

The Founding of the Specialty Boards

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THE AMERICAN BOARD OF ANESTHESIOLOGY was founded in 1938, the thirteenth specialty board approved by the Advisory Board of Medical Specialties and by the Council on Medical Education and Hospitals of the American Medical Association. The ABA was one of nine boards established between the years 1933 and 1938, a period which saw the flowering of the specialty board movement in the United States, the others being the American Board of Pediatrics (1933), of Orthopedic Surgery (1935), of Psychiatry and Neurology (1935), of Radiology (1935), of Urology (1935), of Internal Medicine (1936), of Pathology (1936), and of Surgery (1937).

This proliferation of new specialty boards came about for a number of reasons, but without doubt was triggered by the fact that in 1933 the four original boards—the American Boards of Ophthalmology (1917), Otolaryngology (1924), Obstetrics and Gynecology (1930), and Dermatology and Syphilology (1932)—joined together with the American Hospital Association, the Association of American Medical Colleges, the Federation of State Medical Boards, and the National Board of Medical Examiners to establish the Advisory Board for Medical Specialties. (In 1970, the Advisory Board for Medical Specialties became today's American Board of Medical Specialties.)

With the establishment of the Advisory Board for Medical Specialties in 1933, the House of Delegates of the American Medical Association authorized its Council on Medical Education and Hospitals "to express its approval of such special examining boards as conform to the standards of administration formulated by the Council." Beginning in 1934, therefore, official recognition of specialty boards in medicine has represented collaborative action of the Advisory Board for Medical Specialties and its successor, and the AMA Council on Medical Education (itself the successor to the AMA Council on Medical Education and

Hospitals). The definitive pronouncement of this two-pronged authority hastened the considerations of those specialties which had been thinking about the formation of a board, and precipitated consideration of the formation of a board by the others.

The four original boards were the prototypes after which the ABA and the other eight new boards fashioned themselves; but the specialty boards were by no means mirror images of each other, and the American Board of Anesthesiology designed its Constitution and By-laws, its organizational structure, and its rules and regulations to cope with the particular situations which were peculiar to the specialty of anesthesiology. By 1938, therefore, specialty boards had been established in all of the major fields of medical practice of the day, and the specialty board movement was an accomplished, if unfinished, fact.

It would be overly simplistic to say that the specialty boards had their origins from the publication of the Flexner Report¹ in 1910. The primary thrust of this report was on the quality of undergraduate medical education in this country; still, there is no question that the Flexner Report influenced all reaches of thought concerning medical education, and the quality and competence of medical training at every level. This influence certainly extended as far as the development of the specialty boards; but there were also other more important influences involved in the evolution of the latter.

Fundamental to this movement was the development of the specialties themselves. Up until the turn of the century, when medical knowledge was growing comparatively slowly, the practitioner could keep pace with advancing knowledge. As the Report of the Citizens Commission on Graduate Medical Education stated in *The Graduate Education of Physicians*² (i.e., the so-called Millis Commission's Report), "The techniques that a young physician learned in school or in his internship—or that even earlier physicians learned in an apprenticeship—remained useful for a fair portion of his professional life, or changed so slowly that reading and an occasional post-graduate course enable him to keep up with the advances. . . . Practice kept pace with knowledge."

With the increasing advances of medical and scien-

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tific knowledge, and the gradual shift of the site of medical diagnosis and treatment from the home or office to the hospital, "specialization" began to occur at an increasing rate. Many of these physicians were authentic "specialists," either on the basis of self-study and concentration in a particular field of medical practice, or on the basis of true specialty education and training. Many more, however, were specialists on the basis of their own say-so; frequently a practitioner would take a six-week or two-month "course" in a particular emerging specialty at a medical school center, or major clinic or hospital, and then return to his hometown as a self-proclaimed specialist.

The Public, not to mention the medical profession, had no way of knowing whether or not a physician who called himself a specialist was indeed qualified in that specialty. Any physician who possessed a state license to practice could hang out a sign proclaiming himself a specialist. Ralph Waters, one of the revered pioneers and fathers of anesthesiology in this country, employed this approach himself. As he wrote in his article, "Pioneering in Anesthesiology"³: "Frequently, a 'half-baked' specialist designated himself as paying 'special attention' to this or that. A practitioner especially interested in gynecology, for instance, had printed on the door of his office and on his professional cards and stationery, 'John Doe, M.D., Special Attention to Diseases of Women'. The first formal recognition of limitation in my own practice was upon professional cards carrying the notation 'Practice Limited to Obstetrics and Anesthesia'. This was solely because I like to do such work. . . ."

In addition to being a threat to the public and creating confusion among the medical profession, these self-proclaimed specialists could also jeopardize the specialty itself. Authentic specialists, often with considerable periods of training and study in the field, could not be distinguished from the untrained variety. In short, what constituted a "specialist" was open to a variety of interpretations, since any Doctor of Medicine could list himself, on his own recognizance, as being a practitioner of any one of the increasing numbers of specialty disciplines published in the *Directory of the American Medical Association*.

Furthermore, a profusion of specialty societies, associations, and Academies—some national, some regional—sprang up around the country. In radiology, for instance, there was the American Roentgen Ray Society (1900), the Radiology Society of North America (circa 1915), the American Radium Society (1916), and later, the American College of Radiology and the Section on Radiology of the American Medical Association. These various groups within each specialty provided the member with a semi-proof of

status as a specialist and served to a certain extent (depending upon the requirements for membership) to control who could claim the designation of specialist; and also, of course, provided a forum for the exchange of information and the advancement of the specialty. However, this remained a fairly crude method of identifying the specialist, since any group could get together and form a "specialty society," tailoring the requirements for membership to fit the needs or wishes of the members involved.

There was an even more insidious problem involved in the designation of specialist, and that was the spectre that each of the (then) forty-eight states might enact legislation prescribing requirements within a specialty, with the eventual result that there would be separate state boards of examiners for each specialty. It became the considered judgment of many leaders in the medical profession that some method of control must be established, and "that the practical solution would be for each group to set its house in order and place its mark of approval on those qualified to practice predominantly in that particular field."⁴

The First Specialty Board

These various influences, pressures, and other factors leading to the development of the specialty boards are exemplified in the story of the formation of the first board, the American Board of Ophthalmology. It should be borne in mind, while reading an account of the foundation of this first specialty board, that the concept of an independent examining and certifying body had to be evolved, in addition to the board itself being formed. This is an important point, because concepts, especially brand-new concepts, are usually much harder to come by than simple mechanics of function which tend to either have prototypes from other areas of human activity or evolve fairly logically on a trial-and-error basis.

The situation in ophthalmology around the turn of the century was such that the complexities of the problems were more advanced than in many of the other specialties, which was undoubtedly a factor as to why the ophthalmologists were the first group to form a specialty board.

An editorial in 1920 entitled, "The Unfit in Ophthalmology," stated, "Not much more than a generation ago ophthalmologists held the highest position in the medical profession,"⁵ but the stratification within the specialty was becoming advanced, and not in the best interest of the public, the profession, or the specialty.

Of the several groups of practitioners within ophthalmology, the elite were the true specialists,

who had taken extensive training and study in either the handful of Eye and Ear Hospitals in this country offering residency training positions, or by training abroad—the training in Vienna was regarded as probably the best. These physicians had recognized that the development of the battery-handle ophthalmoscope by Crampton in 1913, the birth of neurosurgery, the development of eye pathology, and the institution of research in the specialty had combined to contribute to the growth of ophthalmology to the extent that it could no longer be considered a part of the practice of “Eye, Ear, Nose and Throat.”

The second strata of specialists were those interested in ophthalmology who traveled abroad to take the courses arranged by the so-called “American Medical Association of Vienna.” These courses were a commercial venture (not unlike the Continuing Medical Education courses of today) and were arranged whenever a sufficient number of American physicians wanted to enroll in such a course. By and large the teaching was good since the instructor (a docent, a senior resident, who was earning extra living expenses for his trouble; “the chief” never gave such courses) was quickly boycotted by the American students if it was not worthwhile.

Another method of obtaining training was through preceptorship: the young man became an assistant working in the office of a clinical ophthalmologist. The former was in essence assisting in a private practice; and if the ophthalmologist took the time to discuss the cases and to direct the preceptors reading and study, this could be good clinical training. It could also be just a lot of hard work without any learning.

Yet a fourth avenue was the “six-week specialist” already referred to previously. This was usually a general practitioner who wished to become a specialist and who attended one of the Eye, Ear, Nose and Throat colleges for a six-week to three-month period. Some did develop a modest degree of competency.

Finally, there was the general practitioner who took a short course in refraction and examined patients for glasses and collected a commission from the optician. He often did not do very good work, even in refracting, and certainly did little to enhance the specialty.

The leaders of ophthalmology, who had been accustomed to being considered true specialists by virtue of training, education, and interest, were appalled at finding their specialty “infested by charlatans.”⁵ And the leaders spoke out.

The President of the American Academy of Ophthalmology and Otolaryngology in 1908 orated: “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 no longer be possible for a man to be called oculist by himself or the laity, after he has spent a month or six weeks in some postgraduate school or after serving as an assistant for six months or a year in some oculist's office. . . . After a sufficiently long time of service in an ophthalmic institution in America or abroad, he (the student) 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.”⁶

The Chairman of the Section on Ophthalmology of the American Medical Association “advocated for specialists’ postgraduate courses and clinical work regulated by law, followed by an examination by expert ophthalmologists to determine fitness to practice. He advised that a committee be appointed to study the subject and to report on measures that might be adopted.”⁶

Edward Jackson, the Chairman of this “Committee on Education in Ophthalmology”, discussed the report before the Section in June, 1914: “. . . This report does not propose the enactment or recommendation of any law regulating the practice of medicine. It is based on the idea that this is not the time to have laws passed regulating the practice of ophthalmology: such laws would not at present be wise or efficient. Any remedy for the present state of affairs with regard to ophthalmology must be found entirely outside of legal requirements and inside the profession; we suggest such a plan.”⁶

The plan had been borrowed from the British Royal Colleges (*i.e.*, the Royal College of Physicians and the Royal College of Surgeons) and understanding the plan therefore requires some knowledge of the positions of the two Royal Colleges.

“The historical division between practitioners of medicine and of surgery, although they had been united at the level of registration, survived at the postgraduate stage. Consultants—even though they were specialists—aligned themselves through their training and diplomas with one branch or the other. The aspiring consultant in any specialty was expected to have the MRCP or FRCS or the university M.D. or M.S. degree before he would be considered for an appointment to a major voluntary hospital. Some specialists crossed the boundary lines between medicine and surgery . . . included narrow ranges in both fields.

Ophthalmologists, otologists, laryngologists, neu-

rologists, and urologists of World War I required specialized knowledge of both medicine and surgery in a functionally limited sphere. But the alliance with one branch (and thus with one College) largely remained. . . ."⁷

The distinct lines between the Royal College of Physicians and the Royal College of Surgeons were being fuzzed by the fact that various specialties were, from a pragmatic point of view, crossing the lines in both directions. The Royal Colleges, to protect their positions, therefore developed Conjoint Boards of the Royal Colleges, establishing diplomas for certain specialties. These diplomas did not have the prestige of the MRCP or FRCS, and were not considered of comparable standard; they did, however, indicate a degree of competence within the specialty, and in certain specialties were widely sought.

Thus, "because of the existence of the Colleges, the pattern of specialty organizations that grew up in England in the 1920s and 1930s was far different from that of the United States where in the same period independent boards to certify specialties were being established."⁷ Nevertheless, the existence of the specialty diplomas awarded by the Conjoint Boards of the Royal Colleges suggested to the Committee on Education of the Section of Ophthalmology of the American Medical Association a method on which to base their own approach to the problem.

"A way of recognizing proper preparation for ophthalmic practice lies more directly within the power of this and similar professional organizations. The experience of the Royal College of Surgeons of England and the Royal College of Physicians of London points the way to a practical method of certifying the proper preparation for ophthalmic practice. The conjoint examining board draws examiners from 21 independent schools of medicine. Its examination lead to no degree. Many who take them already have a right to practice. The expense of the examination is large (\$210.00 in fees, apart from the expenditure of time required). And yet a large proportion of those entering on the practice of medicine and surgery in Great Britain take this examination, although about 40 per cent of the candidates are rejected. The certificate thus obtained is recognized throughout the profession and by public authorities as evidence of proper preparation for professional work."⁸

At their meetings in 1915, each of the three sponsoring societies (the American Ophthalmological Society, the Section on Ophthalmology of the American Medical Association, and the Academy of Ophthalmology and OtoLaryngology) adopted the report of a conjoint committee "regarding the establishment of a joint Board to arrange, control, and supervise

examinations to test preparation for ophthalmic practice,"⁹ and for all intents and purposes the first specialty board had been formed.

There were a number of amenities to be observed—organizational and housekeeping details—but when the three sponsoring organizations had adopted the report of their conjoint committee and each had appointed three representatives to the proposed American Board for Ophthalmic Examinations, the American Board of Ophthalmology (as it became known in 1933) became an entity.

The Development of the Other Specialty Boards

The history of the evolutions of all of the other specialty boards differ in many and varied ways, naturally, but it would serve no useful purpose to recite them in detail, because the specialty boards shared a general common genesis. This is not to say that they all burst forth upon the medical scene at the same time, or even at approximately the same time. It is not to say that they all had the same specific aims or purposes, or even that the motivations for the formation of each individual board were identical. Finally, it is not to say that their approaches to attaining their individual aims (at least in the beginning; they are far more uniform now) did not vary greatly.

However, as the boards evolved, they did come to share, in general, much in common: 1) To raise the standards of education, and establish the competence of the individual specialist practitioner; 2) To accomplish this by providing an examining and certifying process for the specialty; 3) To serve the public, medical profession, hospitals, and medical schools by preparing lists for publication of physicians certified by the board; and 4) To advise the Council on Medical Education of the American Medical Association concerning approval of residency training programs.

The first Booklet of Information issued by the American Board of Anesthesiology in 1938, for instance, listed the *Purposes* of the Board as follows:

- 1) To establish criteria of fitness to be designed a specialist in the practice of Anesthesiology.
- 2) To improve educational facilities and practice in medical schools and hospitals, and furnish lists of these, together with lists of individual instructors who give adequate instruction and training in Anesthesiology.
- 3) To arrange, control, and conduct examinations to determine the qualifications, and grant a certificate to those who voluntarily apply and meet the required standards. Such certificates will serve to provide the public and the professions with the opportunity to select the best possible service.

(Conferring of degrees is a prerogative of the Universities, and the Board of Anesthesiology makes no attempt to grant

degrees, regulate, or control the practice of Anesthesiology in any way whatsoever, by license, or restriction.)

By 1979, the paragraphs in the Board's Booklet of Information devoted to *Purposes* had become longer, more detailed, and more sophisticated in phraseology; but the fundamental goals which they elaborated had not really changed:

- 1) To maintain the highest standards of the practice of anesthesiology by fostering educational facilities and training in anesthesiology. For present purposes, anesthesiology is defined as a practice of medicine dealing with but not limited to:
 - A. The provision of insensibility to pain during surgical, obstetrical, therapeutic and diagnostic procedures, and the management of patients so affected.
 - B. The monitoring and restoration of homeostasis during the perioperative period, as well as homeostasis in the critically ill, injured, or otherwise seriously ill patient.
 - C. The diagnosis and treatment of painful syndromes.
 - D. The clinical management and teaching of cardiac and pulmonary resuscitation.
 - E. The evaluation of respiratory function and application of respiratory therapy in all its forms.
 - F. The supervision, teaching, and evaluation of performance of both medical and paramedical personnel involved in anesthesia, respiratory and intensive care.
 - G. The conduct of research at the clinical and basic science levels to explain and improve the care of patients insofar as physiologic function and the response to drugs is concerned.
 - H. The administrative involvement in hospitals and medical schools necessary to implement these responsibilities.
- 2) To establish and maintain criteria for the designation of a specialist in anesthesiology.
- 3) To advise the Liaison Committee for Graduate Medical Education concerning the training required of individuals seeking certification as such requirements relate to residency training programs in anesthesiology.
- 4) To establish and conduct those processes by which the Board may judge whether physicians who voluntarily apply should be issued certificates indicating that they have met the required standards for certification as a specialist in

anesthesiology. A competent anesthesiologist possesses adequate measures of knowledge, judgement, clinical and character skills, and personality suitable for assuming independent responsibility for patient care.

- 5) To serve the public, medical profession, hospitals and medical schools by preparing lists for publication of physicians certified by the Board.

The establishment of the specialty boards presaged, reflected, and fostered a fundamental change in the practice of medicine, the era of specialization. They were at least as important in relation to graduate medical education as the Flexner Report had been to the development of quality undergraduate education, and a very strong argument can be made that they were even more important to the manner in which medical practice has evolved in this country during the past three quarters of a century.

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