillern said that the proposed board would consist of ten members and that it would examine candidates for admission to the societies. "It will act," he explained, "in exactly the same way as the American Board for Ophthalmic Examinations. Certificates will be given, and the men will en-

joy all the rights and privileges that certificates give those in ophthalmology."<sup>93(p467)</sup> The Academy's examining board was dissolved. It had remained operative for four years, 1921 through 1924, and fulfilled its function in both letter and spirit.

The American Board of Otolaryngology was formally organized on Nov 10, 1924, in Chicago, and the first examination was held the following May.<sup>94</sup> Like the Academy's examining committee, the new otolaryngology Board divided candidates into three classes according to the number of years spent practicing otolaryngology, but the experience categories were revised upward: those who had practiced less than five years, those who had practiced five years and less than ten years, and those who had practiced ten years or more.<sup>95</sup>

Prior to the first examination, the Board issued invitations to some members of the sponsoring societies for certification without examination. At the 1925 meeting of the American Triological Society, it was reported that 359 men had applied to be awarded the certificate on their merit. An additional 263 had applied for examination.<sup>96</sup> By the time of the Academy's 1925 meeting in late October, Thomas Carmody was able to announce that 355 men had been examined and certified and that 132 men had come before the Board during its second examination given at the meeting.<sup>97(p421)</sup> These figures are substantial when compared with the small number of men who appeared for the first few examinations of the ophthalmic Board, and they evidence understanding and acceptance of the certification plan. "It is gratifying," said the Academy secretary, "to remind our membership that this advance in Oto-Laryngology, as well as in Ophthalmology, is due largely to the Academy's influence."<sup>97(p420)</sup>

Appointed in 1924 as Academy representatives to found the otolaryngology board were Thomas E. Carmody, a member of the



Academy's examining committee, and William P. Wherry (Fig 21). Of the other members of the Academy's board, all except John M. Ingersoll were among the inaugurators of the national board: Joseph C. Beck and Robert C. Lynch represented the AMA Section on Laryngology, Otology and Rhinology, and Harris P. Mosher and Ross H. Skillern represented the American Laryngological Association.<sup>93(pp448,449)</sup> Both of the Academy's original delegates were to serve for many years, Dr Wherry until his death in 1942 and Dr Carmody until his death in 1946. Table 5 gives a complete listing of Academy representatives to

the American Board of Otolaryngology.

Formation of the second national specialty board added strength to the influence of this plan. "The organization of the National Board of Examiners in Oto-Laryngology," reflected Edward Jackson, an architect of the ophthalmic Board, "has manifestly quickened the interest in such examinations, and the great interest that has developed in graduate courses in the two specialties bears eloquent testimony to the timeliness and importance of the movement in which this Academy has taken an important and honorable part."<sup>97(p423)</sup>

TABLE 4  
ACADEMY REPRESENTATIVES TO THE AMERICAN BOARD OF OPHTHALMOLOGY

NAME	YRS SERVED (INCLUSIVE)
Wendell Reber, Philadelphia	1915-1916
Walter B. Lancaster, Boston	1915-1920 and 1936-1939
Frank C. Todd, Minneapolis	1915-July 1918
William H. Wilder, Chicago	1917-1922 and 1931-1935
John R. Newcomb, Indianapolis	October 1918-1922
Allen Greenwood, Boston	1921-1923
Lee Masten Francis, Buffalo, NY	1923-April 1926
Edward Jackson, Denver	1923-1925
F. Phinizy Calhoun, Sr., Atlanta	1924-1929 and 1932-1934
John M. Wheeler, New York	1926-1931
James M. Patton, Omaha	1926-1930
Sylvester J. Beach, Portland, Me	1930-1936
Thomas D. Allen, Chicago	1934-1935
Everett Goar, Houston	1935-1938 and 1944
William L. Benedict, Rochester, Minn	1936-1943
Jonas S. Friedenwald, Baltimore	1937
Cecil S. O'Brien, Iowa City	1938-1945
Grady Clay, Atlanta	1939-1942
Frederick C. Cordes, San Francisco	1940-1951
Algernon B. Reese, New York	1943-1950
Robert J. Masters, Indianapolis	1945-1952
Derrick T. Vail, Jr., Chicago	1946-1953
F. Bruce Fralick, Ann Arbor, Mich	1951-1958
Gordon M. Bruce, New York	1952-1959
Alson E. Braley, Iowa City	1953-1960
Kenneth C. Swan, Portland, Ore	1954-1961
W. Banks Anderson, Durham, NC	1959-1966
Fred M. Wilson, Indianapolis	1960-1967
F. Phinizy Calhoun, Jr., Atlanta	1961-1968
Leonard Christensen, Portland, Ore	1962-1969
Joseph A. C. Wadsworth, Durham, NC	1967-1974
Robert W. Hollenhorst, Rochester, Minn	1968-1975
Edward W. D. Norton, Miami, Fla	1969-1976
Goodwin M. Breinin, New York	1970-1977
Bruce E. Spivey, San Francisco	1975-
Thomas P. Kearns, Rochester, Minn	1976-
Melvin L. Rubin, Gainesville, Fla	1977-
Dan B. Jones, Houston	1978-

TABLE 5  
ACADEMY REPRESENTATIVES TO THE AMERICAN BOARD OF OTOLARYNGOLOGY

NAME	YRS SERVED (INCLUSIVE)
William P. Wherry, Omaha	1924-June 1942
Thomas E. Carmody, Denver	1924-August 1946
Frank R. Spencer, Boulder, Colo	1942-1948 (replaced Dr Wherry)
Carl H. McCaskey, Indianapolis	1946-1952 (replaced Dr Carmody)
W. E. Grove, Milwaukee	1949-1951
Francis E. LeJeune, New Orleans	1952-1964
Gordon F. Harkness, Davenport, Iowa	1953-1956
George F. Reed, Syracuse, NY	1957-1976
Frank D. Lathrop, Pittsford, Vt	1966-1976
G. O'Neil Proud, Kansas City, Kan	1977-1978
Roger A. Boles, San Francisco	1977-1978