Seminars in Colon and Rectal Surgery 26 (2015) 120–125

Contents lists available at ScienceDirect

Seminars in Colon and Rectal Surgery

journal homepage: www.elsevier.com/locate/yscrs

History of specialty training and board certification in colon and rectal surgery

Bruce G. Wolff, MD[a,b,c,*], David J. Schoetz Jr, MD[d,e,f,g]

[a] College of Medicine, Mayo Clinic, Rochester, MN
[b] Division of Colon and Rectal Surgery, Mayo Clinic, Rochester, MN
[c] American Board of Colon and Rectal Surgery, Mayo Clinic, Rochester, MN
[d] American Board of Colon and Rectal Surgery, Lahey Hospital and Medical Center, Burlington, MA
[e] Tufts School of Medicine, Lahey Hospital and Medical Center, Tufts University, Burlington, MA
[f] Department of Colon and Rectal Surgery, Lahey Hospital and Medical Center, Burlington, MA
[g] School of Medicine, Tufts University Burlington, MA

A B S T R A C T

Colon and rectal surgery as a separate and identifiable specialty dates back to the early 1900s. Development of training programs, beginning as proctology preceptorships and evolving to residency programs recognized by the Accreditation Council for Graduate Medical Education, demonstrate the value of the unwavering dedication of the founders of the field. Similarly, creation of an independent Board with its own certification procedures has maintained the independence and integrity of the specialty despite external pressures to return to general surgery. Both the development of the board and training programs are reviewed in detail.

Colon and rectal surgery had long been recognized in the United Kingdom, particularly through the St. Mark's Hospital in London (the "birthplace of modern colorectal surgery"). Proctology as a specific field of medical study and practice had been established by the early pioneers in the field, led in the United States by Dr. Joseph Matthews of Louisville, Kentucky; he had studied at St. Mark's Hospital and returned to Kentucky to practice and teach. He limited his practice to colon and rectal surgery and created a Department of Proctology at the Kentucky School of Medicine. He and other early practitioners founded the American Proctologic Society, of which Dr. Matthews was the first president. Matthews was also the president of the American Medical Association, thus providing some basis for the influence of proctologists in organized medicine as a whole.

The Advisory Board for Medical Specialties had been established in 1933 in response to concerns regarding educational standards and certification of medical specialists. Before the establishment of this organization, which was the precursor of the American Board of Medical Specialties, there was no way for organized medicine to establish and verify minimum standards of performance for each specialty. Originally, the groups involved included the Boards of Ophthalmology, Dermatology, Obstetrics, and Gynecology and Otolaryngology along with representation from physicians, hospitals, medical educators, and creators of examinations with the express purpose of attempting to standardize the processes for creation of and documentation of standards for recognizing specialists. It was decided that each specialty would utilize its own experts to create and validate its own certification process.

Interest in the specialty of proctology grew, as reflected in the expanding numbers of members in the American Proctologic Society, and in 1933 Dr. Curtice Rosser of Dallas, in his presidential address, strongly advocated for the development of an independent specialty board that would define the curriculum of the specialty and develop a method of certification of appropriately trained individuals. As a result, the American Board of Proctology was incorporated in 1935; shortly thereafter they petitioned the Advisory Board to begin to function independently. At that time the Council on Medical Education of the American Medical Association, which was charged with accrediting specialty boards, asked that the proctologists delay incorporation until approval from the American Board of Surgery, which occurred in 1937.

In a seemingly politically motivated decision, the Advisory Board decided that the American Board of Surgery should be in charge of the development of certification in proctology and the American Board of Surgery then approved the American Board of Proctology as a subsidiary board. Rules were established that

* Corresponding author at: Division of Colon and Rectal Surgery, Mayo Clinic, Rochester, MN.
E-mail address: Wolff.Bruce@mayo.edu (B.G. Wolff).

http://dx.doi.org/10.1053/j.scrs.2015.04.002
1043-1489/

mandated that those interested in proctology must first complete all of the components of general surgery training as well as successfully complete the examination for surgery and then additionally complete proctology training and pass a separate examination in proctology. When one completed all of this, and after passing the examination, the individual would receive a certificate in proctology but *not* in general surgery, despite having first completed training and certification in that field.

Furthermore, the American Board of Proctology was to be a subsidiary committee of the American Board of Surgery. The original eight members of the committee were charged with generating a list of recognized experts in proctology who would be certified without examination; a list of 77 names was submitted and formed the basis of the "Founders list." With the exception of this list, all new candidates for certification in proctology were held to the standard of complete training in general surgery followed by complete training in proctology, as outlined in the original requirements. This training paradigm was so onerous that from 1942 to 1949, only eight candidates actually were certified in proctology. The American Board of Surgery continued to urge the proctologists to relinquish their aspiration for independence and belittled the field itself such that it had little academic respectability. Fortunately, the pioneers in this field were undeterred; concerned that the arrangement with the Board of Surgery would result in the demise of proctology as a distinct specialty, they appealed to the ABMS and the AMA Council. To their surprise, both highly influential governing organizations were supportive of the proctologists and yet the American Board of Surgery refused to follow their advice. The American Board of Surgery adopted the stance that proctology training required either three or 4 years of general surgery and they continued to insist on subsidiary board status for the proctologists. Once again the American Proctologic Society and the original central certifying committee of the Board of Proctology, after long but cooperative negotiations between a specialty society and the certifying body, presented a unified petition to the Advisory Board (ABMS) and when the American Board of Surgery once again refused to acquiesce, in 1949, the American Board of Proctology was recognized as an independent board and became the 18th primary specialty board; this was 14 years after the initial incorporation of the American Board of Proctology, which had preceded the American Board of Surgery by 2 years. This protracted and at times acrimonious process is the foundation of some of the persistent differences of opinion between these two boards even to this day.

The original board comprised 10 members; originally there were four (4) representatives of the American Proctologic Society, four (4) from the American Medical Association section of Gastroenterology and Proctology, and two (2) from the section of Proctology of the Southern Medical Association. Over time, the number of directors has increased to sixteen (16) plus the executive director. Currently, the representation includes four (4) from the American Society of Colon and Rectal Surgeons (ASCRS), two (2) from the American College of Surgeons, two (2) from the Association of Program Directors in Colon and Rectal Surgery (APDCRS), and six (6) from the American Board of Colon and Rectal Surgery (ABCRS). Since 1979 there has been one voting member representing the American Board of Surgery; similarly, one member of the ABCRS is a representative to the American Board of Surgery. This has been a mutually beneficial arrangement between the two boards.

The original board in its bylaws established the possibility of two consecutive 4-year terms for each member, with the sole exception of the Executive Director. It was the belief of the original founders that one individual without term limitations was necessary to provide historical memory and continuity. Recently, it was decided to amend the bylaws and place a 10-year term limitation on the Executive Director, with the possibility of two consecutive 5-year terms. The first transition based on this system will occur in 2016.

Training of colon and rectal surgical specialists has come through an interesting evolution since the mid-19th century. At that time, there were certain individuals who declared a special knowledge or interest in proctologic surgery, principally hemorrhoids. There was no training for this, and this was largely a matter of self-proclamation. Nevertheless, a few individuals achieved a reputation for this, but there was no academic institutional recognition of anorectal surgery. Later, in the 1870s and 1880s, apprenticeships, or preceptorships, were undertaken, in which for a varied period of time, a young surgeon would associate with a more senior surgeon and become designated as a specialist in proctology. Another avenue was to travel to Europe, principally Germany, for from 3 months to a year studying specialized techniques. Again, there was no formal recognition as a surgical specialist.

Dr. Louis Wilson, in charge of graduate medical education at the Mayo Clinic Foundation, commented that some physicians trained in Vienna for a few months, returning with a certificate and "beer breath." Approximately 15,000 Americans did some type of observational or other training in Austria, Germany, and Switzerland between 1870 and 1914.[1]

The advent and broad application of anesthesia, fostered by Long, Wells, and Morton, as well as the antiseptic method as proposed by Lister, and asepsis, ushered in a golden period of surgery in the later 19th and early 20th century. There was an explosion of procedures, both intraabdominal and other complex operations, which were quickly developed and practiced with a relatively low morbidity and mortality. With this burgeoning ability to counter disease surgically came the need for many well-trained surgeons. This, of course, gave rise to programs of surgical training not only to provide future teachers and department heads but also well-trained practitioners in the specialized field of surgery.

Colon and rectal surgery has always been closely associated with general surgery, and as we have seen elsewhere in this chapter, there was considerable controversy early on as to whether proctology, or indeed colon and rectal surgery, was in fact a legitimate subspecialty. In order to understand the training it is necessary to briefly review the training of all surgical specialists, and the changes that took place in the late 1800s and 20th century.

William S. Halsted and William Osler were very much affected by the German system of training in the later part of the 19th century, and adopted much of this when the Johns Hopkins Hospital opened in 1889. This was the first residency program in the US and was a "pyramidal" residency module in which eight young men would begin a residency, but only one of the eight would actually complete the full residency, in essence serving as a first assistant or chief resident. The others became known as assistants. Residents were required to live in the hospital. They were not allowed to be married. Dr. Halsted expected his residents to work 362 days a year. In the 33 years that Dr. Halsted ran his residency program, he finished complete training of 17 surgeons. However, almost all of the surgeons he trained went on to pursue careers in academic surgery and also to train other surgeons. On the heels of the Flexner report, which came out in 1912 and castigated the current system of medical education at the time, there were many improvements made. Many homeopathic hospitals became allopathic, and gradually other institutions began their own residency programs. These, as with the Hopkins model, revolved around one individual who made all of the decisions and did almost all of the teaching. Naturally, this type of program was not satisfactory for many young surgeons, as there was decreased morale in these programs, and less than optimal