29. The Changing Fellowship

There is no real excuse for combining the specialties on account of any anatomical relationship. They merely happen both to be in the head.

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TO TEACHERS' SECTION, 1938

A 1957 SURVEY of the specialty of Academy members showed ophthalmologists outweighing otolaryngologists 47% to 30%, with 23% of members still combining the specialties. These percentages reflected the actual practice of the 85% of members who responded and not their Board certification.[1(p752)]

First EENT specialists, then otolaryngologists, and now ophthalmologists held a plurality in the Academy. These fluctuations had passed virtually unremarked and unrecorded. Otolaryngology's recruitment problems had contributed to the shift in the dominant specialty. Of far greater consequence to the Academy was the dominance of those practicing only one specialty over those practicing both.

Theories on why the eye and the ear, nose, and throat were combined in specialty practice are roughly equivalent in number to the number of those who have addressed the subject. Probably the only safe thing that can be said on the matter is that the eye, ear, nose, and throat were all sensory organs, all vital to perception and communication, and all above the clavicle.

The practice of EENT got its foothold at a time when many physicians who chose to specialize adopted two or more areas. There was no particular rationale for the specialties practiced together. They were presumedly chosen on the basis of personal proclivity for certain types of cases and community requirements. Limitations of knowledge and of what could be done for the patient and communities undermanned with physicians dictated a versatile specialism.

Although ophthalmology as a specialty was more developed than otolaryngology a hundred years ago, it was also a most popular sideline of everyone from the itinerant medicine man who rolled through town hawking cures for all ailments to the the general practitioner and surgeon. Otolaryngology covered such a broad and nebulous zone that it was not considered a sideline but rather stock in trade for most practitioners.

Physicians generally didn't consider either specialty developed enough to merit exclusive practice. Charles H. Mayo is said to have remarked that in his early days of practice he did cataracts and mastoids between operations.[2] General surgeons, in fact, did much of the ophthalmologic and otolaryngologic surgery.

The combination of eye, ear, nose, and throat appeared at least superficially logical, and it came to be perceived by the public as one branch of medicine. In specialty education, most of which took place at the practice level, the organs were grouped together although they were studied separately. The medical profession itself treated EENT as one branch of specialism. Statistics in the 1920s and even 1930s on specialties chosen by medical graduates lump together ophthalmology and otolaryngology under the designation EENT.

As science began to be added to the art of medicine, first slowly and then at an almost incredible pace, not only did ophthalmology and otolaryngology become distinct full-time specialties but subspecialties developed within each specialty, and the process continues. Separate examining Boards and separate, university-based training programs helped disjoin ophthalmology and otolaryngology in training and in practice. Although it became less common for young physicians to attempt training in both specialties during the 1930s, there were still plenty of established EENT specialists. Time alone would wither their numbers.

From its beginning, the Academy, reflecting the attitude of its members, regarded ophthalmology and otolaryngology as separate specialties—and sciences—that were often practiced together. This philosophy neither encouraged nor discouraged combined practice; it merely recognized, respected, and accommodated it. Educational programming, committee work, and other phases of endeavor were planned cooperatively on a separate but equal basis, with accommodation made for those practicing both specialties.

There was little interest on the part of Academy leaders in determining how many members practiced ophthalmology, how many otolaryngology, and how many combined the two. For many years, there was a fair contingent in all three categories, and the society's job was to serve them all.

When combined practitioners reigned as an obvious majority, meeting programs were arranged so that members could attend both ophthalmology and otolaryngology sessions. In 1924, the custom of scheduling a few concurrent sessions was abandoned at the request of specialists who did not want to miss any of the scientific reports. Later, as combined practice declined and the Academy was faced with devising a more effective utilization of time and space at meetings, one specialty's instruction courses were run simultaneously with the other specialty's scientific program, an arrangement that still gave the EENT specialist an option.

When the Academy was smaller and ophthalmologists and otolaryngologists were more allied professionally and within the Academy framework, there was good-natured partisanship. Harris Mosher was always good for a roguish verbal arrow aimed at the ophthalmologists. Once, after listening to a lengthy discourse from the ophthalmology side, Dr Mosher grabbed attention with, "I am quite sure that I should bore some of the eye men, and I am absolutely sure that some of them bore me"[3]—and then proceeded with an oration twice as long. In truth, two heads were often better than one in working out educational plans and problems, and both specialties benefited from the rebound of ideas.

For purposes of organization and administration, the Academy classified members by type of fellowship (Active, Honorary, Life, and others) but not by specialty until the 1970s. Specialty listings in the Academy directory chronicle changes in the makeup of the membership, but the directory does not always give a true reading of the practice situation.

Prior to 1918 no specialty designation was included in the roster of members. By 1920 most members had specified their field of practice as they wished it announced, and the directory shows that 65% combined the specialties, 17% practiced otolaryngology exclusively, 15% practiced ophthalmology exclusively, and 3%

did not specify. Most of the combined specialists practiced the full range of both specialties, but a few practiced ophthalmology and one or two areas of otolaryngology. The most popular limited combination was ophthalmology and otology.

Twenty years later the percentages look much different. The 1940 directory listings indicate only 23% of members in combined practice, 47% in otolaryngologic practice, and 30% in ophthalmologic practice. The trend represented by these percentages is no doubt accurate, but the percentages are weighted by certain Academy rulings and reflect only partial truth regarding the actual practice of members.

A constitutional amendment approved in 1929 (and effective through 1952) stipulated that Fellows would be classified in the membership directory as practicing only that specialty for which they held a Board certificate and would not be listed as combined specialists unless they held a certificate from both Boards.* The ruling was applicable only to Fellows elected after 1929 and not to those already Academy members, some of whom held no Board certificate.[4(p528),5(pp957-958)]

The effect of this amendment, and perhaps as important, of the changing pattern of practice, is quite apparent in the 1940 directory. More than half of the Life and Senior Members listed themselves as combined specialists, while only 19% of the Junior Members were allowed to claim both specialties. It was widely acknowledged that many members listed by their specialty Board certification were actually practicing both specialties.

*Even after the directive that members be listed in accordance with their Board certification was stricken from the constitution, the practice carried over, and directory listings continued to understate the frequency of combined practice. Once again, in 1974, the Council approved a motion that specialty designations in the directory be determined by Board certification. The later ruling concerned primarily secondary designations, such as plastic surgery, since the practice of both specialties was by that time rare.

It would be hard to find any specialists today who would relish the idea of having to pass the examinations of two specialty Boards, and it is likely the same held true a few decades ago. The Academy added another rock on the scale that further discouraged physicians from attempting certification by both Boards. It had happened that men would take the examination of one specialty Board and, failing that, would then take and pass the examination of the other specialty Board, thus making themselves eligible for Academy membership.

In 1927, a resolution was adopted which stated that a candidate failing either the ophthalmology or otolaryngology Board could not be accepted for membership until he first cleared the failure.[6(p381)] Although the resolution was meant to protect the integrity of the Boards and the Academy requirements for membership, its likely effect was to influence new specialists, many of whom had some training in both specialties (and practiced both specialties), to apply for certification from that Board whose examination they felt most assured of passing. This ruling was rescinded in 1939.[7(p25)]

Because of the listing-by-certification mandate, and the probability that many combined specialists, once they had passed one Board and qualified for membership, became too busy and too far removed from their training to bother with another Board examination, directory listings during the thirties and forties give a good picture of the Board certification of members but a rather distorted picture of practice.

During the 1940s, ophthalmology candidates for membership began to catch up in number to otolaryngology candidates. By 1950, it was about an even split, and then otolaryngology candidates nose-dived to a mere 75 in 1955 as compared with 257 ophthalmology candidates.

The tables turned, and the 1957 survey revealed an exact reversal of the 1940 oto-

laryngologist-to-ophthalmologist ratio. Among the almost one fourth of members who said they practiced ophthalmology and otolaryngology, 17% were certified by the American Board of Ophthalmology, 61% by the American Board of Otolaryngology, and 22% by both Boards.[1(p752)]

The survey was taken to garner information for the Teachers' Sections and to determine if costs might be cut by distributing such items as the *American Orthoptic Journal* only to those interested. As late as 1954, it had been guesstimated that 65% of members were practicing in both fields and that attempts to adjust mailings by specialty would result in minimal savings.[8(p904)] The survey proved this wrong, and some discrimination in distribution of material ensued.

Reliable data on the practice of members would become more important as ophthalmologists and otolaryngologists became uncomfortable with the Academy's representation of two specialties. President Lawrence R. Boies polled the membership again in 1962 and found combined specialists had faded to 14%.[9(p16)] Another decade and there would be only a scattering of them left. Ophthalmologists would continue to outnumber otolaryngologists and by a slightly larger margin—59% to 39% in 1977.