25. Concerns During the Fifties

No doctor can conduct a general medical practice with satisfactory service to his patients unless he has a working knowledge of disease of eyes, ears, nose and throat.

A. C. FURSTENBERG, 1959

In 1950, 33% of approved residencies in otolaryngology were vacant, and in 1951, 40% of the approved first-year residencies were unfilled.[1] It must have been the height of irony and frustration for many men who had worked so hard to provide residency positions to find them going begging. The specialty once claimed by so many was now being chosen by so few.

The dramatic decline in applicants for otolaryngology residencies was in part due to the attitude that the advent of antibiotics had dealt a mortal blow to the specialty. Young physicians harbored the notion that the field was shrinking and wasn't broad enough to warrant three years of training after internship.

However, the question of how far a young man could go in the field had been around for a long time. Harris Mosher had been asked by medical students of the 1930s if there was any future in otolaryngology as compared with medicine and surgery. His answer was always, "Prevent chronic progressive deafness, cure otosclerosis, or otitic meningitis, and a monument in the Hall of Fame awaits you."[2]

There was determined effort during the fifties to retard erosion of the specialty's scope and to broaden the dimensions of practice by expanding knowledge and abilities in the field. The decade brought new developments in otology and new emphasis on head and neck surgery, on surgical restoration of function, and on research.

While the specialty's most prominent members spread the gospel of vast room for medical progress in otolaryngology, recruitment to the specialty was a major issue. How well otolaryngology was represented and presented during the years of medical school and internship would, of course, influence future practice decisions.

Although ophthalmologists were not experiencing the same problems as otolaryngologists, they were equally disturbed by the disparity and frequent inadequacy of undergraduate instruction in their specialty. "If we wish to have a sufficient number of men entering our specialties, we must do a job of undergraduate education,"[3] asserted A. D. Ruedemann, Sr.

Concern with the medical student's education in ophthalmology and otolaryngology began to take shape in the 1940s. Before being abolished in 1942, the Teachers' Section had

turned its sights on undergraduate education. The question was how much training in ophthalmology and otolaryngology a medical student needed before he could be loosed on the public as moderately "safe."

Time was limited for the medical student. Discussions of the necessary training held an air of compromise and resignation to the less than optimal. Thomas J. Walsh, who had just taken over the Department of Otolaryngology at Washington University, St. Louis, expressed it. "If we are going to teach otolaryngology in the undergraduate school, we have at least to give it sufficient time to make the student able to use his tools and to make him conversant with the diagnoses he is going to come across. It is not our showing him mastoids, because I don't think even the boldest of them will try to do mastoidectomies unless they have had experience. They will try to do tonsillectomies. They will miss the diagnosis of cancer of the larynx. They will leave a man hoarse for a long time, simply because they cannot look into a larynx. I think it is our job to show them how. . . ."[4(p187)]

The consensus was that medical students should be taught enough ophthalmology and otolaryngology to recognize disorders and their relationship to general diseases and to pass on a patient to the specialist when warranted. Dr Ruedemann alleged that the paltry undergraduate instruction in ophthalmology and otolaryngology engendered a feeling of disrespect among general medical men for the specialist and a lack of confidence in what the specialist could do. A patient was turned over to the ophthalmologist, he claimed, only as a last resort. "We just are not training our internists to recognize either ophthalmology or otolaryngology as a specialty to fit their needs, and we are not training sufficient men in either field to fit the needs of the public."[4(p185)]

In 1946, the Academy appointed a committee in each specialty to outline a proper undergraduate introduction to the specialty.

The ophthalmology committee sent questionnaires on the amount and nature of ophthalmic training to directors of ophthalmology departments at 40 leading medical schools. Based on a study of the replies, the committee formulated a general model for undergraduate instruction. They recommended that study of the anatomy, physiology, and pathology of the eye be included as part of the regular courses in these subjects and that a minimum of 40 hours and a maximum of 60 hours be required in the department of ophthalmology (with 60% to 80% of the time devoted to clinical instruction).[5] Their report was published and sent to the deans of medical schools and to professors of ophthalmology.

The otolaryngology committee prepared similar questionnaires but soon found that their project was being duplicated by the American Board of Otolaryngology and took no further action. LeRoy Schall was heading the Board's Committee on Undergraduate Teaching whose job was to construct a minimum program for undergraduate instruction.[6] When Dr Schall arranged a gathering of otolaryngology teachers at the Academy's 1949 meeting to discuss his committee's recommendations, the interest aroused—and the problems in otolaryngology—precipitated a request to the Academy's Council to reinstate a Teachers' Section.[7]

The ophthalmologists echoed the request, and in 1950, the Council approved the idea, with Lawrence R. Boies in charge of the otolaryngology section and A. D. Ruedemann, Sr, again in charge of the ophthalmology section.

For the next 14 years, questions related to the teaching of the two specialties received yearly analysis, with the hope of formulating plans for improvement. Sometimes the sections combined their programs to discuss undergraduate education and the need to see that enough introduction to the specialties was provided in medical school and internship to attract students of high quality into the fields. By 1964,

both groups seem to have lost incentive and they were disbanded for a second time.

With respect to undergraduate education, both specialties suffered similar treatment. Gordon Hoople reported in 1956 that the amount of time allotted for teaching otolaryngology in medical schools ran the gamut from 4 hours to 152 hours.[8,9] Dr Ruedemann reported that the number of hours devoted to ophthalmology peaked at 180 hours and bottomed out at 0.[3]

Such statistics elicited similar responses from both groups of specialists. Basic familiarity with the specialty should be part of the working knowledge of every physician. And lack of exposure to the specialty in medical school and internship—a poll showed 50% of beginning interns had not decided on a specialty[1]—made it less likely for physicians to consider it a practice option.

Otolaryngologists pointed out that a large share of everyday patient care fell within their boundaries. Surveys indicated that 25% of a general practitioner's work was otolaryngologic,[8] and some put the percentage much higher. It made no sense, they insisted, for the subject to have less than 2% of all clinical teaching time allotted to it.

When the AMA Council on Medical Education and Hospitals failed to approve internships in ophthalmology and otolaryngology in 1953, many decried the action. Since a majority of states made an "approved" internship mandatory for licensure, applications for ophthalmology and otolaryngology internships were withdrawn.[10] The ophthalmologists were particularly chagrined. Alan Woods called for an official protest from the Academy.[11(pp923-927)] Algernon Reese said there was a feeling the specialties sometimes got inferior men because young physicians could not afford a long training period after internship.[12(p815)]

Dr Woods and others believed that the medical graduate could safely embark directly on his specialty training, provided the hospital had the facilities to present, during the first year, the necessary experience and orientation in general medicine and surgery. His protest motion, however, was voted down by Academy members.[12(pp814-815)]

Otolaryngologists were most concerned with establishing a positive image and future for their specialty. This meant in part a well-defined status for the specialty in medical schools and hospitals. Otolaryngology's rather fluid boundaries with general and specialty medicine produced an identity problem at the academic and practice level. This was a cause of mounting anxiety and, before long, action that vocalized for the first time the idea of splitting the Academy.

In cultivating research and development in otolaryngology, the Academy committees on conservation of hearing, plastic and reconstructive surgery, head and neck surgery, laryngeal and voice physiology, and research in otolaryngology all played a part. New interest and attainments in subspecialty areas were to expand the capacity of practice and the extent of education. To keep tabs on the progress of teaching, the otolaryngologists revived their Teachers' Section in 1968.