34. Resolution and Expectation

Aside from . . . tradition there is nothing amiss with looking forward to the day when two groups of specialists, who have in a sense different interests and different kinds of expertise, in fact, form two different organizations.

DAVID SHOCH
TO THE COUNCIL, 1975

RAPID AND RADICAL CHANGES in Academy operations and organization naturally produced questions as to what it all meant. There was initial skepticism about the wisdom of restructuring into divisions on the one hand and criticism that it was not a large enough step toward separation on the other. Both skeptics and critics asked what tangible results would accrue. All but a few members welcomed the promise of separate meetings and the prospect of their primary educational organization giving a more appropriate distinct identity to each specialty.

Those who worked out the divisional structure took pains to assure members that this was not a meaningless organizational shuffle, that it would in fact afford ophthalmologists and otolaryngologists more opportunity to chart their own course. Once the divisions were activated, the separate executive committees took equal pains to demonstrate that they were not merely going to conduct business as usual. Each executive committee eagerly accepted the new independence as a challenge to improve Academy services and representation of the specialty.

As events progressed, it became clear that Academy reorganization was making the difference that leaders promised and members hoped for. The corporate Bylaws and divisional Standing Rules delineated further, almost complete, autonomy for the divisions with respect to their operations, plans, and budgets. The divisional concept looked to be the initial step toward separation. Each division was gaining the time, experience, and foundation for an orderly transition to an independent society.

The organizational framework devised for the AAOO, Inc, could be adapted to provide the basis for two freestanding societies. During 1978 the same men who worked on incorporation of the combined Academy worked to do just that. Drs Straatsma, Blodi, Sampson, and Spivey for the Division of Ophthalmology and Drs Derlacki, Alford, Kos, and Reed for the Division of Otolaryngology formulated articles of incorporation, bylaws, and standing rules for separate societies.

In large measure, the prospective new academies were fashioned in the image of the old one. With changes necessary to reflect the fact that each society would represent a discrete specialty, the Articles of Incorporation for the

combined Academy became the Articles of Incorporation for the American Academy of Ophthalmology and the American Academy of Otolaryngology.

In their proposed bylaws, the Ophthalmology Academy and the Otolaryngology Academy provided for an officer group similar to that of the combined Academy. The otolaryngologists eliminated the position of third vice-president and reduced the number of councillors from four to three. The executive vice-president was named chief administrative officer for the new academies as he had been for the divisions.

Each new academy would be managed by a board of directors which, like the Board of Directors of the AAOO, Inc, would consist of the elected officers, including the councillors, and the three most recent living past presidents, the executive vice-president, and the editor. Both specialties eliminated the divisional office of member-at-large and designated their councillors members-at-large, which is what councillors were intended to be when the Academy Council was created.

The plan for the separate societies as well as the resolution that called for their creation was presented to members via Academy publications in July 1978. In August 1978, the Articles of Incorporation for the American Academy of Ophthalmology and the American Academy of Otolaryngology were filed with, and recognized by, the secretary of state for Minnesota.

The final reckoning awaited the vote of the Academy's ophthalmologists and otolaryngologists who were meeting separately in 1978 for the first time in 82 years. Indeed for most members the separate meetings represented the most immediate and concrete result of Academy reorganization. The vote was somewhat an anticlimax to the developmental phases that had spanned five years, but it was so because of the care and skill with which they had been carried out. Members of the Division of Otolaryngology on Sept 11, 1978, and members of the Division of Ophthalmology on Oct 23, 1978, overwhelmingly approved dissolution of the combined Academy and creation of a new American Academy of Otolaryngology, Inc, and American Academy of Ophthalmology, Inc.

While the specific issue was resolved, other questions that were a part of it remained, or were partially answered by the divisions and then separate Academies as they outlined goals and priorities. What did autonomous units hope to accomplish? Could members expect changes in programs and activities? How would separate societies better serve science, education, and patient care in the specialties? Some general answers lay in the reasons for separation. In addition to organizational size and identity, the burgeoning amount of knowledge and techniques associated with each specialty, subspecialization, recertification procedures, and attention to federal involvement in medicine were among the reasons for and hopes for autonomous societies that could expand activities to cover the differing requirements and circumstances in ophthalmology and otolaryngology.

Alone and in conference with representatives of other organizations in the specialty, both executive committees reviewed the entire spectrum of current and projected Academy activities. These critiques elicited suggestions, some of which were targeted for action. Although the programs and activities that emerge will be unique to each specialty, ophthalmologists and otolaryngologists expressed similar needs.

For medical practice to live up to the capabilities of medical science and technology, a three-dimensional effort is required. Educational planning for a specialty must be coordinated on a national level to achieve the widest dissemination and cover the broadest amount of material, without unnecessary duplication.

This cooperative, organized planning must meet professional requirements for continuing education and recertification, whatever form the latter takes.

Prevention of disease and early diagnosis and treatment demand a shoulder-to-shoulder relationship among all fields of medicine and between physicians and others working on the health care team. An extension of educational programs in a specialty must be directed toward other specialists, primary care physicians, medical students, and allied health personnel to keep them apace of fundamental knowledge and developments in the field.

And last, but certainly not least, is the need for scrupulous attention to relationships with, and education of, the public and the government.

Interaction with other national organizations in ophthalmology and otolaryngology is necessary for creative, productive planning on all three fronts. To this end, the Division of Ophthalmology began holding a yearly Long-Range Planning Conference with participants from at least 15 other ophthalmic organizations. In October 1976, the ophthalmologists established a Program Council consisting of representatives from these national societies.

In June 1977, the Division of Ophthalmology opened an Office of Governmental Relations in Washington, DC. This office is to monitor government activities related to ophthalmology, identify those of particular importance, and facilitate presentation of guidelines and perspectives on these matters by Academy officers, members, and committees. Coordination of Academy efforts with those of other societies is central to the purpose and effectiveness of this office.

Otolaryngologists have been active along similar lines. In 1976, the Division of Otolaryngology Executive Committee brought together 21 representatives for an Intra-Specialty Conference of National Otolaryngological Organizations. This conference precipitated work to organize a coordinating body for national otolaryngologic societies. With the degree of subspecialization in otolaryngology and the many subspecialty societies, otolaryngologists are particularly eager to form a central agency that can unify planning for, and representation of, the specialty.

To effect the much-needed mutual exchange between government and physicians in approaching health care issues, standing and special committees of the Academy of Otolaryngology are cooperating with established Washington offices of other otolaryngology groups. Together these groups will prepare and present information, recommendations, and the specialty viewpoint.

For programs that reach outward beyond the bounds of the immediate membership, ophthalmologists and otolaryngologists will rely on their continuing education committees which have already made some efforts in this area. Additionally, the Academy of Ophthalmology's standing Committee on Public and Professional Education and the Academy of Otolaryngology's standing Committee on Public and Professional Information will play a part. In the past, standing committees devoted to a specific area of the specialty have developed information for distribution to other professionals or the public. They will probably do so on a larger scale in the future.

Members are reaping direct and indirect benefits from these activities. Program changes were noticeable at the separate 1978 meetings. With more educational time and format flexibility, specialty planners expanded the curriculum. One derivative of the conferences with other societies was greater emphasis on subspecialties in ophthalmology and otolaryngology and an increase in joint programming with subspecialty organizations. A possibility

that has received at least passing thought by leaders of both new Academies is that of holding regional scientific meetings in addition to the annual meeting. It is only one of many possibilities that will be considered by the new Academies as they look to the future.

The largest anticipated benefit of separate societies is simply the freedom for ophthalmologists and otolaryngologists to concentrate solely on the needs of their specialty. Events of the seventies were a consequence of the Academy's effectiveness and success as an educational organization and of the advances in medical knowledge to which the society was dedicated. In 1959, William Benedict wrote, "The evolution of an educational body in a group of practicing physicians to the extent that it has been accomplished in the Academy is without precedence in American medicine."[1] That is the Academy's legacy to its offspring, to the specialties of ophthalmology and otolaryngology, and to the future.

The material rending of the Academy occurred Jan 1, 1979. The assets, properties, and affairs of the Division of Ophthalmology and Division of Otolaryngology were transferred to the new corporations. The American Academy of Ophthalmology and Otolaryngology, Inc, was dissolved. On April 15, 1979, the American Academy of Ophthalmology moved its headquarters to San Francisco. The American Academy of Otolaryngology retained the Headquarters Office in Rochester, Minn.

In 1981, the American Academy of Ophthalmology and the American Association of Ophthalmology merged, but the name American Academy was retained.

Also in 1981, the American Academy of Otolaryngology—Head and Neck Surgery and the American Council of Otolaryngology merged, and the expanded Academy name was retained.

Strictly interpreted, no historical period has a life of its own apart from the past of which it is the projection and the future to which it leads. Yet in a sense each day has its own biography.

JOHN W. DODDS, QUOTED IN
Stanford Mosaic, 1962