The American College of Surgeons: A Legacy of Leadership

LD Britt, MD, MPH, FACS

I want to recognize my distinguished national and international colleagues on the dais, including several of the Past Presidents. I particularly want to acknowledge and thank Dr Eastman (Chair) and Dr Pellegrini (Vice Chair) of the Board of Regents, along with the other Regents and Officers who have been so supportive, and the executive leadership of the Board of Governors. This body on the stage truly represents the best of surgery, worldwide.

I, too, want to take this time and acknowledge and thank the wonderful staff of the American College of Surgeons, with special recognition of Ms Barbara Dean, Ms Maxine Rogers, and Counsel Paula Goedert, who worked so closely with me during my tenure as a Regent and when I became Chair of the Board. I especially want to recognize our new and very gifted Executive Director, Dr David Hoyt, who follows the excellent tenure of Dr Tom Russell.

I also would like to recognize several of my former professors and my past and current mentors and professional colleagues. I would be negligent if I did not acknowledge and recognize my very talented faculty and staff at Eastern Virginia Medical School, along with current and former residents of the Eastern Virginia Medical School surgical family. And I would be the most remiss if I did not recognize my lovely and supportive wife, Dr Charlene Britt (the real doctor in the family), my in-laws, the Mebane family, and my very close friends. I now want to focus my attention and direct my remarks to the Fellows of the American College of Surgeons.

I enthusiastically dedicate this presidential address to the patient. It has been and still is a privilege for me to have played any role, large or small, in the management of each and every patient since the start of medical school in the 1970s.

Although this is technically the 96th Clinical Congress, this year actually marks the 100th anniversary of the Clinical Congress. There was no Clinical Congress meeting in 1918 due to the war and flu epidemic, and there were no formal Clinical Congress sessions held for successive years in the early 1940s because of the war campaign. I thought it would be appropriate to frame the historical perspective of both the Clinical Congress and the American College of Surgeons, as a prelude to the theme of my address. The first Clinical Congress was held in Chicago in 1910. It was officially called the Clinical Congress of Surgeons of North America. Reportedly, the template for this idea was the Society of Clinical Surgery, which was organized in 1903 for "the purpose of demonstrating to a group of surgeons the clinical and technical methodology used in the different leading clinics."[1]

Believing that this forum of clinical activity needed to be expanded, Dr Franklin Martin, the principal architect, established the Clinical Congress. Thirty-five hundred subscribers to the journal *Surgery, Gynecology* and *Obstetrics (SG&O)* were invited, as guests of the journal, to Chicago. *SG&O* was established in 1905 to record the work of "men who were actually doing surgery, a practical journal for practicing surgeons; edited by active surgeons rather than by literary writers remotely connected with clinical work."[2] Dr Franklin Martin, founder of the journal, wanted practicing surgeons to be the contributors. He also wanted *SG&O* to be an independent professional publication not directed by corporate or commercial interests. This journal (now called the *Journal of the American College of Surgeons*) ultimately became the publication organ of American College of Surgeons.

The Clinical Congress, at that time, was a 2-week meeting. For its inaugural meeting, there were 1,300 registered attendees, although many others attended but didn't register. Reportedly, while en route to New York from Chicago by train to attend the third Clinical Congress, Dr Martin had an epiphany and conceived, perhaps, his greatest concept —establishment of a "college" for surgeons. Recognizing that the Clinical Congress was an unqualified success, Dr Martin also knew that more organizational structure and oversight would be needed. Having access to a stenographer was one of the attractions of the Twentieth Century Limited, the luxury train that Dr Martin was riding en route from the New York meeting. He dictated to the stenographer the objectives of this proposed permanent organization in 5 succinct paragraphs:[3]

Disclosure information: Nothing to disclose.

Presented at the American College of Surgeons 96th Annual Clinical Congress, Washington DC, October 2010.

Received November 17, 2010; Accepted November 17, 2010.

From the Department of Surgery, Eastern Virginia Medical School, Norfolk, VA.

Correspondence address: LD Britt, MD, MPH, FACS, Department of Surgery, Eastern Virginia Medical School, 825 Fairfax Ave, Ste 610, Norfolk, VA 23507-1912. Email: brittld@evms.edu

ISSN 1072-7515/11/$36.00
doi:10.1016/j.jamcollsurg.2010.11.009

- To provide a learning environment for surgeons to have a "practical surgical experience" instead of listening to "literary treatises based on theoretical deductions."
- To enroll American surgeons who, in the opinion of their "confreres," were competent to do surgery and were "morally and ethically reliable," along with being loyal to the profession.
- To eliminate "financial dickering" (eg, fee splitting) and "bar from its ranks" those surgeons who violated this rule.
- To seek by "legitimate means" to protect the public from "incompetent, dishonest, and unnecessary surgery" and "to take lead, and bring to bear" all the resources of organized scientific medicine in an endeavor to improve the entire environment in which surgery and medicine were being taught or practiced.
- To assist the public "in obtaining all the benefits of scientific advice and all the services of preventive medicine" in order for society to be able "to distinguish between the reliability of scientific medicine and false sophistries of quackery."

These principles formed the cornerstone of the foundation for the American College of Surgeons—now the world's largest organization for surgeons.

The following is an excerpt from the Articles of Incorporation for the American College of Surgeons:

> To establish and maintain an association of surgeons, not for pecuniary profit but for the benefit of humanity by advancing the science of surgery and the ethical and competent practice of its art; by establishing standards of hospital construction, administration, and equipment, and all else that pertains to them; by engaging in scientific research to determine the cause, nature, and cure of disease; by aiding in better instructions of doctors; by formulating standards of medicine; and methods for improvement of all adverse conditions surrounding the ill and injured whenever found. To accomplish these benevolent and charitable aims, it shall be within the purposes of this corporation to use those means which from time to time may seem to it wise, including research, publication, education, the establishment and maintenance of libraries, museums, and other agencies or institutions appropriate hereto, and the co-operation of any other such activities, agencies, or institutions already established or which may hereafter be established.[1]

On November 25, 1912, the charter was granted by the State of Illinois for the establishment of the American College of Surgeons.

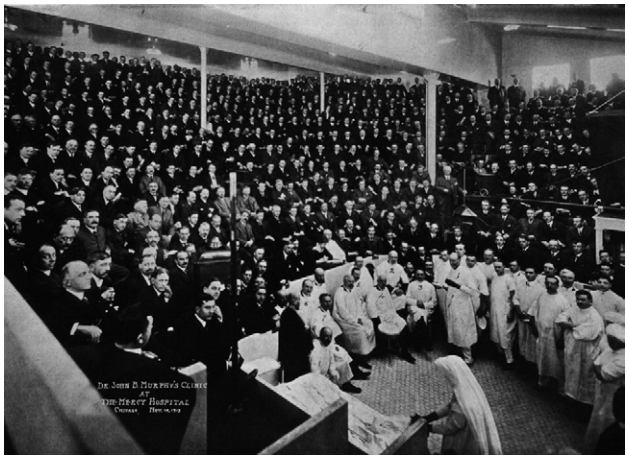

Figure 1. At the fourth Clinical Congress held in Chicago (1913), Dr John Murphy demonstrates his surgical expertise during a "clinic" at Mercy Hospital.

Figure 1 is a photo of the "clinic" held by Dr John Murphy during the 1913 Clinical Congress. I have used this historical perspective in order to shine a light on leadership—leaders and leadership during a period when the profession of surgery was in disarray and surgical quackery and profit-oriented charlatans were omnipresent. It was a period when resources were scarce and the economy anemic. The leadership role of Dr Franklin Martin, founder and the 11th President, which is permanently etched in the very fabric of this organization, has been well chronicled by many. Dr John Cameron, 88th President of the American College of Surgeons, did a masterful job during his presidential address of highlighting the superb leadership of Dr John MT Finney, the first President of the American College of Surgeons.[4]

Before I unveil the theme of this address and deliver the charge to you as new Fellows of the College, I would like to briefly underscore the leadership prowess of another architect of this organization, Dr George Crile of Cleveland (Fig. 2). Dr Crile, perhaps best known for being one of the key founders of the Cleveland Clinic, was a prominent member of a cadre of visionaries. Dr Crile's leadership help set the course of the American College of Surgeons. In collaboration with Dr Franklin Martin, John Murphy, and a few others, Dr Crile clearly echoed the vision of the group regarding this permanent organization. He stated that "we want one that would have the function of a college – postgraduate education and standardization."[5] Dr Crile and others believed that the College should be patterned after the US federal government and the government of Canada, whereby states and provinces would be recognized as units of the organization. The proposed organizational structure

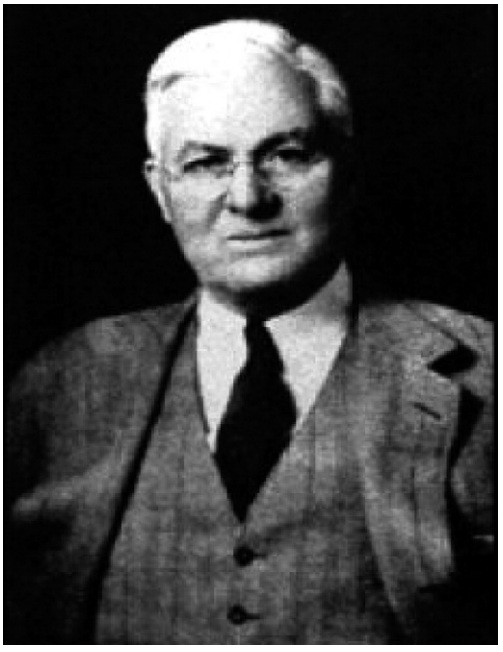

Figure 2. Dr George Crile, perhaps best known for being one of the key founders of the Cleveland Clinic, was a major architect in the development of the American College of Surgeons.

included the Board of Regents, the Board of Governors, Director General (Dr Franklin Martin), and a Central Credentials Committee. Dr Crile, a pivotal member of the committee for the original bylaws, rules, and regulations, demonstrated what I believe is the quintessential attribute of a true leader—that ability to put goals ahead of personal ambition.

Both Drs George Crile and John Murphy were potential candidates to hold the office as the first President of the American College of Surgeons. However, in Dr Crile's autobiography, the following statement should be interpreted as his desire to achieve advancement of an organization, instead of the advancement of self interest:

> Both Murphy and I were sounded out as to accepting the presidency, and we expressed the opinion that it would get better cooperation if it were given to an Eastern president who would win over the conservatives of the Eastern seaboard.[5]

Table 2. Dr George Crile's Official American College of Surgeons (ACS) Leadership Roles

A founder and life member
President (1916 to 1917) – the second ACS President
Member of the original Board of Governors
Chairman of the Board of Regents (1913to 1939)
Member of the Board of Regents (1913 to November 6, 1941)
Acting Director of the ACS from March 7, 1935 until autumn of 1939
Innumerable committees

Table 1. The Inaugural Board of Regents of the American College of Surgeons

George E Armstrong (Montreal)
George E Brewer (New York)
Herbert A Bruce (Toronto)
Frederic J Cotton (Boston)
George Crile (Cleveland)
John MT Finney (Baltimore)
William D Haggard (Nashville)
Edward Martin (Philadelphia)
Franklin H Martin (Chicago)
Charles H Mayo (Rochester)
Robert E McKechnic (Vancouver)
John B Murphy (Chicago)
Albert J Ochsner (Chicago)
Harry M Sherman (San Francisco)
Charles F Stokes (Washington, DC)

On May 5, 1913, Dr John MT Finney was selected the first President of the American College of Surgeons. Any cynicism regarding this personal account rapidly evaporates upon realization that Dr George Crile was a prominent member of the inaugural Board of Regents (Table 1) and had a legacy in the American College of Surgeons that is, to date, unparalleled (Table 2). Probably, with the exception of Dr C Rollins Hanlon, no one has had more official leadership involvement with the College.

In May 1913, 4 American surgeons were informed by the President of the Royal College of Surgeons (England) that they had been selected to have conferred on them the Honorary Fellow status. Dr George Crile was chosen as one of the select few, along with Harvey Cushing, William Mayo, and John Murphy for this coveted recognition. The following quote by Dr Crile best captures the overarching and enduring mission or calling of the American College of Surgeons: "The American College of Surgeons ever since its inception has been constantly extending its interest not for the benefit of the surgical profession but primarily for the general public."[5] He goes on to state, "the task of the American College of Surgeons . . . to see that there are good surgeons and good hospitals all over the US and Canada . . . "[5]

The following commentary, about relinquishing his official duties with the College demonstrates Dr Crile's unselfish leadership:

> And now I was facing another change. Evarts Graham whose term as President had just expired had grown to be such an enthusiastic supporter of the

> program of the College that I felt it important not to have a lapse in his official connection with the governing board. But inasmuch as the terms of five members of the Board of Regents, who were highly qualified for re-election had expired, the only way that we could re-elect the five members and Dr Graham was through my resignation and the election of Dr Graham. So I resigned.[6]

This opened up the chapter for another leader of the organization. Although he is best known as the key figure in creating the American Board of Surgery, Dr Evarts Graham was also Chairman of the Board of Regents of the American College of Surgeons and led its effort to condemn fee splitting and "ghost" surgery.[7] He charged that fee splitting still existed among the fellows of the ACS, but that the Regents had done nothing about it. He stated that "fee splitting" kept surgery in hands unfit and untrained to do it. He went on to say that:

> The bane of the medical profession among its surgeon specialists is usually the fee splitting proposition. By this is meant the division of surgical fees unknown to the patient being referred to the surgeon who divides the fee most liberally regardless of his surgical ability.[7]

There are many other leaders who could be chronicled, such as Drs Hanlon, Leffall, Organ, Copeland, Healy, Jones, and Anderson, and there are many others who never served as a Governor, Regent, or an Officer. The American College of Surgeons has a legacy of leaders who put the interest of patients first, even when such an emphasis conflicted with the economic best interests of the surgeon. It is a legacy that no amount of advertisement can create. Today, the American College of Surgeons has leaders that transcend gender, ethnicity, race, and professional or specialty orientation.

We have some difficult months and years ahead. Leadership—your leadership—will be needed. Although America is facing an avalanche of threats that can adversely affect the well being of its population, the quality of and access to health care are the 2 main variables that can have an impact on health status. While challenges still exist, the American College of Surgeons continues to be a leader in quality improvement initiatives. The aforementioned historical perspective underscores the fact that, as an organization with a legion of leaders, the American College of Surgeons has been a beacon for quality care and patient safety, with an unwavering emphasis on professionalism and ethics. No organization has had a more powerful and enduring mantra.

There are, indeed, historical "revisionists" who believe they are emending the record of what occurred in the past, but what they are actually doing is rewriting history and, unfortunately, are overlooking important elements and milestones of this great organization. The pivotal role that the American College of Surgeons has played in both defining and implementing quality patient care and the standardization of the hospital environment to ensure safe care can never be overlooked or dismissed.

Although it has had key allies and effective alliances, the American College of Surgeons has been the perennial leader of optimal patient care and patient safety. As the College approaches its 100th anniversary, it is recognized as the premier resource for best practices in management of the surgical patient. For example, the Advanced Trauma Life Support (ATLS) course is the prototype of such best practices. Celebrating its 30th anniversary this year, the Advanced Trauma Life Support course has had (and continues to have) an irrefutable impact on the care of the critically injured patient regionally, nationally, and internationally. This program is just one of a growing list of successful initiatives launched by the American College of Surgeons.

The College's flagship will always be education. The accreditation of education institutes, the verification of trauma centers, the accreditation of bariatric programs, etc, represent the continual effort of the College to carry out its mission. There has been no better steward of quality care and safety than the American College of Surgeons. The American College of Surgeons has never needed any other authority to define its mission. I often recall what my parents taught me regarding this point—never leave to others the task of defining yourself.

The environment today is different and the disincentives are greater. However, our core values remain the same. Amidst a changing landscape, we cannot bask in "nostalgic euphoria." All of us — as Fellows of the College—must adapt to change without compromising the core values that made the American College of Surgeons the flagship for quality care and patient safety. As our new Executive Director, Dr David Hoyt, continues to emphasize, "the College has consistently demonstrated its commitment to quality and the surgical patient through its quality of care programs."[8]

We need to be the principal architects redefining and redesigning the landscape of health care, not the "think tanks" of corporate America. As an organization and individually, we must fulfill our professional responsibilities to society, which would include excellent patient outcomes, wise resource allocation, and effective self-regulation.

Whether we consider ourselves members of the "House of Surgery" or citizens of the "Village of Surgery" (where

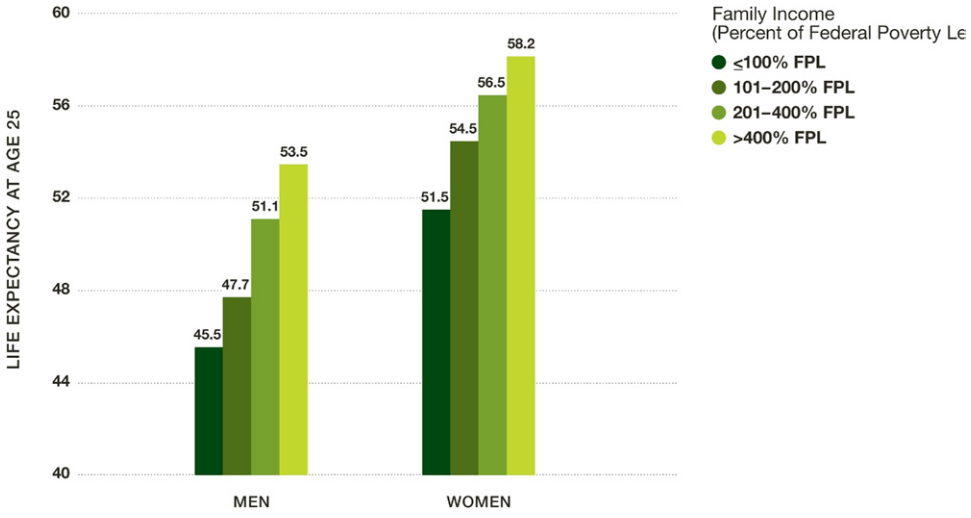

Figure 3. Adult life expectancy increases with increasing income. Men and women in the highest income group can expect to live at least 6.5 years longer than poor men and women. This chart describes the number of years that adults in different income groups can expect to live beyond age 25. For example, a 25-year-old woman whose family income is at or below 100% of the federal poverty level (FPL) can expect to live 51.5 more years and reach an age of 76.5 years. (From: the Robert Wood Johnson Foundation, with permission. Prepared by the Center on Social Disparities in Health at the University of California, San Francisco, CA; and Norman Johnson, US Bureau of the Census. Source: National Longitudinal Mortality Study, 1988-1998.)

there are housing neighborhoods), we have an unbreakable contract with society to provide optimal care for the surgical patient. Such care can be represented as a 3-legged stool, with the 3 legs being quality, safety, and access, respectively. In my opinion, the doors of the "House of Surgery" have always been open to all who need surgical care. However, with a growing population, an aging population (with the associated increase in comorbidities), increasing (and unprecedented) unemployment figures in many areas in America, with declining reimbursement, and innumerable disincentives, the challenges are daunting, for these are the essential ingredients for deepening access problems, which are the underpinnings for health care disparities.

While addressing an audience that included a cadre of health care providers, Dr Martin Luther King stated that "of all the forms of inequality, injustice in health is the most shocking and the most inhumane."[9] Dr King was defining health care disparities. If the greatest health risk in 1955 was acquired heart disease, to which huge research resources were devoted to develop treatment paradigms, then the greatest health risk in 2010 has to be lack of access to care. Some have said that health care inequities and disparities will be the new era of civil rights for the 21st century.

A recent publication sponsored by the Robert Wood Johnson Foundation underscores the alarming disparities in health care based on differences in income, race, ethnic origin, and geography (Figs. 3 to 7).[10] As leaders, we must address this issue as we have addressed other perplexing challenges in the past. That has been our legacy as a great organization. From dismantling fee splitting schemes (which allowed patients to be sent to the highest bidder, irrespective of his or her competency) to being the architect for safer hospitals, to providing continued educational programs for the entire surgical community and establishing accreditation and verification processes to ensure a high standard of health care delivery, leaders in the American College of Surgeons have carried the mantle.

Granted, we cannot do this alone. It will, undoubtedly, take formation of strategic alliances and the ability to have all stakeholders at the table, including the patients. We need to provide the type of leadership that transcends specialty interest—leadership that places an emphasis on what is best for the individual patient and what is best for the population. The 3-legged stool that represents optimal care for the surgical patient will not stand if access is broken or disconnected (Fig. 8). It does not matter how strong the quality might be or how many broad-based safety initiatives have been established. If the access axis is severely weakened, optimal patient care will falter. There is no quality without access.

As leaders, we need to be the first to acknowledge when there is "an elephant in the room" that no one else wants to acknowledge. Disparity in health care, irrespective of how it might be codified, is the antithesis of the mission of this great organization. During the Clinical Congress, an exhaustive account of the many past and current scientific achievements in

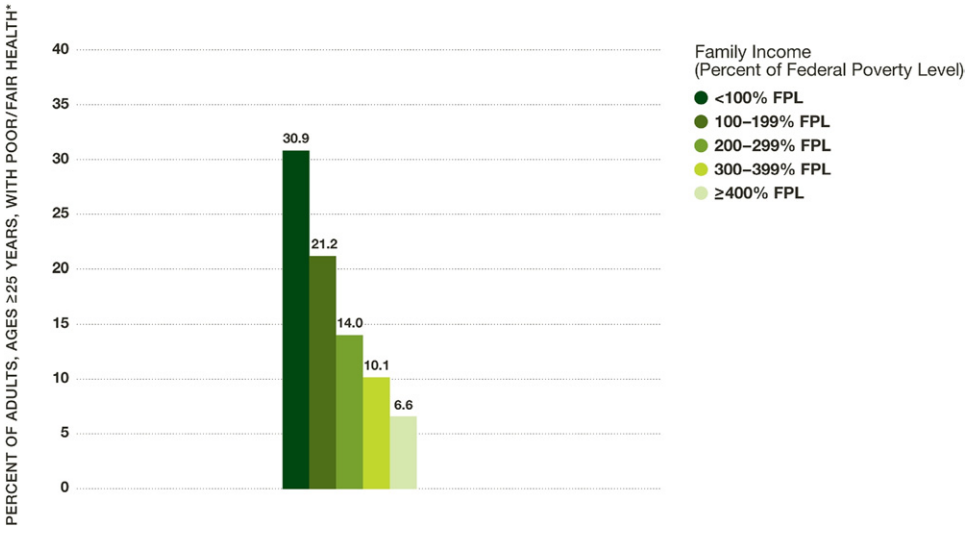

Figure 4. Lower income is associated with worse health. Compared with adults in the highest income group, poor adults are nearly 5 times as likely to be in poor or fair health. (From: the Robert Wood Johnson Foundation, with permission. Prepared by the Center on Social Disparities in Health at the University of California, San Francisco. Source: National Health Interview Survey, 2001-2005.) *Age-adjusted. FPL, federal poverty level.

surgery can be continually emphasized, but the question that will always linger is: what good is scientific achievement if it cannot be translated to all who need it?

There exists a great paradox that highlights a stifling $2 trillion health care industry that can boast about having the most advanced technology, the best centers of excellence, an exponential increase in translational research, but with a contrasting backdrop of declining access to health care, overcrowded hospitals and emergency departments, innumerable errors in patient management that lead to increased morbidity and mortality, and suboptimal preventive care. This country is not getting good value for its health care dollar expenditure

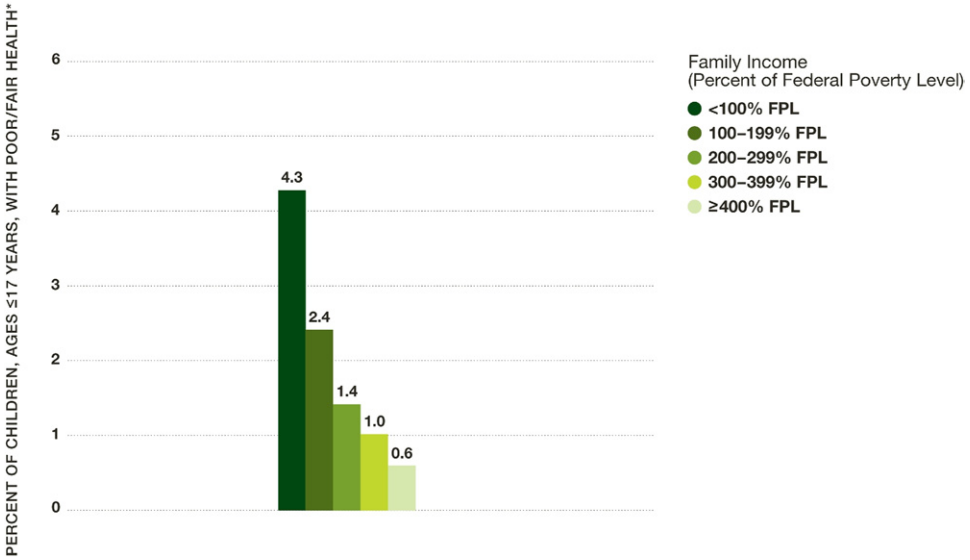

Figure 5. Suboptimal health status of a child is associated with parents' income. Children in poor families are about 7 times as likely to be in poor or fair health as children in the highest income families. (From: the Robert Wood Johnson Foundation, with permission. Prepared by the Center on Social Disparities in Health at the University of California, San Francisco. Source: National Health Interview Survey, 2001-2005.) ∗Age-adjusted. FPL, federal poverty level.

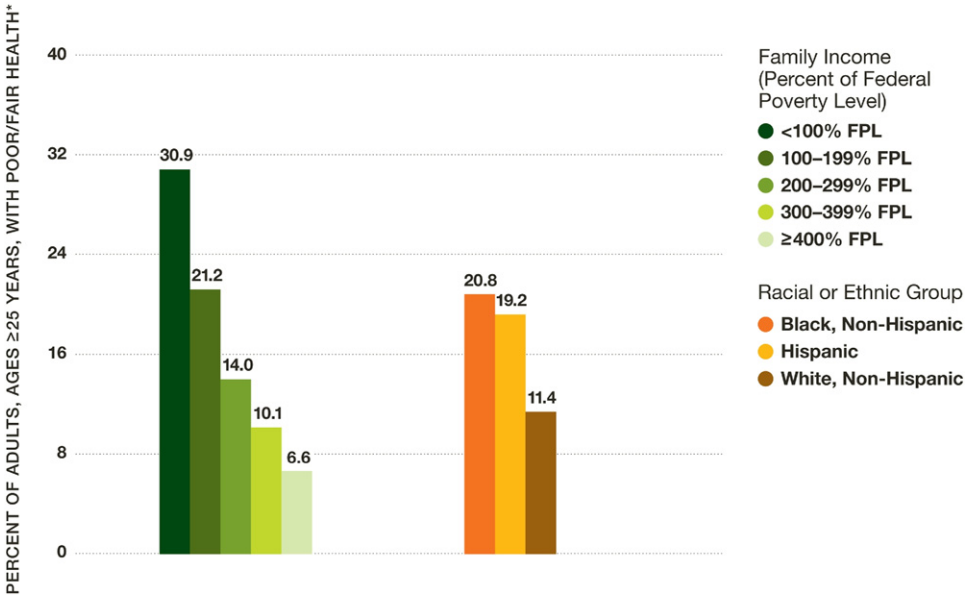

Figure 6. Racial and ethnic differences in health status. Poor or fair health is much more common among black and Hispanic adults than among white adults. (From: the Robert Wood Johnson Foundation, with permission. Prepared by the Center on Social Disparities in Health at the University of California, San Francisco. Source: National Health Interview Survey, 2001-2005.) *Age-adjusted. FPL, federal poverty level.

(Fig. 9). The ACS has already begun its leadership role in addressing these challenges. Under the leadership of many, including Past President Dr George Sheldon and former Chair of the Board of Regents, Dr Josef Fischer, the declining surgical workforce has been well documented and recommendations have been made to the US Department of Health and Human Services on how to reverse this trend.[11]

There has been the steady promotion of proven effective health care, which has been the mainstay of the ACS Division of Research and Optimal Care. Also, the Division of Education continues to provide ways to enhance the learning environment for the surgeon in order to ensure ongoing competency of the surgical community. In addition, the College has been quite vocal about its support of expanded health care coverage to address this specific aspect of health care disparities.

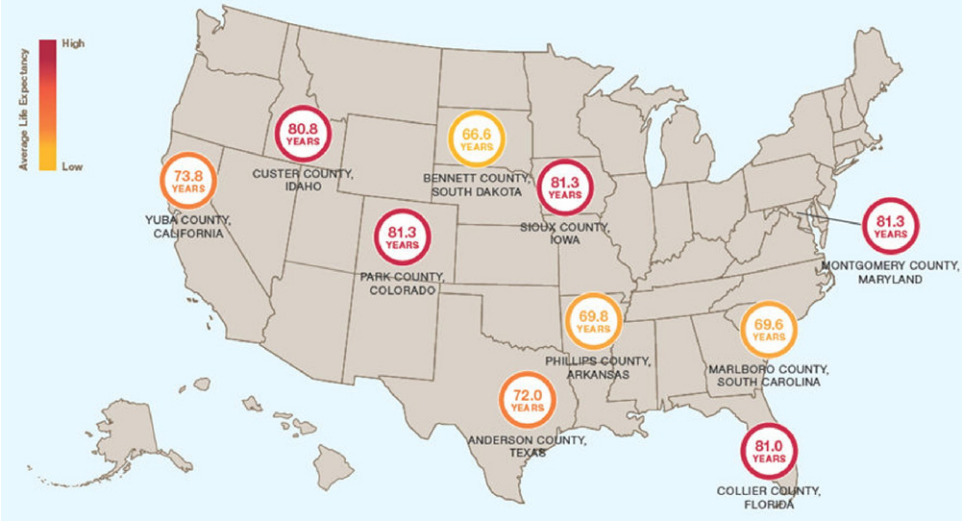

Figure 7. Differences in life expectancy and quality of life based on geography. (From: the Robert Wood Johnson Foundation, with permission.)

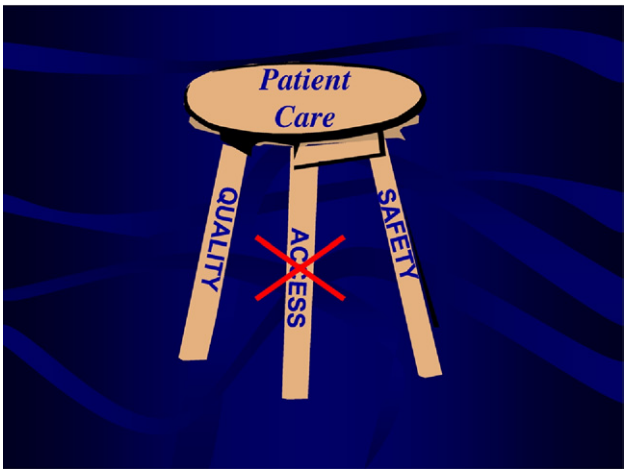

Figure 8. Optimal surgical care depends on quality, safety, and access.

The Renaissance period, familiar to most of us, occurred from the 14th century into the 17th century. I do feel that this period that we are currently in, which many are labeling as the "medical crisis" era is ***our*** renaissance period, in which new leadership will emerge and assist in addressing these challenges. As the population in this country expands by another 25 million each decade, the health care disparities will only get worse. Resolution of this problem will not involve infusion of even more money. On the contrary, this is, perhaps, one of the few societal dilemmas in which more money will not make things better. What we will need is the best and brightest minds to come up with a strategy that will definitively curtail the growing health care disparities.

Fortunately, some of the best and brightest minds are in the audience tonight, being inducted into the American College of Surgeons. Sure, this country has the most resource-intense environment that ever existed. And, sure, you can bring up the old adage that "a rising tide floats all boats," but the prevailing problem is the fact that not everyone has a boat! I truly believe it will be your generation that will be able to effectively address the dilemma of why Americans receive only one-half of the recommended medical care, as reported by the Rand Corporation.

As the newly inducted Fellows of the American College of Surgeons, you have entered into a career-long contract to best represent the imperishable mission and ideals for the College. With this gathering today marking the 100th year since the inception of the Clinical Congress and the fact that we are just 3 years shy of the centennial anniversary of the American College of Surgeons, it seems only fitting that we all renew our commitment to the original tenets of this great organization. Each one of you must demonstrate, in your own way and in your individual unique environment, the leadership that will be required to preserve the ideals of

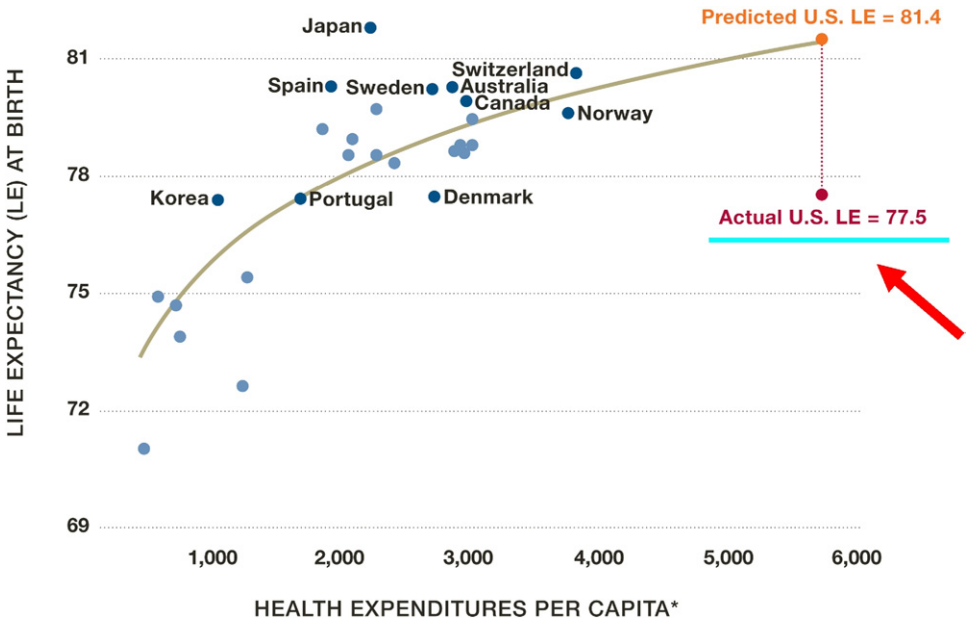

Figure 9. America is not getting good value for its health dollar. The US spends more money per person on health than any other country, but our lives are shorter—by nearly 4 years—than expected based on health expenditures. (From: the Robert Wood Johnson Foundation, with permission. Prepared by the Center on Social Disparities in Health at the University of California, San Francisco. Source: OECD Health Data 2007. Does not include countries with populations smaller than 500,000. Data are for 2003.) *Per capita health expenditures in 2003 US dollars, purchasing power parity.

the American College of Surgeons during one of the most turbulent and labile periods that this nation has faced.

I can only imagine your thoughts and, perhaps, quiet commentary now—questioning how anyone could expect you to be a leader given your relatively young age and the fact that you are a "brand new" Fellow. I will share with you a quote by Sir William Osler that was shared with me when I went through my application process to become a Fellow of the American College of Surgeons (FACS):

> Take the sum of human achievement in action, in science, in art, in literature – subtract the work of men above forty, and while we should miss great treasures, even priceless treasures, we would practical be where we are today . . ... The effective, moving, vitalizing work of the world is done between the ages of twenty-five and forty. The young men (women) should be encouraged and afforded every possible chance to show what is in them.[12]

This is your time to lead. Your leadership role cannot be delegated; you either exercise it or you **abdicate** it. Remember, for each one of you leaving this setting tonight, the clear charge to you is that the American College of Surgeons needs your **leadership** and America needs your leadership. Also, know that trust is a requisite for leadership, and trust cannot be achieved when character is lacking.

It is my belief that the American College of Surgeons is an organization that has not missed on opportunity to favorably affect the "life trajectory" of a patient, an organization that has made a difference, an organization that needs your leadership.

I will close with this quote by Martin Luther King Jr, "Life's most persistent and urgent question: What are you doing for others?"[13]

REFERENCES

1. Muller GD. The College and American surgery. Surg Gynecol Obst 1941;72:529–533.
2. Martin FH. Presidential Address: The American College of Surgeons – The Past, The Present and The Future [Delivered at the Convocation of the American College of Surgeons, Boston, October 12, 1928].
3. Ochsner A. A report of our founders. Bull Am Coll Surg 1953; 38:15–23.
4. Cameron JL. John Miller Turpin Finney: The first president of the American College of Surgeons. J Am Coll Surg 2008;208: 327–332.
5. Crile G. George Crile: An Autobiography (Grace Crile, ed). (Vol. I). Philadelphia and New York: JP Lippincott Company; 1947:230–237.
6. Crile G. George Crile: An Autobiography (Grace Crile, ed). (Vol II). Philadelphia and New York: JP Lippincott Company; 1947: 570.
7. Mueller CB. Everts A Graham: The Life, Lives, and Times of the Surgical Spirit of St. Louis. Hamilton and London: BC Decker; 2002:25–34.
8. Hoyt DB. Looking forward. Bull Am Coll Surg 2010;95:4–5.
9. King ML. Jr. Presentation at The Second National Convention of the Medical Committee for Human Rights; March 25, 1966; Chicago, IL.
10. Overcoming Obstacles to Health. Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America. February 2008.
11. Sheldon GF. The surgeon shortage: constructive participation during health reform. J Am Coll Surg 2010;210:887–897.
12. Bliss M. William Osler: A Life in Medicine. New York: Oxford University Press; 1999:323–324.
13. King ML. Jr. Conquering self-centeredness. Speech presented at Dexter Avenue Baptist Church, Montgomery, AL, August 11, 1957.