Part 4

EVOLUTION AND ADAPTATION

28. Rank and Requirements

The success or failure of any medical society or similar scientific body is merely a reflection of the interest and labors of its members.

GORDON B. NEW
THE PRESIDENT'S ADDRESS, 1945

THE ACADEMY always prided itself on being a democratic organization, meaning that its doors were open, with reasonable restrictions, to all those practicing ophthalmology and otolaryngology. The society was considered the "primary" organization in ophthalmology and otolaryngology, the one that young men joined first and that represented all manner of interest and all facets in the specialties.

The Academy was somewhat avant-garde in its successful attempt to create a national educational medical society—many medical groups were small, restrictive, or local or all three—and in its philosophy that it was the new and inexperienced specialist who most needed membership in medical organizations. Dr Wherry was fond of pointing out in the 1930s that in the larger specialties, the many small medical groups were being amalgamated into larger academies, on the order of the Academy.

"Fewer but stronger societies," he said, "having definite educational objectives are desirable, not only from an economic viewpoint but also since in strength lies ability to fulfill an expectancy."[1]

The nature of the basic requirement for Active Fellowship in the Academy changed only once over the years. Prior to creation of the American Board of Ophthalmology and the American Board of Otolaryngology, a candidate for membership had to have been engaged in special practice for a specified period of time. Three to five years in special practice was required at first, and this was later reduced to one year.

In the early 1920s, Board certification was required. The ophthalmology and otolaryngology Boards were the only acceptable certifying bodies until 1942 when the American Board of Plastic Surgery was added to the list.[2(p133)] Constitutional revision, effective in 1953, deleted the naming of specific Boards and left it to the discretion of the Council.[3(p958)]

In turn, the Council approved certification or accreditation by the Royal College of Physicians and Surgeons of Canada in 1953, by the Royal College of Surgeons of England in 1962, and by the Royal College of Surgeons of Edinburgh, Royal College of Surgeons of Ireland, Royal Australian College of Surgeons, and Royal Australasian College of Surgeons (New Zealand), all in 1976.[4(p923), 5(p110), 6]

Divisions or extensions of the Active Fellowship category varied over the years to accommodate tradition and circumstance.

The first division was the Member-Fellow distinction, established in 1903, which separated the new specialist (Member) from the specialist with more experience (Fellow). This ranking was a period piece in an era when most specialty societies limited their membership to those of established reputation. A longer time in specialty practice and a thesis were required of Academy Fellows. A Member could be elevated to Fellowship after two years in the Academy, provided he met the other requirements.

Constitutional revision in 1912 deleted the two classes of membership in favor of a single class of Active Fellows. Also included in the constitution was a status called Life Membership, to which Active Fellows could be elevated as a reward for service. As the name connotes, this was a paid up Life Membership in the Academy with all attendant privileges. For more than 20 years, there was no defined criterion for awarding Life Membership, and it was the Council's prerogative to recommend candidates. Election required a unanimous vote of the members. In some instances, Life Membership was an alternative to being, as some called it, "kicked upstairs" to Honorary Fellowship, which took men out of the mainstream of Academy affairs since Honorary Fellows could not vote or hold office.

The custom of making especial men Honorary Academy Fellows dated back to the Academy's earliest days. This was a signal honor that could be granted to anyone who aided medical progress in the specialties (Fig 57). The requirements and obligations for Active Fellowship did not obtain. The Council recommended candidates, and election required a unanimous vote of the Academy at an annual meeting.*

The Great Depression precipitated another division of the Active Fellowship in 1934 (Fig 58). Despite the Depression, the Academy's financial picture remained sound and one of continued growth. Partially because of this, the Council agreed to follow an extremely liberal policy in the matter of unpaid dues, with the result that by September 1933, fully 21% of the membership was delinquent.[7(p447)] The Academy was forced to tighten up its policy on delinquent dues, but at the same time a classification of Senior and Junior Fellow was instituted.

A member was classified as a Senior Fellow after he had paid dues continuously for 25 years, and his annual dues were reduced to one half the usual amount. After payment of dues for five years as a Senior Fellow, he automatically became a Life Member with no dues required. All other members (except Honorary) were designated Junior Fellows.[7(p447)] The Senior and Life membership classifications were a way of expressing appreciation for continued fellowship and service to the Academy's senior citizens who were thought to be less economically stable than the younger men.

It may be added that the annual dues set by the Council were and would remain for many years modest in the extreme. The dues increase from $5 to $10 in 1921 (the extra $5 designated to build the Research Fund) was allowed to stand for almost 30 years until there was a slight increase to $12 in 1950.[8(p148)]

The Academy had managed quite well. Most of the planning and administration of programs was done voluntarily by members; the society did not maintain an expensive headquarters

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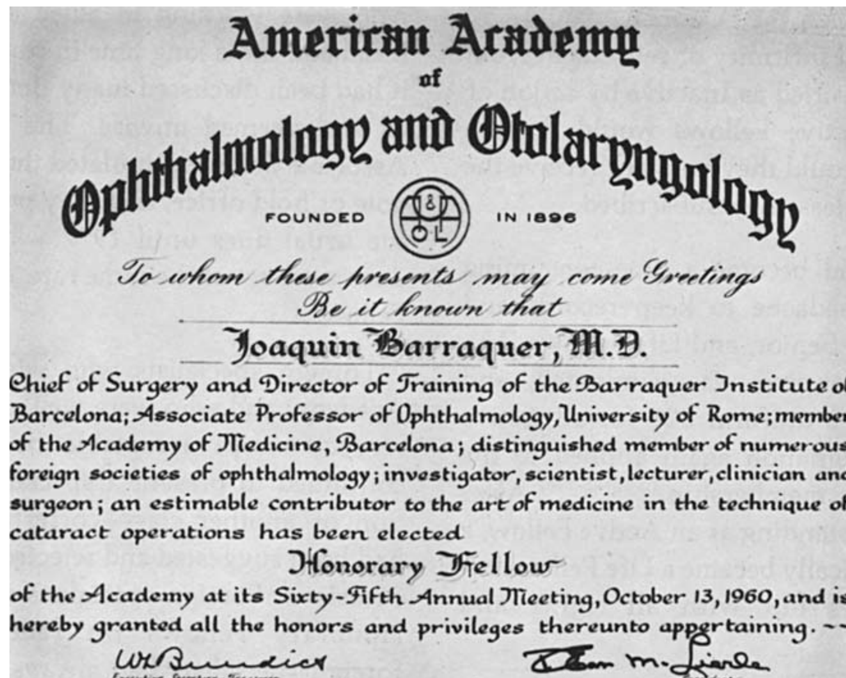
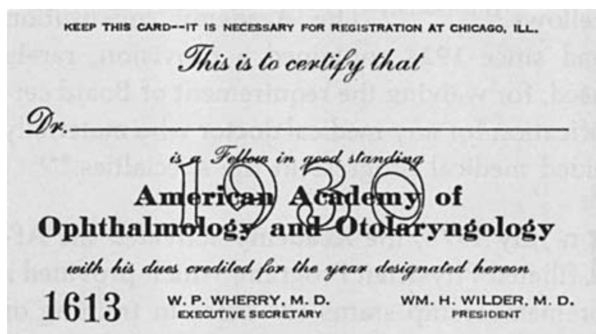
*Under new Bylaws adopted in 1977, all candidates for membership had to be recommended by the Academy Board of Directors and receive a three-fourths affirmative vote at an annual meeting. Unanimous approval of Honorary Fellows or of Active Fellows admitted under the clause waiving Board certification was not required. Further revision of particulars, but not of membership classes, was made in the separate Bylaws for the American Academy of Ophthalmology, Inc, and the American Academy of Otolaryngology, Inc. Most important among these was the requirement by both Academies of 35 rather than 25 years in good standing as an Active Fellow before the automatic awarding of Life Fellowship.



American Academy
of
Ophthalmology and Otolaryngology
FOUNDED IN 1896

To whom these presents may come Greetings
Be it known that
Joaquin Barraquer, M.D.
Chief of Surgery and Director of Training of the Barraquer Institute of Barcelona; Associate Professor of Ophthalmology, University of Rome; member of the Academy of Medicine, Barcelona; distinguished member of numerous foreign societies of ophthalmology; investigator, scientist, lecturer, clinician and surgeon; an estimable contributor to the art of medicine in the technique of cataract operations has been elected
Honorary Fellow
of the Academy at its Sixty-Fifth Annual Meeting, October 13, 1960, and is hereby granted all the honors and privileges thereunto appertaining.--

Fig 57.—Honorary Fellowship certificate.



KEEP THIS CARD--IT IS NECESSARY FOR REGISTRATION AT CHICAGO, ILL.
This is to certify that
Dr. ____________
is a Fellow in good standing
1930
American Academy of
Ophthalmology and Otolaryngology
with his dues credited for the year designated hereon
1613 W. P. WHERRY, M. D. EXECUTIVE SECRETARY WM. H. WILDER, M. D. PRESIDENT

Fig 58.—Membership card as first provided in 1930.

operation; and programs tended to be self-supporting. In addition to administrative costs, the largest yearly expenditures were for the annual meeting and the TRANSACTIONS, and these expenses were more than offset by revenues from each. (Besides income from advertisers and subscribers, TRANSACTIONS' revenues included a portion set aside from members' dues and candidates' fees.)

However, in the late 1940s and early 1950s, the expenses of administration and of the TRANSACTIONS went up astronomically (from 1946 to 1951, general administrative costs, which included heavy support for committees, for the film "Embryology of the Eye," and for publication of the transactions and directories from the first Pan-American Congress of Oto-Rhino-Laryngology and Broncho-Esophagology, went from $18,000 to $78,000, and the costs attendant to publishing the TRANSACTIONS went from $14,000 to $35,000). In 1951, the Academy squeaked by on a narrow deficit margin, with expenses exceeding income by $877.62. By 1952, the TRANSACTIONS was operating with a $20,000 deficit. Surviving the increased overhead expenses meant another dues increase, this time a more hefty one to $20 in 1954.[4(p924)]

In the meantime, the Council had approved (in 1950) a new membership classification of Inactive Fellow.[9(p177)] For years, the Council had dealt individually with the cases of members who for various reasons, temporary or permanent, found dues an economic hardship and requested exemption. Inactive Fellowship was a way of allowing those members who no longer required active membership to retain some participation in the Academy. Senior and Junior

Fellows, delineated the Council, could by reason of physical infirmity or retirement from practice, be reclassified as Inactive by action of the Council. Inactive Fellows would pay no dues but neither could they vote nor receive the TRANSACTIONS unless they subscribed.

By 1960, it had become a time-consuming administrative headache to keep records and books for Junior, Senior, and Life Fellows. The Junior-Senior grouping was eliminated, and dues were set at a uniform $25 for all Active Fellows, the designation again applied to the main body of the membership.[10(pp845-846)] After 25 years in good standing as an Active Fellow, a member automatically became a Life Fellow, exempt from dues but with all rights and privileges.*

Another small annual dues increase of $5 came in 1963, with the entire amount going to the TRANSACTIONS.[5(p107)] Finally, by the end of the 1960s, the Academy was faced with either bowing out to inflation or catching up with it and allowing some leeway for both future inflation and future development. The increase to $100 in 1970 helped launch the Continuing Education Programs and put Academy operations in readiness for expansion.†

The Academy requirement of Board certification for all but those few men whose accomplishments gained them Honorary Fellowship left out many scientists who were working in areas closely related to ophthalmology and otolaryngology but who were not themselves specialists in the Academy fields—a group that grew larger as the science and technology of each specialty developed—and it also excluded foreign ophthalmologists and otolaryngologists who were not likely to be certified by an acceptable Board.

In 1957 a membership category of Associate Fellow was added to extend membership to distinguished scientists and physicians who were not ophthalmologists or otolaryngologists but who were working in allied fields.[11(p856)] The idea had been a long time in coming to pass, for it had been discussed many times by the Council and deemed unwise. The rules governing Associate Fellows stipulated that they could not vote or hold office, and they paid only one half the usual dues until 1977 when their annual dues were set at the same rate as that for Active Fellows.†

Foreign specialists who wished to join the Academy and who were well qualified in every respect except acceptable Board certification continued to present a special problem. Creation of another class—corresponding fellow—had been suggested and rejected on a number of occasions. Foreign specialists were admitted as Honorary Fellows (in fact, distinguished foreign specialists had always accounted for a fair share of the Honorary Fellowship), as Associate Fellows, and even at times as Active Fellows.[12(pp150-151)] The Academy constitution had since 1924 contained a provision, rarely used, for waiving the requirement of Board certification for any medical doctor who materially aided medical progress in the specialties.*[13]

In July 1974, the Academy activated the Affiliated Physician Program, which provided a premembership status for those in training or those just out of training and not yet Board-certified. This idea, too, was an old one, first suggested in 1939 when the Academy was considering home study courses for residents. Provisional membership for specialists in training was proffered as one official way of extending the Academy's educational programs beyond the immediate membership.[14(p13)]

The Affiliated Physician Program was for graduates of accredited medical schools who were in a full-time ophthalmology or otolaryngology training program or in a precer-

†For further changes in the annual dues, see chapter 33, "The Corporate Anatomy," p 304.

tification status for a medical specialty Board acceptable for Academy membership. To be eligible, a physician had to be enrolled, or have been enrolled, in the Ophthalmology Basic and Clinical Science Course or the Otolaryngology Continuing Education Course. After participation in parts I and II of a course, membership in the Affiliated Physician Program could be extended for a maximum of four years by paying a $25 annual fee.

Affiliated physicians enjoyed the privileges of preregistering for an annual meeting without charge and purchasing instruction course tickets before the meeting. They also received the news bulletin as an introduction to the Academy and its educational activities.