The American College of Osteopathic Surgeons

A Proud History



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By Ellis Siefer, D.O.
College Historian





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Author's Note

This book about the American College of Osteopathic Surgeons (ACOS) is more than a history of the College from its founding in 1926 to the present. It also is a tribute to the visionary leaders and committed members who have nurtured and directed the ACOS and the profession. Their tireless devotion and numerous contributions have been invaluable in raising training standards for osteopathic surgeons and, thereby, the quality of patient care, and in giving osteopathic physicians a respected voice in the greater medical community and our nation's capital.

It is my hope as you read this book that you will better appreciate and take even greater pride in the many achievements the College and our illustrious profession have made in the last sixty-nine years. And, by knowing where we have been and how we have evolved, you will come to understand more fully the challenges we face today and tomorrow.

Like so many other books, this one would not have been written without the help of numerous individuals who lent their time and support, and supplied me with the records, correspondence, and materials a work of this magnitude required. I espe-

cially want to thank Executive Director Guy D. Beaumont, Jr.; Wanda Highsmith, former senior assistant executive director/meetings manager; the late Esther F. Martin, former executive secretary of the ACOS, former executive director of the American Osteopathic Board of Surgery, and wife of the late Orel F. Martin, D.O.; and Howard R. Graney, D.O., who played an invaluable role in the development of this history.

I also would like to offer my thanks to T. Susan Hill and Beth Mende Conny of Network Communications for their editorial assistance, and to the United States Surgical Corporation and ACOS Auxiliary, whose financial support made the production of this book possible.

Ellis Siefer, D.O.
January 1995

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Chapter 1: The Early Days

1926–1939

From its modest beginnings in 1926, the American College of Osteopathic Surgeons (ACOS) matured quickly, devoting itself to the setting of high educational standards and the development of educational opportunities for its growing membership.

Its early years were filled with many achievements, from the inauguration of annual meetings—precursors of the Annual Clinical Assembly (ACA)—which featured live presentations, to the creation of standards for teaching and nonteaching osteopathic hospitals and the physicians who sought to practice in them. These years also witnessed the creation of the first osteopathic hospital training program for interns, the establishment of membership categories that incorporated different levels of training, and the recognition of the College's first Fellows.

Such efforts, coupled with the dedication and farsightedness of ACOS's founders, set down the roots that enabled the College to continue its healthy growth and to meet the many challenges that lay before it.

Early Days

In June 1926, fifty-two years after physician Andrew Taylor Still founded a school of osteopathy, ten surgeons met during the American Osteopathic Association (AOA) convention in Louisville, Kentucky, to discuss the founding of a new professional association. Its purpose: to set high educational standards for its members and to provide continuing surgical education.

On January 26, 1927, that dream became a reality, and the American College of Osteopathic Surgeons was incorporated as a not-for-profit, tax-exempt organization. Dues were $10 per year and covered mailing and some meeting expenses.



Andrew Taylor Still (center), founder of osteopathic medicine, with several of his students. Seated on his immediate right is Orrin O. Bashline, D.O., one of ACOS's founding members. Kirksville, Missouri, circa 1907.

According to charter member Albert C. Johnson, D.O., the College's founders "were desirous of retaining the osteopathic concept in its relationship to the practice of surgery, for each of them was sufficiently experienced in surgical practice to recognize the value of Dr. Still's teachings in the care of surgical patients. Up to the present time that osteopathic influence still prevails wherever the members of the American College of Osteopathic Surgeons gather."

Initially, the College was to meet with the AOA on a yearly basis. Difficulty in arranging space at the AOA convention and differences between the groups'

ACOS Chronology

- ***1874***—*Physician Andrew Taylor Still founds a school of osteopathy.*
- ***1926***—*The Bureau of Hospitals is first mentioned in the 1926-1927 American Osteopathic Association yearbook.*
- ***January 26, 1927***—*The American College of Osteopathic Surgeons (ACOS) is incorporated. The American Hospital Administrators (Osteopathic) is folded into the ACOS.*

educational programs, however, led to a 1928 decision to hold separate meetings. Nevertheless, College members continued to recognize the importance of the AOA in the profession.



George M. Laughlin, D.O., one of the founding members of the ACOS.

Precursors of today's ACA, the meetings were held every year from 1928 to the present, with the exception of 1945, when wartime travel restrictions forced the cancellation of that year's program. The meetings themselves were designed as a forum for osteopathic surgical specialists to engage in ecumenical educational programs. Held in cities that had more advanced hospital surgical facilities, they featured the very first live surgical presentations (or "wet clinics," as they then were called), using patients who had been gathered specifically for them. The clinics gave attendees an opportunity to exchange surgical techniques and ideas, as did the presentation and discussion of original scientific papers taken directly from members' practices. In addition, members had an opportunity to view motion pictures, which were introduced as a teaching aid at the 1929 annual meeting. The subject of the first film, provided through the courtesy of Davis & Geck, was methods of preparing catgut for suture material.

From ACOS's original incorporation statement

"We, Dr. George M. Laughlin, Dr. John Deason, Dr. S.D. Zaph, Dr. O.G. Weed, Dr. F.R. Bigsby, Dr. A.G. Hardy, Dr. Orel F. Martin, and Dr. Harry Collins, do by these present enter into an association for educational, scientific, and fraternal purposes under Article II, Chapter 90, of the Revised Statutes of Missouri, 1919, as herein after more fully set forth."

—January 26, 1927

Highlights of the 1929 Annual Clinical Meeting Program
Kansas City, Missouri

The Problem of Training the Prospective Surgeon
The Standardization of the Postoperative Care
Professional Responsibility to the Osteopathic Hospital
The Business and Ethical Relationship between Specialist and Referring Physician
Arthroplasty of Hip and Elbow
Prostatectomy and Nephrectomy
Reduction of Fractures under Local Anesthesia
Cholecystectomy
Gastric Resection

Hospital Standards/Inspections and Surgical Residencies

From its earliest years, the College set standards for teaching and non-teaching hospitals in cooperation with the AOA's Bureau of Hospitals.* This cooperative arrangement had its roots in the way osteopathic hospitals then were managed. Usually, a surgeon was the chief executive officer, and these surgeon CEOs had their own society, the American Hospital Administrators (Osteopathic), or the AHA. They met with AOA, but when the College was established, the AHA folded into the ACOS, and its members brought to the College their interest in hospital standards. The AHA also transferred its funds to the College's treasury. Thus, the AOA Bureau was composed almost entirely of ACOS senior surgeons, and they performed all hospital inspections during the College's first decade. (Orel F. Martin, D.O., Harry L. Collins, D.O., and John P. Schwartz, D.O., who founded the hospital inspection program, conducted the majority of these inspections.)

In addition to hospital inspections, the ACOS made recommendations to the AOA regarding the qualifications surgeons had to have to operate in approved hospitals. Until the ACOS developed these standards, the only qualifications required to do surgery were those established by individual hospitals.

The College also set standards for formal hospital training programs. This was especially important because at the time the ACOS was founded, the surgical residency, as it is known today, was unavailable in osteopathic institutions. Most surgeons received their surgical training through preceptorships, serving as apprentices or assistants to surgeons until they were deemed qualified to perform procedures on their own. Such training was often supplemented by having surgeons visit outstanding teaching centers in the United States and Europe.

As another of their early tasks, ACOS founders decided to allow interns who had fulfilled certain requirements the opportunity to work at other hospitals for a period of one month; all of their expenses were paid. This was the first time trainees were able to participate in a so-called "out-service" program. Participating hospitals included Southwest Osteopathic Sanitorium

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* *Today, the Bureau of Hospitals is called the Bureau of Healthcare Facilities Accreditation.*

in Wichita, Kansas; Monte Sano Hospital in Los Angeles, California; Lakeside Hospital in Kansas City, Missouri; and Massachusetts Osteopathic Hospital in Boston, Massachusetts.

Early Membership Categories

As its membership increased, the College grew more sophisticated and established membership categories that incorporated different levels of training.

In its early years, the College established a Junior membership for young surgeons who were not yet qualified for Senior membership. Prior to 1935, Junior surgeons had to submit ten surgical cases and a scientific thesis. They also had to serve a one-year internship in a satisfactory training facility or document that they had served a preceptorship under a surgeon with recognized qualifications. After July 1, 1935, surgeons seeking Junior membership first had to complete one year of an approved internship, the standards for which were set by the ACOS. (An interesting note: Junior members were not allowed to advertise themselves as College members. Such advertising was considered unethical because they had not yet completed their training, and those who did advertise lost their membership.)

Surgeons who applied for Senior membership were required to meet all requirements for Junior membership and to present twenty-five surgical case records acceptable to the ACOS Executive Committee. In addition, applicants were to present a thesis within one year and to present one or more acceptable case records annually. (Publication of an article in an osteopathic periodical was considered equivalent to writing a thesis.)

Senior member applicants also had to present certified evidence of at least five years' first assistantship to a qualified surgeon, during which time they were required to have assisted in no fewer than 500 major surgical

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- *1928—The ACOS holds its first annual convention.*
- *1929—Moving pictures are introduced at the annual conference as a teaching aid courtesy of Davis & Geck. Also at the conference, the ACOS honors its first Fellows.*
- ***July 1, 1935**—Surgeons wanting to obtain Junior membership must complete a one-year internship. Surgeons applying for Senior membership must present twenty-five surgical case records, a thesis, and evidence of at least five years' assistantship to a qualified surgeon, among other requirements.*

operations, or to have performed no fewer than 300 major surgical cases on their own or under the supervision of a senior surgeon on the staff of a recognized hospital. (Prior to 1935, they were required to assist at 200 or more surgical operations, 100 of which were to be classified as major.) To maintain their standing as senior surgeons, they had to perform a minimum of twenty-four major surgical procedures each year.

The ACOS also created the membership classification of Fellow for surgeons who had at least five years' senior surgical practice. Fellow candidates had to show evidence of better than average surgical skill, participation as a surgical trainer, and service to the profession (e.g., lecturing at the annual convention, serving on College committees, etc.). Fellow candidates also had to be recommended by the ACOS Education Committee and elected unanimously by the ACOS Trustees.* The College conferred its Fellow degree** on its first three recipients at its 1929 meeting in Kansas City, Missouri. The recipients—George M. Laughlin, D.O., W. Curtis Brigham, D.O., and George J. Conley, D.O.—were cited for their "contribution to the welfare of humanity, through a lifetime devoted to the practice and teaching of surgery in the osteopathic field."

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* *Today's Fellow requirements continue to be stringent. Although unanimous approval by the ACOS Board of Governors no longer is required, a three-fourths vote is necessary.*

** *Years later, recipients were granted the "title" of Fellow rather than given a "degree," which can be awarded only by a college or university.*

Chapter 2: Growing Pains and Gains

1940–1949

Throughout the 1940s, the American College of Osteopathic Surgeons (ACOS) continued to raise educational standards and improve hospital training programs. It also established criteria for recognition of emerging surgical specialties and helped create the American Osteopathic Board of Surgery (AOBS) to certify the qualifications of osteopathic physicians. Meanwhile, other osteopathic specialty groups, societies, and associations emerged. Evolving from the American Osteopathic Association (AOA) was the American Osteopathic College of Radiology (AOCR), and from the ACOS, the American Osteopathic Academy of Orthopedics (AOAO). Both groups met annually with the ACOS at the Annual Clinical Assembly (ACA).

Concurrent with these efforts, the College upgraded its membership requirements to reflect the steady advances in surgical training. It also introduced new membership services such as *The Bulletin,* the precursor of today's *ACOS News.* These activities created a need for a permanent College staff and engendered sufficient interest among the growing membership that the concept of a trustee-led organization was abandoned in 1943 in favor of a member-elected board of governors.

ACOS Matures

During the 1940s, the ACOS undertook important organizational changes to provide a stronger structure to support the needs and interests of its growing membership.



Orel F. Martin, D.O., 1940

Of prime importance was the decision in 1940 to name a permanent administrator and to establish a College headquarters. Consequently, Orel F. Martin, D.O., of Boston, Massachusetts, assumed the office of ACOS Secretary/Treasurer. (His wife, Esther, assisted him and later would assume many of his responsibilities as his health failed.) Boston, thus, became the ACOS's first permanent headquarters location, giving stability to the maturing College, and it was to that city that then Secretary/Treasurer Albert C. Johnson, D.O., sent all of the materials necessary for conducting ACOS business: minutes of previous meetings, stationery, account cards, rubber stamps, the College seal, and the organization's cash balance of $398.55—all of which were kept in what correspondence jokingly referred to as a "shoe box."

Over time, Dr. Martin would become a legend within the College as well as a role model for future generations of osteopathic physicians. A "New England Yankee," he exemplified many of the positive characteristics of that stock: He was courageous, scrupulous, and of sound judgment. He knew right from wrong and acted upon his beliefs. And, despite years of poor health, he served the ACOS devotedly, helping to ensure its growth and working with colleagues to develop rigorous standards for hospital inspections and training programs.

At the 1947 ACA, Dr. Martin was offered a $5,000 honorarium in addition to expenses for his untiring work in support of the College. Soon after, his failing health, coupled with the rigors of a strenuous surgical practice and New England's harsh climate, necessitated his retirement to

Coral Gables, Florida, where he became the full-time Secretary/Treasurer of the ACOS. (ACOS headquarters would remain in Coral Gables, until 1985, when it was relocated to Washington, D.C.)

A second important organizational change was the adoption of a new constitution in 1943, which replaced ACOS trustees with a board of governors. In accordance with Article IV, only members who held the degree of Fellow were to serve on the Board, which was charged with directing and conducting all College affairs, except as prescribed by the bylaws. The Board was to have fifteen members, including nine elected members and the members of the Executive Committee: the President, Vice-president, President-elect, Secretary/Treasurer, and two immediate past presidents. The new structure was more democratic and gave members a greater voice in College governance.

The 1940s also saw the introduction of *The Bulletin.* Precursor of the *ACOS News,* it was the College's first regularly published newsletter and one of several services the ACOS established to meet members' interests and needs. Initially, it was sent to Senior members only. That policy changed in 1942, however, when all physicians who had completed their applications for Junior and Associate* membership received copies. A new dues structure, approved the year before, funded this and other new services.

Throughout the decade, the publication served as a vital link between the ACOS and its members, keeping them abreast of educational opportunities, professional matters, and College activities. For the first time, in 1944, it featured photographs, including one of the mayor of Detroit shaking hands with Dr. Martin and Past President Richard A. Sheppard, D.O., at that year's ACA.

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* *Then, as now, Associate memberships were available to certain nonsurgical physicians.*

ACOS Chronology

- ***1939****—The ACOS gives its approval to the formation of the American Osteopathic Board of Surgery (AOBS).*
- ***1940****—The AOBS is established and receives the AOA's sanction to qualify and certify general surgeons and specialists in urology, orthopedics, and anesthesia.*
- ***1940****—The ACOS hires its first permanent administrator—Orel F. Martin, D.O.—and establishes a College headquarters in Boston, Massachusetts.*

Bulletin

AMERICAN COLLEGE OF OSTEOPATHIC SURGEONS

Vol. IV NOVEMBER, 1944 No. 5



DR. GEORGE C. WIDNEY, Albuquerque, N. M. President 1944-45

OUR NEW PRESIDENT

Dr. George C. Widney of Albuquerque, N. M., was inducted into office at Detroit for the year 1944-45.

Doctor Widney became a member of the College in October, 1935.

He graduated from Kirksville in 1916 and formerly conducted a hospital at Lexington, Nebraska.

For the past four years Doctor Widney has been the head of the New Mexico Osteopathic Hospital at Albuquerque.

Congratulations and Good Wishes, Doctor Widney.

KEYS

Newly elected members desiring to obtain membership keys should address communications to:

DR. HAROLD E. DONOVAN
Donovan-Harris Hospital
Raton, New Mexico

Please enclose check in the sum of $9.75 with your order. (Orders take from six weeks to two months to fill.)

The Detroit Reporter

The 17th Annual Clinical Assembly held at Detroit was the most inspiring and successful meeting ever enjoyed by the A. C. O. S.

Doctor Kani, the General Chairman of Convention Arrangements, and his Co-Chairmen, Doctor Seyfried and Doctor Hovis, had planned all arrangements so that the Assembly in itself was a smooth-running "three-ring educational forum".

The Hotel Statler provided us with the most satisfactory and adequate facilities we have ever had.

His Honor, Mayor Edward J. Jefferies of Detroit, "broke bread" with our committee chairmen and the Board of Governors prior to the official opening of the meeting on Monday afternoon.

Msgr. Edward J. Hickey, Chancellor of the Archdiocese of Detroit, read the Invocation; and this was followed by an address of welcome by Mayor Jefferies.

Doctor Sterrett presented a program which was well diversified and of intense interest to all in attendance.

The speakers presented new and interesting papers; and the audience appreciated the "on time" feature which Doctor Sterrett provided through his "light signal" system.

The three hospitals presented a wide diversification of cases; and the surgeons' demonstrations were outstanding.

The splendid cooperation of the hospitals, their professional and nursing staffs, cannot be too highly commended.

There were 164 members of the College in attendance. The number of members and guests present exceeded any previous meeting.

Monday evening's Conclave, for members only, was easily the out-

(CONTINUED ON PAGE 2)



PAST PRESIDENT SHEPPARD and SECRETARY MARTIN Being Welcomed by Mayor Jefferies

The November 1944 issue of The Bulletin.

In 1948, *The Bulletin* featured an article titled "The Surgeon Must Be Able to Prove It." It was the earliest article to refer to a successful lawsuit against physicians. The case at hand dealt with proper consent forms and noted that many osteopathic hospitals had ruled that physicians had to carry professional liability insurance as a requisite for hospital privileges.

Hospital Training Programs Evolve

Throughout the decade, the ACOS continued to be integrally involved in the hospital inspection program, which was under the aegis of the AOA's Bureau of Hospitals. College members continued to serve as inspectors and to recommend educational standards for evolving internship, then residency, programs.

For approval of an internship program, the training period had to be no less than one year for credit to be given. Intern compensation was not to exceed $25 per month, and interns were not allowed to moonlight. Internship report forms were sent to all surgical trainees, who were required to outline all of the surgical work they performed during the year. The report, accompanied by a $5 validation fee submitted to the ACOS, was used to evaluate whether a physician's training complied with established ACOS standards for Candidate status.

The training of surgeons

"Most of the training an aspirant gets must come through his own efforts. No teacher can force knowledge into a student's brain. Consequently, most of the world's great surgeons have been largely self-made. If it were not so, the differences existing between operators would be slight. Halstead, Crile, Murphy, Balfour, Moynahan, and hundreds of others lifted themselves by their own bootstraps. Nobody taught Dandy how to do the first ventriculogram; Blalock had nobody to tell him how to anastamose the subclavian to the pulmonary artery.

"As always, there is plenty of room at the top. At the bottom and halfway up, the ladder is crowded. More of us who complain bitterly because somebody is always stepping on our fingers, might do well to climb up higher where the rungs are clear."

—From 1948 remarks made by Albert C. Johnson, D.O., ACOS's first Life Member. Dr. Johnson was an excellent surgeon and teacher, and an innovator who was one of the first proponents of early ambulation.

During this time, the College also recommended standards for practice

> "Resolved, that the Board of Trustees of the AOA in meeting assembled recommended that the approved standards recommended by the ACOS for the practice of major surgery in osteopathic hospitals be incorporated in the AOA *Hospital Inspection Code Book* (which pertains to the approval of hospitals for the teaching of interns) and that the adoption of those standards be made a prerequisite for the grading of teaching hospitals."
>
> *—From a 1940 ACOS executive meeting to resolve differences between the College and the American Osteopathic Association (AOA)*

of major surgery in osteopathic hospitals for inclusion in the AOA hospital inspection code. In 1941, the AOA adopted these recommendations. The ACOS continued to inspect teaching hospitals for compliance with the standards and to recommend that institutions in compliance be approved by the AOA. The standards, set forth in the *Hospital Inspection Code Book,* were finally distributed to hospitals in 1946.

The first surgical residencies were established shortly thereafter following a 1946 decision by the AOA Board of Trustees to approve the College's recommended standards for this new level of training. Hospitals associated with osteopathic colleges were the first to institute such programs, and by 1948, nineteen hospitals had been granted approval for training in anesthesia, eye, ear, nose, and throat, internal medicine, obstetrics, orthopedic surgery, pathology, radiology, general surgery, and urology.

The residency training program standards were developed in conjunction with the hospital inspection program. Bureau of Hospitals inspectors evaluated hospitals according to their ability to train interns and residents. Standards for staffing approved hospitals also were designated, as were "class" designations for institutions. Class B hospitals, for example, were those with twenty-five to fifty beds (or more if they had no certified chairman of a department of surgery). Class A hospitals were to have fifty beds or more; they also were required to have a board-certified physician as chair of their department of surgery.

- ***1941**—The American Osteopathic Academy of Orthopedics (AOAO) is founded.*
- ***1941**—A symposium on "Total War Injuries to Civilians—Effects and Treatments" is featured at the Annual Clinical Assembly.*
- ***1941**—The American Osteopathic Association (AOA) adopts ACOS-recommended standards for practice of major surgery in osteopathic hospitals for inclusion in its hospital inspection code.*

In addition, the Bureau of Hospitals developed rules and regulations to ensure that there was enough volume of clinical material to train residents and that residents received adequate supervision and were engaged in a "proper" reading program. Residencies had to be full time and had to be preceded by internships.

The Bureau also worked with the various, newly established osteopathic specialty certification boards (see below) to ensure that hospital training standards meshed with certification standards. In this task, the ACOS continued to play a role. Further, the Board of Governors in 1948 allocated $2,000 to support the AOA's hospital inspection program.

In the mid-1940s, in keeping with its efforts to tie membership categories to training, the ACOS Executive Committee voted to allow surgical residency training as an optional avenue for candidacy. The Executive Committee also voted in 1945 to eliminate Junior memberships by 1950 and to create a "Preceptor" status, and to allow physicians to remain in general practice while training in surgery. The training period was for five years, after which the trainee was eligible for certification.

American Osteopathic Board of Surgery Created

In 1940, the AOBS was organized to encourage the study, improve the practice, and ensure competency in the practice of surgery and the surgical specialties. Groundwork for the organization had actually begun in 1939, when the AOA Board of Trustees established the Advisory Board for Osteopathic Specialists* to study the issue of certification of emerging specialties. The Advisory Board was charged with developing bylaws and other implementing documents for what would become the osteopathic certifying boards. It also was charged with establishing certification regulations and requirements.

At the request of the Advisory Board for Osteopathic Specialists, the president of the ACOS appointed a committee to prepare bylaws and establish regulations for the functions of a certifying board for surgery. The committee also was to recommend an organizational structure for the

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* *The Advisory Board for Osteopathic Specialists today is called the Bureau for Osteopathic Specialists.*

First members of the American Osteopathic Board of Surgery

Dr. Howard E. Lamb, Chairman	Denver, Colo.
Dr. Ralph P. Baker, Vice-chairman	Lancaster, Pa.
Dr. Robert Rough, Treasurer	Los Angeles, Calif.
Dr. John P. Schwartz	Des Moines, Iowa
Dr. Albert C. Johnson	Detroit, Mich.
Dr. Edward G. Drew	Philadelphia, Pa.
Dr. Harry L. Collins	Chicago, Ill.
Dr. Lucious B. Faires	Los Angeles, Calif.
Dr. George M. Laughlin	Kirksville, Mo.
Dr. William W. Jenny	Los Angeles, Calif.
Dr. Orel F. Martin	Boston, Mass.

proposed certifying board, as well as the criteria specialists had to meet for certification in various surgical specialties. Considerable controversy erupted, however, over which group would grant certification—the AOA or the ACOS. Ultimately, the AOA prevailed.

On June 26, 1940, the AOBS received AOA sanction and became a complete, functioning board to qualify general surgeons and specialists in urology, orthopedics, and anesthesia.* The certifying board was approved based on the following criteria:

1) To be approved by the AOA's Advisory Board, a new certifying board should represent a well-recognized and distinct specialty of practice.

2) It should be composed of representatives of an AOA-recognized specialty organization.

3) A certifying board should:

   a) determine whether candidates have received adequate preparation and training as defined by the board's established requirements;
   b) provide a comprehensive test of the ability and fitness of such candidates; and

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* *Today, the AOBS is the certifying board for the following surgical specialties: urology, thoracic-cardiovascular, general vascular, general surgery, neurosurgery, and plastic and reconstructive surgery. All of these surgical disciplines are represented on the certifying board, which remains a committee of the AOA. Certification is recommended by the AOBS, and final approval is decided by the AOA Board of Trustees.*

c) make recommendations regarding the competency of candidates who have satisfied AOBS requirements to the AOA Board of Trustees, which would then certify said candidates.

That year, in keeping with the AOA requirement for ACOS representatives to serve as members of the AOBS, College President Edward B. Jones, D.O., forwarded to the AOA his recommendations for the Board's first members.

AOBS eligibility requirements for certification, like ACOS membership requirements mentioned earlier, evolved and became more rigorous over time to reflect changes in training. Just as the ACOS established one-year internships as a prerequisite for Junior membership, then abolished Junior memberships and established Candidate memberships requiring additional training, so did the AOBS require first internships, then also residencies to be eligible for certification in general surgery, urological surgery, and orthopedics.* Actually, an early applicant could qualify with an internship or its equivalent, which was defined as at least two years as an assistant to a recognized surgeon who gave the applicant adequate training in preoperative, operative, and postoperative care. Applicants then were to serve at least a five-year preceptorship to a qualified surgeon or surgeons. (A grandfather clause also enabled surgeons who had practiced for three years under an ACOS- or AOA-approved "Senior" surgeon on a hospital staff to take the certification exam.)

Initially, no residencies were available for general surgery. However, the five-year preceptorships allowed trainees to work under a surgeon part time

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* *The American Osteopathic Academy of Orthopedics (AOAO) was founded in 1941. Certification in orthopedics was bestowed by the American Osteopathic Board of Surgery (AOBS). Board members who were orthopedic surgeons were responsible for designing the examination questions. The Academy established its own certifying board in 1979. Many members of the AOAO also belong to the ACOS.*

- ***1942**—The ACOS annual convention folds into the newly organized Annual Clinical Assembly (ACA), which is created to provide a forum for ACOS members and members of other osteopathic specialty groups.*
- ***1942**—To better meet members' interests and needs, the ACOS sends copies of its recently released newsletter,* The Bulletin, *precursor of the* ACOS News, *to Junior and Associate members. Previously, it had been sent to Senior members only.*

and to have a general practice part time, if the surgeon under whom they were training was board certified. As residency programs were created, the preceptorships became less common.

Completing surgical training did not entitle one to become board-certified but, rather, "board eligible." Candidates had to demonstrate active practice in surgery and pass written and oral exams, and a practical exam. Inspectors (ABOS representatives) would come to the hospital where the candidates had their privileges and review the case charts and observe the candidates perform surgical procedures (usually two or three major cases).

Applicants in urological surgery, orthopedic surgery, or anesthesia had to present satisfactory evidence of graduate specialty training, which was defined as not less than three years in an approved preceptorship, other hospital training programs, or clinics sponsored and/or approved by the AOBS and the AOA.

The certification fee for all new applicants was $50, which sum was forfeited if the AOBS found the applicant ineligible. Those who did not pass the exam were allowed to retake it within one year without additional charge. Incumbent "senior" surgeons, who did not have to take an examination if they had the endorsement of five other ACOS "Senior" members, paid only $5 for their certificate.

Other Specialties Emerge

During the decade, other osteopathic physicians seeking specialized training followed the ACOS's lead, establishing specialty groups to meet their educational needs.

First, osteopathic physicians interested in orthopedics developed training programs, with preceptorships approved by the ACOS. In 1941, they formed the American Osteopathic Academy of Orthopedics (AOAO), which has met with the ACOS yearly at the ACA since 1949. Also in 1941, osteopathic radiologists founded the AOCR and developed their own training programs. The group met with the ACA from 1947 until 1986.

In 1949, osteopathic physicians specializing in obstetrics and gynecology—then a nonsurgical specialty—approached the AOBS with the purpose of establishing a satisfactory manner of obtaining certification in major gynecologic surgery. The result of the meeting was the recommendation

that requirements for gynecologic surgical training needed to be developed before a certification program was instituted. Without establishing training standards, gynecologic surgeons would not be supported in their desire to be certified and granted hospital privileges for surgery. ACOS President Frank A. Dilatush, D.O., upheld these ideas, saying:

> The American College of Osteopathic Surgeons is a participating organization in the inspection and evaluation of the osteopathic hospitals. In this work it is particularly concerned with the qualifications of physicians accorded major surgical privileges in any osteopathic hospital. The American College of Osteopathic Surgeons has no way of evaluating the surgical ability, experience and proficiency of physicians certified in obstetrics and gynecology, and it has no direct concern or authority in regards to what surgical privileges may be accorded to physicians so certified.

By insisting on the establishment of training requirements for gynecologic surgery, the ACOS, in one sense, spurred the gynecologic specialists to establish recognition for a new surgical subspecialty, so the specialists could apply to a hospital medical staff and qualify to receive major surgical privileges.

- ***1943***—*The College adopts a new constitution, which replaces ACOS's trustees with a board of governors.*
- ***1944***—*Photographs are featured in* The Bulletin *for the first time.*
- ***1945***—*Intensified fighting overseas and civilian travel restrictions stateside force the first and only cancellation of the ACA.*
- ***1945***—*The Executive Committee votes to eliminate Junior membership by 1950 and to create a "Candidate" status. The Committee also votes to allow preceptorships, whereby physicians remain in general practice while training in surgery for a five-year period. A residency was three years.*
- ***1946***—*The Trenery Lecture is held for the first time at the ACA in honor of Floyd Trenery, D.O., founder of the American Osteopathic College of Radiology.*
- ***1946***—*The AOA distributes its* Hospital Inspection Code Book *to osteopathic hospitals.*
- ***1946***—*The ACOS formalizes the first surgical residency programs following the 1946 AOA Board of Trustees approval of standards for this level of training. Within two years, nineteen osteopathic hospitals will be approved for training in anesthesia, eye, ear, nose and throat, internal medicine, obstetrics, orthopedic surgery, pathology, radiology, general surgery, and urology.*

The Annual Clinical Assembly

Beginning in 1942, the ACOS annual convention became part of the new Annual Clinical Assembly (ACA). That year's gathering featured the first ACOS conclave, which was such a great success that it became a regular Monday night event.



A scene from the ACOS conclave held at the 1946 ACA in Kansas City, Missouri.

Various other format changes were introduced over the years. Educational programs became more in-depth, clinical pathology conferences were introduced, commercial exhibitors began participating in the meetings, color films provided by Davis & Geck made their debut, and preconvention meetings were instituted during which surgical board examinations and committee meetings were held. In 1946, the Trenery Lecture was held for the first time in honor of Floyd Trenery, D.O., founder of the AOCR. Often, an ACOS Fellow would introduce the distinguished AOCR members who delivered the lecture. (The lecture would be given every year until 1986, when the AOCR no longer met at the ACA.)

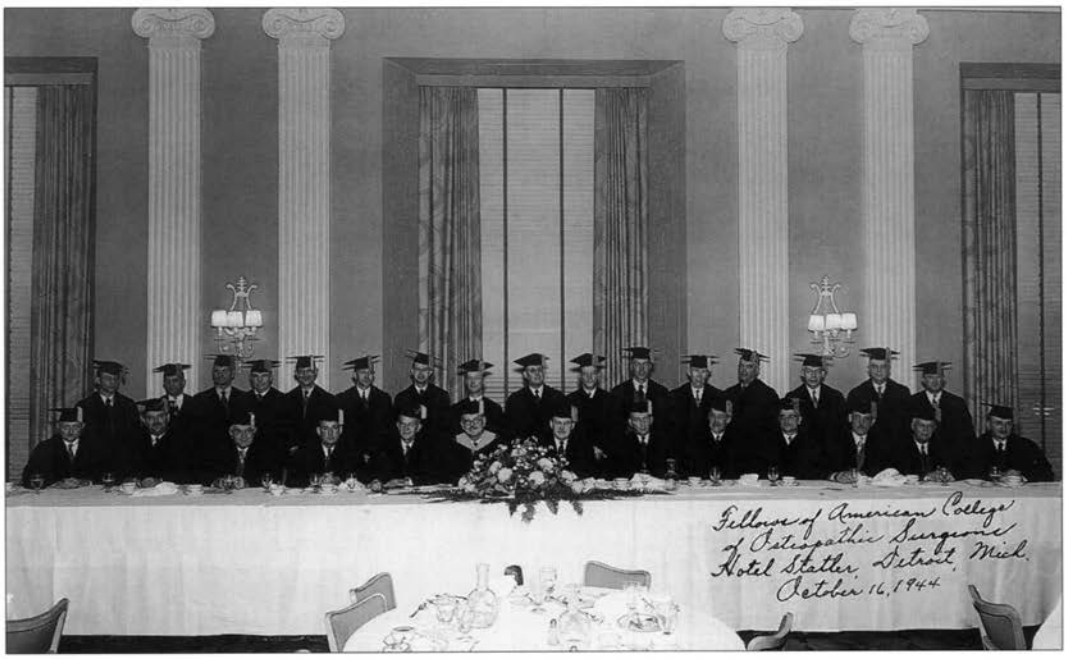
In 1948, ACOS lifetime memberships were granted for the first time, a past presidents luncheon was held, and scientific exhibits were featured. Following the ACA, abstracts of scientific papers were published in Los Angeles under the auspices of the Osteopathic Surgical Society of Los Angeles.*

The American Osteopathic Hospital Association (AOHA)** also began holding combined meetings at the ACA, during which they discussed hospital standards and staff organization. Topics included minimum standards for intern and resident training, x-ray, clinical, and pathology laboratories, medical records and libraries, patient occupancy, and certification.

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* *The publication of ACOS abstracts by the Los Angeles Society, which also included the Society's business matters, demonstrated the strength of the College's California contingency. This would later prove significant when osteopathic physicians in that state were given quasi M.D. degrees in lieu of D.O. degrees, thereby weakening the College, the AOA, and the osteopathic profession.*

** *AOHA, which was founded in 1934, changed its name in 1993 to the American Osteopathic Health Care Association. It has retained the same acronym, however.*



ACOS Fellows gather at the 1944 ACA in Detroit, Michigan.

World War II

During World War II, osteopathic physicians were not accepted for commission because of restrictive armed services policies created by the American Medical Association. Nevertheless, they served nobly during the war years by providing high-quality care for civilians and returning soldiers. In 1941, for example, the College featured an ACA symposium titled "Total War Injuries to Civilians—Effects and Treatment," which touched on simple and compound fractures, poison gas, burns, and head injuries.

Although the war was being fought on distant shores, its effects were felt at home, especially in 1945, when intensified fighting overseas and civilian travel restrictions stateside forced the cancellation of the ACA. That year, forty-five Junior members were elected to the College—the largest class ever—and fourteen Senior members were added. The ACOS also published its very first directory to keep members in touch with one another.

Excerpt from a 1946 KMBC radio interview of Albert C. Johnson, D.O., on early ambulation

Announcer: We've heard a great deal during the war and since the war's end ... about almost phenomenal reductions in length of time surgical patients remain in bed after operations. Generally speaking, would you say these reductions were in the patients' best interest ... or were they made necessary because of the shortage of hospital beds?

Dr. Johnson: A combination of the two. There has been a shortage of hospital beds, of course, and it will probably last for some time. But don't think for a minute that doctors have been hurrying their patients out of the hospital just to get beds for the other patients, without considering possible harmful consequences. The fact is that more doctors are coming to believe that the sooner a patient resumes normal activity after an operation, the better off he will be.

The discussion went on to include the benefits of shorter stays in bed after surgery in order to decrease complications. Prior to that time, it was standard for patients to be confined to bed for two weeks following major surgery. Obviously multiple complications such as thrombophlebitis of the lower extremities resulted; however, these resulted less frequently in osteopathic hospitals because of daily osteopathic treatments given to the bedridden patient, such as rib raising and leg motion.

- ***1947**—The American Osteopathic College of Radiologists (AOCR) begins meeting at the ACA. It will continue to do so until 1986.*
- ***1948**—*The Bulletin *publishes its first article on a lawsuit against physicians.*
- ***1948**—The ACOS Board of Governors allocates $2,000 to the AOA's Hospital Inspection Program.*
- ***1948**—ACOS lifetime memberships are granted for the first time.*

Chapter 3: Moving Toward Maturity

1950–1959

The American College of Osteopathic Surgeons (ACOS) moved beyond the growing pains and gains of the 1940s toward maturity in the 1950s.

It was during this decade that the College mourned the passing of Orel F. Martin, D.O., its first permanent secretary/treasurer, and set up its Registry of Training Programs in an effort to formalize and institutionalize all surgical specialty training and to tie training to certification. The 1950s also saw the refinement of the Candidate program and efforts to improve the College's organizational efficiency and effectiveness. And it was during this time that the Annual Clinical Assembly (ACA) became even more sophisticated and encompassing. Its growth mirrored the growth of osteopathic specialties, just as its programs mirrored many of the pressing issues of the day—the development of stringent training standards, the incursion of government in medicine, the conflict between generalists and specialists, and the unethical practice of fee splitting—issues that would continue to challenge the profession in the years to come.

The Passing of a Legend

Of all the important events of the 1950s, one of the most significant was the death of Orel F. Martin, D.O., on January 7, 1957. All members mourned the passing of this giant, who had given so much to the College over the years.

To many, Dr. Martin exemplified Socrates's concept of the educated man: the individual who was decent and honorable in his dealings with others, and agreeable and reasonable, yet steadfast and sober minded in the face of challenges. Like the educated man, Dr. Martin was unspoiled by his success and true to himself. He was also—and always—a true friend to the ACOS, which he helped bring to maturity.

In the months that followed Dr. Martin's death, numerous articles appeared in the *AOA Journal* and other osteopathic publications that paid tribute to the professional influence he exerted for the good of osteopathic medicine. A May 24, 1957, paper, written by James O. Watson, D.O., perhaps says it best:

> "In the passing of Orel Martin, the osteopathic profession and particularly the surgical segment of the profession have suffered a profound loss. Almost from the date of his graduation from the American School of Osteopathy in 1916, he began making significant and important contributions to his profession. He gave leadership to the founding of the Massachusetts Osteopathic Hospital in Boston and practiced an outstanding brand of surgery therein. He was a founding member of the American College of Osteopathic Surgeons and was destined to become an outstanding leader

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ACOS Chronology

- ***1950**—The American College of Osteopathic Surgeons (ACOS) establishes a Registry of Training Programs, following directives from the American Osteopathic Association (AOA).*
- ***1950**—The American Society of Osteopathic Anesthesiologists (today called the American College of Osteopathic Anesthesiologists) attends the Annual Clinical Assembly (ACA) for the first time.*
- ***1950**—ACOS phases out Junior memberships and replaces them with a Candidate classification.*

> of that organization. During the years, his contributions to organized osteopathic medicine are many and they have been listed in so many places that mention of all the areas that benefited from his organizational touch need not be made here. The major fields were the American Osteopathic Association's (AOA) Bureau of Hospitals, the American Osteopathic Board of Surgery (AOBS), the establishment of standards for postgraduate training in surgery, and the sponsoring of the growth and development of the American College of Osteopathic Surgeons. He had a natural genius for organization and this, combined with a clear perception of the needs and the objectives to be obtained in these fields of activity which interested him so much, brought an achievement and result of great significance."

Following Dr. Martin's death, his wife, Esther, became ACOS executive secretary. It was she who had maintained the professional affairs of the College during her husband's long illness with such skill that only those close to the leadership were aware that any change had taken place at the management level. Mrs. Martin served the College until 1960, when she was named corresponding secretary of the AOBS.* Replacing her was Charles Ballinger, D.O.—or "Bally" as everyone called him—who moved from his position as ACOS secretary/treasurer to become the College's first executive director. The change was precipitated by concern as to whether the College could afford both an executive secretary and a secretary/treasurer. The positions overlapped, and this situation was difficult and uncomfortable for both Mrs. Martin and Dr. Ballinger.

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* *In 1958, Mrs. Martin was made an honorary member of the College, and the award of Fellow was bestowed upon her. In 1978, she would receive ACOS's most prestigious award, the Orel F. Martin Medal, for her many accomplishments and years of service.*

The Registry of Training Programs

During the 1940s, the ACOS helped formalize training standards for certain surgical specialties. The task before the ACOS in the 1950s was to register all of these advanced training programs, distill their essential components, formalize and institutionalize all surgical specialty training, and tie training to certification standards. Further, the ACOS would continue to inspect formal hospital training programs to ensure that approved essentials were taught.

Accordingly, the ACOS established in 1950 a Registry of Training Programs, following directives from the AOA's Advisory Board of Osteopathic Specialties. The Registry was designed to catalog the extent and nature of the surgical specialty preceptorships.

> "Every surgical candidate should be chosen with care and his ultimate value as a future teacher be projected so that if and when he is elected to membership, he will be prepared and ready to assume his duty to pass along to students and associates a well-rounded degree of surgical ability."
>
> *—Lucious B. Faires, D.O., from his 1951 address, "A Surgeon and a Teacher"*

Initially, the Registry included specialty surgical preceptorships in neurosurgery, orthopedic surgery, peripheral-vascular surgery, urological surgery, and anesthesiology. Registered programs had to be approved by the AOA's Committee on Accreditation of Postgraduate Training. The physicians (or preceptors) who conducted these programs had to meet rigorous requirements, as did trainees. Preceptors, for example, had to be well-qualified teachers with access to adequate teaching facilities. They also had to be certified in their specialty or be members of the ACOS. Those who were not certified or who were not College members could be designated preceptors if, in the opinion of the approving bodies of the program, they met the

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- *1952—The ACOS adopts a policy limiting exhibits at the ACA because of the extraordinary number of exhibitors requesting space.*
- *1952—The U.S. Supreme Court hands down a decision in the long awaited* Lilly v. IRS *case, which will have a major and long-term effect on osteopathic physicians and other medical providers.*
- *1954—The Orel F. Martin Medal for distinguished service to the College and the osteopathic profession is created.*
- *1954—The Section of Urology meets for the first time at the ACA.*
- *1955—Orel F. Martin, D.O., the College's first permanent secretary/treasurer, becomes the first recipient of the Orel F. Martin Medal.*
- *1955—The AOA Board of Trustees votes to require all specialty colleges and boards to file details of approved residencies with the Bureau of Hospitals.*

necessary qualifications for certification or membership.

Trainees had to have graduated from an approved osteopathic college and to have been members in good standing in the AOA and the state or divisional society. In addition, they had to have satisfactorily completed a minimum of a one-year internship approved by the AOA's Board of Trustees in an institution acceptable to the ACOS and the AOBS. (Trainees who had graduated before 1942 had to have the equivalent of an acceptable internship.) Trainees also had to have no less than two years of general osteopathic medical practice prior to entering a specialty training program. In addition, their programs had to be conducted by an approved preceptor and had to occupy at least 50 percent of their professional efforts.

Surgeons in registered training programs or residencies could qualify to sit for specialty certification boards if they met other standards of the individual board. General surgeons who had additional training in OB/GYN could take the general surgery boards and present themselves as OB/GYN surgeons. OB/GYN surgical residencies did not yet exist.

Gradually, the Registry identified essential elements required for training in the surgical specialties. The availability of this information raised the quality of training programs to new heights.

In 1955, the AOA Board of Trustees voted to require all specialty colleges and boards to file with the Bureau of Hospitals "the essential details of an approved residency in that specialty which shall be the measuring gauge for approval." Correspondence to the various specialty boards at the time noted that because certification was one of the goals of residency training, those responsible for evaluating the training also were to assume a large share of the responsibility

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- *1955—Dr. Martin becomes the first recipient of the AOAO's Annual Appreciation Award.*
- *1956—Osteopathic anesthesiologists request permission to form their own specialty board.*
- ***January 7, 1957**—Dr. Martin passes away.*
- *1958—ACOS's amended charter is granted approval by the Circuit Court of Adair County, Missouri.*
- *1959—The ACOS hires a firm of certified public accountants to assess the College's organizational and dues structure and to determine if Coral Gables, Florida, is the most logical location for its headquarters.*
- *1959—The ACOS creates its Placement Committee to serve as a central bureau for surgeons wishing to change their place of practice and for residents requiring information on professional opportunities.*
- *1959—The ACOS creates a Clearing Committee to field suggestions and/or criticisms of College activities and policies.*

for defining the training requirements for the respective programs.

In keeping with these responsibilities, Dr. Martin, the ACOS's secretary/treasurer, and James M. Eaton, D.O., chairman of the AOBS, prepared the "Basic Requirements of an Approved Residency in Surgery Including the Surgical Specialties." Prior to the publication of these requirements, members of the ACOS and its subspecialties spent innumerable hours researching the standards that would serve as training guidelines. Ultimately, programs were designed for the following specialties: general surgery, peripheral-vascular surgery, plastic surgery, urological surgery, and neurosurgery. (Separate requirements for a training program in obstetrical/gynecologic surgery were not developed,* neither was an outline for anesthesiology, because it was anticipated that anesthetists would request permission to form their own specialty board in the near future.**)

With only minor changes, the requirements for the surgical training programs were approved by the ACOS and the AOBS. Orthopedic training program requirements were added, and all programs were forwarded to the AOA's Bureau of Professional Education for approval.

The following year, after receiving input from John P. Schwartz, D.O., an AOBS member, some other members of the AOBS, and the ACOS Board of Governors, Drs. Martin and Eaton submitted their "Basic Documents of an Approved Residency in Surgery" to the Bureau of Hospitals.This document was to be a basic model for all of the surgical training programs.

The ascendancy of formal residency training programs over preceptor-

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* *Before medical subspecialization, general surgeons operated on all pathology within the abdomen. This included gynecologic surgery, which comprised a large percentage of the cases performed by general surgeons, who considered gynecologic organs an important part of their domain.*

The early practice of obstetrics and gynecology did not include surgery. These gynecologists handled medical problems of the female pelvis. Surgery of the female pelvis, major operations of the external genitalia, and cesarean sections were performed by general surgeons. After some conflict, obstetrics and gynecologic residencies were established at teaching hospitals. The early gynecologic surgeons were trained by general surgeons. In 1934, the obstetricians and gynecologists founded their own college, the American College of Osteopathic Obstetricians and Gynecologists (ACOOG), and their own certifying board in 1942. As with all certifying boards, the AOA approves the board members nominated by the ACOOG.

** *An anesthesiology certifying board was established in 1956.*

ships was now a fact. It is interesting to note that in the midst of all of the work to create formal training programs, a surgeon applied for preceptorship training privileges in a hospital approved for a residency program. The request was emphatically denied.

The Candidate Program

As a result of the formation of residency training programs, the ACOS Board of Governors voted in 1950 to phase out Junior memberships and replace them with a Candidate classification. That summer, Dr. Martin was so inundated with questions from individuals desiring to become candidates that he decided to publish a new *Board of Surgery Booklet,* which outlined all of the prerequisites.

During the 1950s, the Candidate Program was refined. By 1959, Candidates were required to file annual reports of their postgraduate work with lists of operative procedures broken down into majors and minors and segregated totals. This information was transferred to "Candidate cards," and the Candidates' credentials were then reviewed by the Membership Committee.

Changes Within

Like all evolving organizations, the ACOS experienced its share of growing pains. By the end of the decade, despite the College's growth and its consistently successfully annual meetings, there was some concern about the group's financial stability. The ACOS Finance Committee was particularly concerned with the disappointing revenues generated by the ACA and with increased operational costs. In 1959, for example, the College's income from dues was $38,000, while the cost of its salaries was $33,000. Adding to the seriousness of the matter was the fact that the College's reserve, which had been slowly built up over the years, was being used to maintain the organization, a situation that could continue only a few years more at most.

Ultimately, in 1959, the Board of Governors hired Lybrands, Ross Bros., and Montgomery, certified public accountants, to take an objective and hard look at the College's organizational structure. Specifically, the Board

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- ***1960****—Charles Ballinger, D.O., is named the first executive director of the ACOS; Esther F. Martin is named executive director of the American Osteopathic Board of Surgery (AOBS).*

wanted to know if the organization was efficiently organized, staffed, and administered, and if its dues structure and office layout were satisfactory. The Board also wanted suggestions for increasing income, reducing costs, and making other improvements, as well as advice about whether Coral Gables, Florida, was a logical location for its national office.

Lybrands, Ross Bros., and Montgomery made several suggestions. It advised the College to replace the overlapping executive secretary and secretary/treasurer positions with an executive director position. It also recommended that the ACOS office remain in Florida until it could be relocated to Washington, D.C., the hub of healthcare legislative and regulatory activity.

In addition, the firm advised the College to increase membership dues, create income-producing teaching programs, and increase the number of technical exhibits at the ACA. The firm suggested that the ACOS increase the registration fees for groups (orthopedists, radiologists, hospital organizations, etc.) attending the annual convention. The latter suggestion was a sore point for the various organizations in attendance, who believed the College already received a disproportionate share of the revenues from the event. This was true in part, and many meetings were held over the subsequent years with organizations participating at the ACA to discuss finances and establish an equitable distribution for the ACA revenues.

That same year, the ACOS created its Placement Committee, which served as a central bureau where surgeons wishing to change their place of practice or physicians completing their residencies could get information about professional opportunities. The College also created a Clearing Committee, through which suggestions and/or criticisms of ACOS activities and policies could be made. To make its work more visible and effective, the Committee sent members a questionnaire asking them to evaluate membership requirements, especially as they related to training standards. The questionnaire also requested information regarding the postgraduate training and education they had received. Although responses were few in number, the College received several helpful ideas. One member, for example, suggested that a pathologist be invited to participate in case presentations by reviewing the surgical pathology of various surgical specimens and relating this to the symptomatology that the patient presented. This resulted in more in-depth case presentations at the ACA. Eventually, the patholo-

gists' college joined the convention for a short time. Today, case reviews are an important part of the College's educational programs, and pathologists are invited to participate in case presentations.

Incorporation Revisions

Because of poor record keeping during its formative years, portions of the College's papers regarding incorporation had been misplaced. Secretary/Treasurer Dr. Martin sought to remedy this situation, and in 1951, he had ACOS attorney Charles J. Chastang request a certified copy of the organization's incorporation papers from the state of Missouri, where the College had been incorporated in 1927. After reviewing the College's articles of incorporation, Dr. Martin discovered that changes made in the College bylaws over the years departed from the provisions and requirements of the articles of incorporation. Article IV of the College's Articles of Incorporation, for example, provided that the management of the College be vested in a Board of Trustees consisting of seven members; yet Article IV of the ACOS Constitution provided for a fifteen-member Board of Governors.

After the ACOS obtained legal opinions and noted other departures from the original Articles of Incorporation, the charter was amended, approved by the Board and the membership, and then submitted to the Circuit Court of Adair County, Missouri, for approval. Approval was granted in 1958.

Government Interference

In the mid-1950s, some ACOS members grew concerned with government interference with medical practices. The Medicare program had just been proposed, although it was not supported initially by the medical profession. For example, the Ohio State Medical Association, which represented both osteopathic and allopathic physicians, took the position that its members should not participate in the proposed federal program, because doing so would bind its members to accept as payment in full any monies paid by a third party for services rendered to patients. Ohio members maintained that it was the

> "The imminence of socialized medicine is ever threatening, and our collective attitudes and actions form a tremendous influence on how the tide will turn."
>
> *—ACOS President J. Donald Sheets commenting on the proposed Medicare program, from a January 1956 article in* The Bulletin

privilege and right of individual physicians, acting according to established principles of medical ethics, to decide how they would practice their profession, and that it was their right to decide whether or not a fee offered by a third party would be acceptable as payment in full. Eventually, however, an accommodation was reached for a payment method for surgical procedures.

ACA—Continued Success

With each year, the ACA became more successful—and more encompassing. Its growth mirrored the growth of osteopathic specialties and the number of specialty groups participating in the meetings. The ACA also served as a forum through which many of the most pressing issues facing the profession were debated and resolutions proposed and adopted. Among others, these included the development of more stringent training stan-



The ACOS Ceremonial Conclave gets underway at the 1956 ACA in Detroit, Michigan.

dards, the incursion of government in medicine, the conflict between generalists and specialists, and the unethical practice of fee splitting, a particularly contentious issue that would come to a head in the 1960s.

The first meeting of the decade, held in Des Moines, Iowa, featured as its opening speaker the state's governor, William S. Beardsly. Adding a ceremonious touch to the Fellows induction at the Monday night Ceremonial Conclave was the introduction of the beautifully designed velvet and silk hoods in the College's colors—black and gold. The new Fellows gowns also made their debut.

At that year's meeting, two other important events occurred: a past presidents luncheon attended by fifteen of the group's seventeen living presidents, and the participation for the first time by the American College of Osteopathic Anesthesiologists (ACOA), then called the American Society of Osteopathic Anesthesiologists.

Combined meetings with ACOA, the American Osteopathic College of Radiologists (AOCR), the American Osteopathic Academy of Orthopedics (AOAO), and the American Osteopathic Hospital Association (AOHA) strengthened the educational programs of the annual meetings. Throughout the decade, the programs of all the specialties were integrated, as demonstrated by topics such as "Relationship Among Surgeon, Anesthetist, and Patient," presented by anesthesiologists and surgeons; and "Radiologic Evaluation of and Orthopedic Management of Low Back Problems," presented at the AOCR and the AOAO combined meetings. Surgical Forums also were introduced, featuring panels of physicians from surgery, orthopedics, urology, radiology, and anesthesiology. Discussions centered on interrelationships among the various disciplines, and plans for future teaching programs were proposed to create even more cohesive educational offerings.

Throughout the 1950s, visual education programs continued to expand, as did the number of scientific and technical exhibits, the latter of which was organized, under contract, by the able Steven K. Herlitz, who headed an exhibits management company in New York City. The extraordinary number of exhibitors requesting space in 1952 led to the formation of a policy limiting exhibits to those whose products were of specific interest to members. As always, conference participants could view films of operative procedures produced by Davis & Geck. A special room was designated for the teaching films and a schedule published of their show times.



The Orel F. Martin Medal

The number of preconvention meetings also increased during the decade. In addition to the ACOS Board of Governors, the governing boards of the AOCR, the AOAO, the ACOA, and the AOHA met, and the AOBS conducted its written and oral examinations at the ACA. Live surgical clinics were continued until 1954, when the number of conference attendees grew too large to accommodate the program.

In 1954, two years after the College celebrated its silver anniversary, ACOS created its Orel F. Martin Medal for distinguished service to the College and the osteopathic profession. Fittingly, Dr. Martin was its first recipient.* The medal was presented to him at the ACOS Ceremonial Conclave in recognition of his courageous leadership in elevating the standards of surgical practice and his distinguished contributions and services to the College and the profession. James O. Watson, D.O., and John P. Schwartz, D.O., outstanding ACOS leaders themselves, made the presentation. (Both men would receive the medals in later years.)

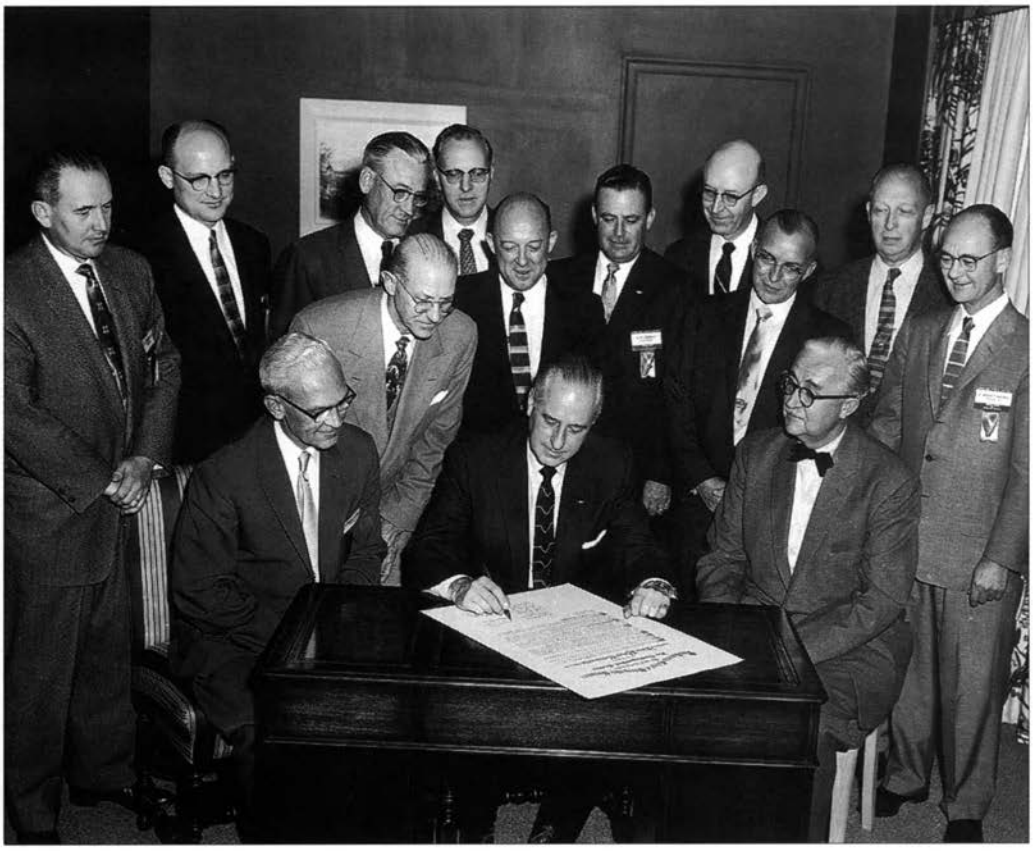
> "The Orel F. Martin Medal is an object of beauty. However, its real beauty is not in the artistry of craftsmanship nor in the precious metal in which it is cast, but rather in that of which it is symbolic. It is, in effect, a symbol of qualities of mind and heart, of an extraordinary capacity for original thought and of vital intellectual energy evidenced by a long record of unselfish service to the College. Thus, the medal is truly a symbol of service as exemplified by the life and work of Orel F. Martin."
>
> *—James O. Watson, D.O.*

Three years later, a gold-headed cane was introduced at the College's Ceremonial Conclave. Inscribed with the names of former ACOS presidents, the cane was to serve as a symbol of the wisdom and experience of the College's past leaders upon which the incoming president could lean. It would be handed down from one president to the next from that time on.**

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* *In 1955, Dr. Martin became the first recipient of the AOAO's Annual Appreciation Award.*

** *In 1993, the United States Surgical Corporation presented the ACOS with a $10,000 grant to extend the length of the staff and provide more space to inscribe the names of past presidents on the presidential cane.*





Above, ACOS past presidents and members of the Board of Governors sign the plaque that will be presented to John P. Schwartz, D.O., the Orel F. Martin Medal recipient in 1956. Right, ACOS President J. Donald Sheets, D.O., presents the plaque to Dr. Schwartz at the past presidents luncheon. The signing and presentation of the plaque is a tradition that continues today.

> "Some of us in the American Osteopathic Association have come to believe that we have outlined the necessity of our separatism. But in separation I think we have come to a position too often where conclaves of the central body of organized osteopathy are deprived of the manpower and brainpower represented in the specialty groups. We are anxious in some way to bring about a union of the brains of our profession so that your voice is more firmly heard in the councils of the American Osteopathic Association."
>
> *—From a speech by AOA President Donald V. Hampton, D.O., during the formal opening session of the 1952 ACA*

Another highlight of the 1954 conference was the first meeting of the Section of Urology. Various topics in urology were addressed, including "The Relation of Urology to the Hospital," "Recent Diagnostic Procedures," "Hematuria in Upper Urinary Tract, "Hydronephrosis," and "Stress Incontinence in the Female Patient." Several of the participating osteopathic urologists were from Los Angeles County hospitals. Later, there would be a significant negative impact on the ACOS urological section, when California osteopathic physicians seceded from the osteopathic profession.

The impressive growth, scope, and stature of the ACA did not go unnoticed by the AOA. Feeling the loss of "manpower and brainpower represented in the specialty groups," it began to revamp its convention program to entice all specialties. This effort partially succeeded and resulted years later in the pathologists leaving the ACA in 1984 to meet in conjunction with the AOA.* The ACOS would continue to improve and expand its independent program, however, and the ACA met with continued success in the decades to come.

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* *Over the years, a number of organizations have met in conjunction with the ACA, which today hosts the ACOS, the American Osteopathic Academy of Orthopedics (AOAO), and the American Osteopathic College of Proctology (ACOPr). Groups that withdrew from the ACA did so for a variety of reasons. One was cost. Another was the size of the convention itself, which restricted the site to large city hotels with adequate meeting and exhibit facilities. Some smaller groups (e.g., the American Osteopathic Hospital Association [AOHA], the American Osteopathic College of Radiology [AOCR], and American Society of Osteopathic Anesthesiologists) preferred to meet in other venues, such as resort locations.*

Fee Splitting

In 1952, the long-awaited decision in the *Lilly* v. *IRS* case was handed down by the U.S. Supreme Court. It would raise numerous and important ethical issues and would have a major and long-term effect on osteopathic physicians and other medical providers. Of more significance, however, the ACOS assumed a position at the forefront of other medical organizations in opposing the practice of fee splitting.

The background of the landmark case is as follows: Thomas B. Lilly and his wife owned and operated optical stores in several towns in Virginia and North Carolina. As was common at the time, physicians not only examined their patients' eyes and prescribed glasses but bought frames and lenses wholesale, and prepared, fitted, and sold them to their patients at a profit. The Lillys offered to fill the prescriptions for physicians and to supply and fit frames for their patients. To compensate the physicians for their loss of profit on the sales, the Lillys, in keeping with the established and widespread practice in their area at the time, paid the physicians one-third of the retail price received for the glasses. Information regarding the arrangement was not revealed to patients, although it was disclosed freely upon inquiry.

In 1943 and 1944, the Lillys deducted these payments on their income tax returns, maintaining that they were ordinary and necessary expenses of doing business. The physicians, in turn, included these payments in their taxable gross incomes. The IRS disallowed the deductions, however, in a 1950 ruling that was subsequently upheld by the Tax Court and the Court of Appeals. According to the ruling, the payments were not tax deductible because they were contrary to public policy and medical ethics.

> "The Pandora's Box of fee-splitting is too full of unpleasant surprises for it to remain a popular practice, except by those who would 'cheat the devil.' Such unscrupulous methods can never be salved by whatever worthy object or excuse is given. The pactolian flood of riches can never drown the pangs of conscience."
>
> *—James M. Eaton, D.O., from his 1952 presidential address on fee splitting*

The U.S. Supreme Court reversed the decision in 1952. Although it did not approve of fee splitting as a matter of business ethics, the Court held that at the time and place in question, the public feeling against such

practices was not so sharply defined as to require disallowance of the deduction. The court also noted that such payments were allowable because they fell within Sec. 23(a)1(A) of the Internal Revenue Code, which covered "all ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business." Such payments represented ordinary expenses because they were necessary to obtain business, the Court stated. Further, the payments made to the physicians and contested as deductions by the IRS amounted to between 56 and 72 percent of the Lillys' taxable business income. The income thus taxed had been transferred long ago to the doctors, who had paid income tax on it.

The *Lilly* decision was significant because it identified which expenses were ordinary and necessary and which were not. Specifically, *Lilly* disallowed deductions that violated state statutes and, in doing so, turned the national spotlight on the fact that twenty-four states had laws forbidding fee splitting*—the arrangement between physicians that a percentage of the professional fee be given to the referring physician.

Fee splitting was prohibited by the AOA Code of Ethics, which all AOA affiliates—including the ACOS—adopted as their own. Yet, among the ACOS leadership, there was almost certain knowledge that the Code was not adhered to universally by its members. A decision was made by the ACOS to enforce the Code among College members. With that decision, the ACOS became the first medical organization to come out publicly and emphatically against the unethical practice of fee splitting. As shall be seen in Chapter Four, the decision also marked the College's entry into a period of open hostility with the AOA that eventually resulted in its threatened ouster in the 1960s from the ranks of AOA affiliates.

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* *North Carolina would institute a law prohibiting fee splitting just before* Lilly *was reversed by the U.S. Supreme Court.*

Chapter 4: Into the Darkness

1960–1969

The 1960s is known as a decade of turmoil and change, and so it was for the American College of Osteopathic Surgeons (ACOS).

During these years, the College would face many a dark day and many a challenge. One of the most difficult and protracted episodes had to do with unethical billing practices. As the first medical organization to come out publicly and emphatically against fee splitting, the ACOS aggressively combatted the practice among its members. In the process, it unintentionally entered on a collision course with the American Osteopathic Association (AOA), not just over ethical issues but over the College's right to self-determination. Ultimately, the ACOS would prevail, but not before the AOA threatened to rescind the College's affiliate status.

Simultaneously, in California, the ACOS faced an even greater threat. There, the merger of the California Osteopathic Physicians and Surgeons and the California Medical Society dealt a serious blow to the development of osteopathic medicine and was responsible for a substantial drop in members and the loss of osteopathic college and county hospital facilities for training programs. Despite this development and efforts by the American Medical

Association (AMA) to draw osteopathic physicians into its ranks, the College bounced back and, in fact, grew stronger. That process would take years, however.

Throughout this dark period, the ACOS remained focused. Moving forward, it greatly expanded educational opportunities and strengthened the Annual Clinical Assembly (ACA) by attracting as participants additional hospital-based specialty groups.

Efforts to Halt Fee Splitting Continue

Fee splitting—those two simple words raised a host of complicated issues in the 1960s regarding not just unethical medical billing practices but the relationship between the ACOS and the AOA. Although both groups opposed fee splitting, the College's fervent efforts to stop such practices among its members—by suspension from the ACOS, if necessary—threatened the AOA and nearly led to the College's disaffiliation in 1968.

The political tensions between the groups did not fully surface in the early 1960s, nor were they evident in the 1950s, when the issue of fee splitting first came to the forefront following the 1952 *Lilly* v. *IRS* decision.

That year, in response to *Lilly* and in an effort to guide ACOS members down the ethical high road, ACOS President Lucious B. Faires, D.O., appointed a special committee, which was chaired by James O. Watson, D.O. The Committee's charge was twofold: to outline strategies for identifying specific members, if any, who were engaged in fee splitting; and to institute remedial measures to stop the practice. The College also passed a resolution that called for educating the public as well as medical students, interns, residents, young physicians, and surgeons about medical ethics; encouraging hospitals and their governing boards to require their staffs to uphold ethical principles and to require that no evidence of unethical financial relations appear on the books of staff members or applicants; and taking punitive action against ACOS members who knowingly were

> "The willingness to talk of the scientific aspects of medicine is in sharp contrast to the reluctance to talk of the economics of medicine. Is not, therefore, the growing impatience of the public and of the lay groups and of the press, understandable?"
>
> *—ACOS President James O. Watson, D.O., from the 1953 presidential address*

guilty of unethical practices. Thus, the ACOS became the first medical organization to come out publicly and emphatically against fee splitting.

Discussion of *Lilly* and billing ethics had continued throughout the 1950s. For the first time, at the 1953 ACA, a presidential address was almost exclusively confined to the topic of medical ethics. The 1954 presidential address also served as a forum for discussing the issue. Two years later, the ACOS and the AOA developed a joint ethical code that reaffirmed their opposition to fee splitting and ghost surgery.* That same year, the American Osteopathic Board of Surgery (AOBS) began requiring applicants for certification to ascribe to the Code's provisions, and the College held the first of numerous hearings into alleged code violations. In 1959, the ACOS Board of Governors created a formal procedure for notifying members who violated the Code, although the punishment for violators had yet to be determined.

> "... the identity of each physician involved in rendering care to the patient and the character of the services be disclosed to the patient, and, if authorized by the patient, to any third party paying for professional services for the professional services of the patient."
>
> *—From the 1958 joint Code of Ethics developed by the ACOS and the AOA*

Efforts within the ACOS were mirrored throughout the country as state legislatures continued to outlaw unethical billing practices and the federal government prohibited fee splitting by physicians reimbursed under the Medicare program enacted in the mid-1960s.

On the surface, all seemed to be going well, as the ACOS, the AOA, and state and federal governments adopted a common stance on the issue. In reality, however, fee splitting continued. Accordingly, the College took a more aggressive approach in the 1960s to combat the practice.

Throughout the 1960s, the ACOS Ethics Committee continued to hold hearings to investigate fee splitting among members. The interrogation of physicians suspected of engaging in unethical billing practices was used as a deterrent as well as a vehicle to educate and, if necessary, chastise surgeons.**

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* *Although the ACOS and the American Osteopathic Association (AOA) required adherence to the same code of ethics, this prohibition of fee splitting marked their first joint effort to establish and enforce medical ethics.*

** *Interrogations were conducted before a court reporter and in accordance with due process rights.*

Although no penalties were imposed initially, Candidates for full membership who were suspected of fee splitting found approval of their applications postponed; Members and Candidates who were not in compliance were threatened with suspension from the ACOS.

Much of the Committee's work centered around hospitals, where most surgeons performed their services. Hospitals were asked to ensure that the billing and collection of professional fees charged by their physicians conformed to the Code of Ethics, and each institution was sent a letter outlining guidelines for ethical conduct. Later, the Committee would learn that hospitals were circumventing the guidelines through the creation of collection agencies that handled all surgery-related medical bills. Under this arrangement, a patient would get one bill from the agency, the lump sum of which was divided between physicians to reflect referrals.

In 1964, the ACOS and the AOA held a joint conference on ethics. At the meeting, both groups proposed changes to AOA's twenty-three-paragraph Code of Ethics in an effort to tighten compliance. Such changes had been ordered by the AOA House of Delegates the year before. The new Code sections, unanimously accepted by the ACOS Board of Governors in a mail vote, were as follows:

- Section 19: "Any fee charged by a physician shall be reasonable and shall compensate the physician for services actually rendered.

- Section 20: "Division of any professional fees not based on actual services rendered is a violation which will not be tolerated within the membership of the Association."

- Section 21: "A physician shall not pay or receive compensation for referral of patients."

In addition to these changes, the AOA and ACOS also passed a resolution requiring a hospital's medical staff to adhere to the Code in order for the hospital to maintain its AOA accreditation.

Two years later, the ACOS and AOA again held a joint meeting in the

latter's Chicago office to discuss the federal government's position on fee splitting, the Internal Revenue Service's treatment of such arrangements, and state statutes prohibiting the practice.

More importantly, the groups met to iron out additional modifications to the Code of Ethics. Specifically, the ACOS wanted to clarify Section 20, which allowed for the division of fees under some circumstances, such as through collection agencies. Thus, the College proposed the addition of Item 4, which held that "Each physician shall render his own bill for his own services and for no other physician." Ultimately, during the lengthy discussions, it was determined that there was no conflict between the AOA Code of Ethics and Item 4, which the ACOS added to its interpretation of the Code of Ethics.

Meanwhile, at the ACA, discussions of fee splitting continued to take front and center stage. For the first time, at a 1964 ACOS Ethics Committee meeting, eleven members were threatened with loss of membership because they had not complied with the Code of Ethics. At this meeting, it also was learned that various surgical departments in osteopathic hospitals were beginning to take a stronger stand against the division of fees. The Detroit Osteopathic Hospital Corporation, for example, had published a statement informing all physicians practicing at any of their corporations to comply with the AOA's Code of Ethics and to render their own bills for their own services and for no other physicians. Other hospitals soon developed similar statements, in large part as a result of their participation in the Medicare program, which prohibited fee splitting.

In 1966, the AOA added to its Code of Ethics the statement that "a physician shall bill individually for any service he renders." Although the

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ACOS Chronology

- ***1952**—The American College of Osteopathic Surgeons (ACOS) becomes the first medical organization to oppose publicly the practice of fee splitting.*
- ***1952**—In response to* Lilly *v.* IRS, *the ACOS passes a resolution calling for educating the public as well as medical students, interns, residents, young physicians, and surgeons about medical ethics.*
- ***1953**—For the first time, at the 1953 Annual Clinical Assembly (ACA), a presidential address is almost exclusively confined to the topic of medical ethics.*
- ***1956**—The ACOS and the American Osteopathic Association (AOA) develop a joint ethical code that reaffirms their opposition to fee splitting and ghost surgery.*
- ***1956**—The American Osteopathic Board of Surgery (AOBS) begins to require applicants for certification to ascribe to the AOA Code of Ethics.*

addition came close to the intent of Item 4, it did not completely denounce combined billing, which the College believed was imperative.

Tensions between the two groups escalated following an AOA directive that stated that AOA members were to adhere strictly to the Code of Ethics and that changes to the Code not approved by the AOA Board of Trustees—such as the addition by the ACOS of Item 4—were nonbinding. In essence, the directive challenged the College's right as an affiliate to act independently and to take steps to suspend its own members. Such suspension was a direct challenge to the AOA to which affiliate members also belonged. Thus, in the mid- to late-1960s, problems of organizational hierarchy and the rights of affiliates to self-determination began to assume as much, or even greater, importance than the issue of fee splitting.

Nevertheless, the ACOS agreed to a moratorium on additional independent interpretations of the AOA Code of Ethics to maintain the peace between the organizations. On December 12, 1966, however, President Theodore F. Classen, D.O., issued "An Important Message," which was sent to all ACOS Members and Candidates.

"It was a revelation to the members of the [ACOS] Ethics Committee, the Officers, and Governors of the College to learn the guises that have been developed for the purpose of dividing surgical fees," the message read. Interviews with Members and Candidates, in fact, revealed that physicians associated with hospitals that had collection plans had declared such agencies a guise for the division of fees.

"In view of these facts," Dr. Classen stated emphatically, "the ACOS Board of Governors has declared these plans unethical." If the services of physicians other than the treating surgeon were required, such services should be billed separately, the message concluded.

Following the release of the message and ACOS Ethics Committee interrogations, a letter was sent to ACOS Members and Candidates containing the following warning:

> "If you fail to accept the suggestion of the Board, or if the Board finds your present practice, or indicated practice, violates the Code of Ethics of the College, then, and in that event, your membership (or Candidate status) is revoked by the Board of Governors ... ."

Dr. Classen's message and the warning letter caused a furor within the profession and released a flurry of denunciatory phone calls and letters to the ACOS from the AOA's president and executive secretary and the president of the American College of Osteopathic General Practitioners, who accused the College of becoming militant. AOA Executive Director True B. Eveluth, D.O., warned the ACOS that it was not "an island unto itself" and reiterated that interpretations of AOA's Code of Ethics not approved by the Board of Trustees were nonbinding.

In a second letter to the ACOS, Dr. Eveluth accused the College of violating the moratorium to which it had agreed. He suggested that the ACOS desist from activities that "aggravate the pot and keep it boiling."

> "When the Medicare program was finally passed and the rules and regulations said that there would be no splitting of fees under any guise whatsoever, the AOA and all its members should thank the ACOS for anticipating this move, and for fighting for the high ideals of no unnecessary surgery, no ghost surgery, no incompetent surgeons, and no splitting of fees. Many members of the osteopathic profession and many of the leaders in responsible positions of the AOA know that unnecessary surgery, ghost surgery, splitting of fees, and untrained surgeons and specialists have been prevalent in our profession. Instead of fighting the ACOS, they should compliment the College for taking a firm position and doing something about these nefarious practices."
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> *—From the 1968 white paper titled "ACOS Membership Authority," written by C. Robert Starks, D.O., chairman of the ACOS Ethics Committee, on the College's battle against fee splitting and the AOA. The paper, which provided Members with a detailed history of the history, was controversial in the eyes of the AOA.*

The ACOS, however, believed it had acted in accordance with the existing Code of Ethics and not in violation of the moratorium; it had merely attempted to sanction physicians who were in violation of the Code's provisions. The ACOS Ethics Committee had worked long and hard for years to aggressively combat unethical billing practices, and it had increasingly become dissatisfied with the AOA's complacent attitude. Such an attitude was especially grating given the development of regulations by the former U.S. Department of Health, Education, and Welfare regarding the payment of physicians under Part B of the Medicare program. Those regulations eventually became the standard of practice across the country and were consistent with the College's ethical stance regarding billing practices. Further, the College believed it

had a right to self-determination, especially in matters relating to the professional conduct of its members.

The conflict between the ACOS and the AOA came to a head in January 1967, when the AOA Committee on Ethics proposed a resolution weakening Item 4 of the Code of Ethics. The resolution stated that a joint or combined bill was not considered unethical and was, in fact, ethically permissible in certain circumstances, such as when a physician engaged other physicians to assist in the performance of a surgical procedure, "whether or not he be a referring physician, and to pay a reasonable amount for such assistance provided the nature of the financial arrangement is made known to the patient."

The real issue, however, was not Item 4 but the right of the ACOS as an affiliate to set its own ethical standards and to discipline its own Members and Candidates. The AOA Board of Trustees maintained that the College did not have this right, and further requested that the ACOS reinstate nine physicians whom the College suspended in 1967 for ethical violations.* ACOS disagreed with AOA's position, citing Article III, Section 7, of its bylaws, which held that "The Board of Governors shall exercise complete authority in regard to the membership status of all Members in the College."

Accordingly, the College did not believe it had to follow AOA's directive and reinstate the Members. For as ACOS Executive Secretary Charles L. Ballinger, D.O., stated in a letter to AOA's Dr. Eveluth, "[ACOS] under its Charter and Bylaws is an autonomous organization and as such will continue to enforce its bylaws as it pertains to its Members and Candidates."**

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* *At a special meeting of the ACOS Board of Governors on March 5, 1967, in Coral Gables, Florida, seven Members and two Candidates were suspended based on a report and hearings of the ACOS Ethics Committee. Although the AOA maintained that the College had not followed due process in suspending the surgeons, and that such suspension should therefore be nullified, the ACOS strictly adhered to the procedures set forth in its bylaws. The interrogations that had led up to the suspensions were conducted formally and courteously, and were attended by the College counsel. The nine surgeons also were allowed to be represented by counsel.*

** *Interestingly at this time, another group was having difficulty with the AOA over the right to control its membership: The Association of Osteopathic Specialty Organizations (AOSO).*

The AOSO—which did not have AOA recognition—held a meeting in Chicago attended by twenty-eight representatives of twelve organizations—all of which were AOA-affiliate specialty organizations and nonpractice organizations, including the American Osteopathic Hospital Association (AOHA) and the Association of Osteopathic Directors and Medical Educators.

In July 1968, at AOA's annual meeting, the House of Delegates passed a resolution requiring ACOS to reinstate its suspended members without prejudice and to "realize the Code of Ethics of the AOA and the AOA interpretation thereof." The Michigan, Texas, and Missouri state osteopathic associations had previously passed resolutions demanding the ouster of the ACOS, and the former two also had pushed for the establishment of a substitute college of surgeons by the AOA. The College was given an October 1 deadline to comply with the AOA resolution.

The College's Board held a number of meetings to discuss the issue and ultimately decided that it should be put before the membership—something that would not be possible until late in October, during the Annual Clinical Assembly (ACA). On October 15, AOA Executive Director Edward P. Crowell, D.O., sent the ACOS a letter notifying the College that its affiliation had been rescinded and that a new affiliate had been established in its stead: the American Osteopathic College of Surgeons, or the AOCS.***

Surprisingly, the AOA's action seemed to spur attendance at the ACA a few weeks later. The number of participants reached an all-time high, and members demonstrated their allegiance to the College and encouraged it to continue its fight to maintain high ethical standards.

Following the convention, six ACOS members brought suit in Tarrant County, Texas, district court against the AOA to prevent the disaffiliation of the College and the formation of AOCS. The six included Gordon S. Beckwith, D.O., Thomas T. McGrath, D.O., Albert C. Johnson, D.O., Arthur M. Flack, Jr.,

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In the main, these organizations were sympathetic to the difficulties the ACOS was facing, although they made it clear that their organizational purpose was not to pressure the AOA; instead, it was to promote an exchange of information to improve patient care and professional education, and to create better professional relationships and closer communications between specialty practice and nonpractice organizations. For years, the group had sought AOA recognition but for unexplained reasons had been refused. Like the ACOS, the organizations were concerned about their inability to control their own memberships.

The loosely organized AOSO would be re-established in the late 1980s as the Federation of Osteopathic Specialty Organizations (see Chapter 6, pages 94–95).

****Ironically, several years earlier, the ACOS considered modifying its name to the American Osteopathic College of Surgeons. It decided against the change, however, because it was believed that the word "osteopathic" should modify "surgeons" rather than "college."*

"This is to inform you that on October 1, 1968, the Board of Trustees of the American Osteopathic Association, in accordance with a resolution adopted by the AOA House of Delegates on July 23, 1968, rescinded the official affiliate status of the American College of Osteopathic Surgeons and established a new College of Surgeons."

—From an October 15, 1968, letter to ACOS from AOA Executive Director Edward P. Crowell, D.O.

"We are now an autonomous organization. Consequently, we are in a position to interpret and implement our Code of Ethics and Bylaws and continue our stand against the immoral, unethical, and unlawful practice of fee splitting, without interference from political osteopathy. ... It is my sincere wish that we can eventually resolve our differences. However, strict application of our Code of Ethics requires stringent and steadfast adherence to our convictions."

—ACOS President Charles H. Brimfield, D.O., from his inaugural address at the 1968 ACA, just a few weeks after AOA disaffiliated ACOS

D.O., Richard A. Michael, D.O., and Dr. Classen, the latter four of whom had served as ACOS presidents. As a result of their suit, a temporary restraining order was issued.

In January 1969, the AOA Board of Trustees passed a resolution calling for binding arbitration to resolve the issue of ethics and whether ACOS had the right to sanction its own members. The ACOS Board of Governors approved the resolution in February.

- ***1956***—*The ACOS holds its first hearings into members' alleged violations of the AOA's Code of Ethics.*
- ***1960***—*The ACOS introduces an expanded and improved membership directory.*
- ***1961***—*The California Osteopathic Association and the California Medical Society merge, threatening the existence of the ACOS and negatively impacting the profession for years to come. As a result of the merger, ACOS expels its California members.*
- ***1962***—*By a statewide referendum, the voters of California vote to disband the Osteopathic Board of Examiners. Osteopathic graduates are thereby prevented from taking their state osteopathic medical boards and becoming licensed as osteopathic physicians (D.O.s) in the state.*
- ***1962***—*The* ACOS News *makes its debut.*
- ***1963***—*For the first time, the ACOS offers a postgraduate course for surgical residents.*
- ***1964***—*For the first time, the ACOS Ethics Committee threatens eleven members with loss of membership for violating the Code of Ethics.*

After several postponements, the first meeting under the auspices of the American Arbitration Association (AAA) was held. Arbitrators were selected who were to address the following issues:

1) When the ACOS disciplines a Member, does the AOA have the right or power to negate such disciplinary action?

2) Did the ACOS afford proper hearing to the Members and Candidates that the College disciplined by the Board of Governors action voted unanimously in a special meeting of the Board, March 6, 1967?

3) With respect to its own members, does the AOA have the right, power, duty, and obligation to oppose the division of fees under any guise whatsoever?

4) With respect to its own Members and Candidates, does the ACOS have the right, power, duty, and obligation to oppose the division of fees under any guise whatsoever?

In 1969, arbitrators upheld the actions of the ACOS. In essence, they denied the AOA the right or power to negate a disciplinary action taken by the ACOS if the physician had a proper hearing. The arbitrators also ruled that the ACOS had followed proper procedures in this regard. Further, they stated that both organizations not only had the right *but the obligation* to oppose the division of fees under any guise. The arbitrators recommended that the suspended and denied members be given the opportunity to be re-examined and readmitted if they were found to be in compliance with the ethical codes.

The ACOS had prevailed. It was a victory not just for the organization and the profession, but for patients across the country.

AMERICAN ARBITRATION ASSOCIATION, Administrator

Commercial Arbitration Tribunal

In the Matter of the Arbitration between
AMERICAN OSTEOPATHIC ASSOCIATION

AND

AMERICAN COLLEGE OF OSTEOPATHIC SURGEONS

Case Number: 51 10 0027 69

Award of Arbitrator(s)

~~I~~(WE) THE UNDERSIGNED ARBITRATOR(S), having been designated in accordance with the Arbitration Agreement entered into by the above-named Parties, and dated July 8, 1969 and having been duly sworn and having duly heard the proofs and allegations of the Parties, ~~AWARD~~ FIND as follows:

A.

1) With respect to the question "Where ACOS disciplines a member, does AOA have the right or power to negate such disciplinary action?" The answer is no insofar as discipline pertains to ACOS membership.

2) "Did the ACOS afford proper hearing to the following listed members and candidates in the College disciplined by the Board of Governors in action voted unanimously in a special meeting of the Board, March 6, 1967?" The answer is yes.

3) "With respect to its own members,does the AOA have the right, power, duty and obligation to oppose the division of fees under any guise whatsoever?" The answer is yes.

4) "With respect to its own members and candidates, does the ACOS have the right, power, duty and obligation to oppose the division of fees under any guise whatsoever?" The answer is yes.

The arbitrators also desire to have forwarded to ACOS, the recommendation of the arbitrators that ACOS once again offer the three (3) members of ACOS who were disciplined, an opportunity to apply for reinstatement and a hearing on such application and to report on the basis of current fee practices the findings and decision of ACOS as to each doctor who so applies for reinstatement to AOA.

The arbitrators also suggest that similar steps be taken with respect to the two applicants for membership whose applications were denied.

B. The administrative fees of the American Arbitration Association in the total sum of $200.00 shall be borne equally by the parties, therefore, the RESPONDEI shall pay to CLAIMANT the sum of $100.00 for their share of the fees previous advanced by CLAIMANT to the Association.

C. This Award is in full settlement of all claims to this arbitration.

The July 8, 1969, ruling of the American Arbitration Association.

The California Split

The fight to uphold ethical billing practices and the right to organizational autonomy were not the only challenges the ACOS faced in the 1960s. Of even greater seriousness was the merger of the California Medical Society and the California Osteopathic Association. That event would threaten the College's very existence and would affect the ACOS and the osteopathic profession for years.

The merger took place in 1961, and as a result, the ACOS expelled its California members. (ACOS bylaws held that College members had to be members of the AOA, to which these physicians no longer belonged; hence, the action taken against them.) In addition, the College replaced its newly elected president, Ernest G. Bashor, D.O., of California, with Kamig Tomajan, D.O. This was an unprecedented move, marking the first and only time an ACOS president had served two terms.

The crisis was precipitated by osteopathic physicians in California who believed that merging with allopathic physicians gave them more prestige and supported a statewide referendum to disband the Osteopathic Board of Examiners, a measure that was to go before California voters in 1962.* The Board of Examiners had been authorized in 1922—at the request of osteopathic physicians and surgeons in that state.

The ACOS opposed the California merger for several reasons. One of the most pressing was that it represented a serious setback to the development of osteopathic medicine, a relatively new and small profession that was entering a critical period of its development. To accept the merger was to accept that osteopathic medicine had no contribution to make to the practice of medicine, an untrue yet serious charge that might be echoed beyond the state's borders. Also of concern to the College was the substantial potential drop in members and, thereby, dues, and the loss of osteopathic college and county hospital facilities for training programs. Estimates were that some seventy-two approved residences and 100 internships would be lost. In fact, some 2,500 members would be lost, accompanied by a 20 percent decrease in training opportunities. The subspecialties of neurosurgery, thoracic surgery, and urology were especially hard hit.

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* *The Board, in fact, was disbanded, preventing osteopathic graduates from taking their state medical boards and, thereby, becoming licensed in California. The AOA would fight that decision in the courts and would prevail twelve years later.*

To complicate matters further, the fledgling American Academy of Osteopathic Surgeons (AAOS) was recruiting members, an effort that further weakened the College. The AAOS had even tried to recruit as its executive director Esther Martin, the former executive secretary of the ACOS, who had recently become executive director of the AOBS. She declined.

The expulsion of the ACOS members residing in California was not without controversy. Howard E. Lamb, D.O., a respected surgeon who had joined ACOS two years after its founding, advocated for the former members, most of whom wanted to retain their membership, "even though the [osteopathic] program in California is consummated and the two professions are amalgamated."

Dr. Lamb noted that membership in the American College of Surgeons (ACS) did not require members to belong to the AMA; he, therefore, proposed that the ACOS change its bylaws, making the College autonomous from the AOA. The AOA membership would no longer be required, thus allowing the readmission of California members as honorary, dues-paying members.

Ultimately, the ACOS rejected this measure. Loyalty to the profession and organized osteopathy was essential, it maintained. The College's position also was adopted by the AOA, which decided to fight to preserve the practice of osteopathic medicine in all states. For as John P. Schwartz, D.O., so eloquently stated, "Those who joined this College in the interest of bettering their own positions and now join with organized medicine for the same purpose have no claims on this College that justify special consideration."

The blow inflicted by the loss of the California contingent was a hard one. And yet, in keeping with the determined spirit and professionalism of ACOS leaders and members, the College held firm. Much of the remainder of the decade was spent replenishing its surgical training programs. In the rebuilding process, however, the educational and residency programs, like the organization itself, grew stronger, better, and more encompassing.

Critical Moments in History: The California Split

—From October 30, 1961, remarks by John P. Schwartz, D.O., FACOS

"Members of the American College of Osteopathic Surgeons, I want to precede my remarks by submitting to you one question, and this is: 'What is the responsibility of the American College of Osteopathic Surgeons to our national organization, the American Osteopathic Association?' The AOA anticipates a loss of some 1,500 members in California. This constitutes a serious setback in the development of osteopathic medicine, not just because of income loss or numerical membership count, but through a reduction in the total impact of this relatively small profession in a critical period of its development.

The damages to all facets of osteopathy by the merger in California are significant and quite evenly distributed. Loss of the osteopathic college and county hospital facilities may be considered as the most serious single area of damage. The training programs in osteopathic hospitals will be lessened by seventy-two approved residencies and more than 100 internships. The specialty colleges will, along with the rest of the affiliates, suffer losses in membership and highly qualified associates.

Perhaps the side effects of the merger will constitute the most serious and the more lasting problems. The wide span of publics, including osteopathic physicians themselves, which must act favorably to the merger, had to be told and convinced that osteopathy has no contribution to make and has no scientific or social reasons to exist. The D.O.s with the able assistance of the M.D.s have inflicted what may be irreparable damage to osteopathic medicine in California, and these damages are being projected beyond the borders of California into other states. When the voters of all California go to the polls in 1962, they will be asked to eliminate the Osteopathic Board of Examiners, which they authorized at the request of osteopathic physicians and surgeons in 1922. Now the osteopathic physicians are asking them to reverse that decision in the plan to eliminate everything osteopathic in that state.

Our colleagues throughout the profession expect continued loyalty and leadership from us. Ever since this College was formed in 1926, its objectives have been to encourage the study of the science of surgery, surgical diagnosis, pathology, and the application of osteopathic principles, practice, and treatment thereto. Some of us were around in those days, and I doubt that much consideration would have been given to a group from any state which held that because of their interest in leaving the osteopathic profession they should be given special consideration by this College. I haven't heard any official state sentiment in that direction since that time. Yet now, thirty-five years later, we are hearing sugges-

The California Split continues on page 52

From *The California Split*, page 51

tions that we rewrite our Bylaws so as to separate ourselves from the American Osteopathic Association in order to accommodate a group that has decided to abandon the osteopathic profession and seek 'prestige.'

Those who find no prestige in their D.O. degrees will bring none to this College by their membership therein. Nor will this College gain prestige by disassociating itself from its osteopathic foundations.

AOA, through its House of Delegates representing all states, has decided it can and will fight to preserve the osteopathic school of practice in every state. While AOA does not represent the entire osteopathic population, it represents the vast majority. AOA asks and expects the American College of Osteopathic Surgeons to face its responsibilities with objectivity and the determination that the future and importance of the profession transcends personal or financial consideration. And I contend that this College should suffer its share of the damages inflicted by the defecting members, along with the rest of the organization.

Appeasement has been the device of the weak throughout history and has not solved any problems. To appease is to postpone, and to postpone will serve no more useful purpose here than elsewhere. Those who, through their actions or their willingness to take a stand, acceded to the plot to withdraw from osteopathy have no claims on this College or its future. Those who joined this College in the interest of bettering their own positions and now join with organized medicine for the same purpose have no claims on this College that justify special consideration.

We, as individual D.O.s, as surgeons, or as a specialty College, cannot improve or even maintain the status we now enjoy by denouncing or ignoring the principles and concepts of our heritage. To strike our colors now is to admit to a fraudulent past and a gross violation of a public trust.

I think there is not one of us who does not regret that this situation exists, and I think there are few, if any, of us without the courage to meet our responsibilities. To compromise or equivocate now is to weaken all that we have worked so determinedly to develop.

I began with a question and I close with one: 'Do we comfort the forces which seek to destroy our profession or does this American College of Osteopathic Surgeons maintain our long-standing position of leadership in this profession?'"

Other AMA Efforts to Absorb Osteopathic Physicians

In 1969, the AMA House of Delegates approved amendments to its bylaws that allowed qualified osteopathic physicians admission as full and active members of the Association. Osteopathic physicians also would be considered for certification and allowed to participate in AMA-approved intern and residency programs. AOA President Roy S. Young, D.O., rejected the action as arrogant, however, stating that it was a frantic effort on the part of the AMA to absorb and dominate a competing school of medicine.

Certainly that had been the case in California, and ACOS President Charles H. Brimfield, D.O., was determined that it not happen again, even though the AMA offered to honor AOBS certification exams and allow the osteopathic certifying board to write its own.

The AMA threat was a real and pressing one, for the AMA was itself threatened by the growth of the osteopathic profession and by the increased support it was receiving from the government and the public. The AMA delegates stressed the urgency of the matter, noting that a new osteopathic college was going to be established in Michigan unless the growth of the osteopathic profession was halted in that state and through the nation. State after state with restrictive osteopathic practice acts pleaded with the AMA to take action because the osteopathic groups were proposing equal practice rights throughout the states, measures that were increasingly difficult to defeat in the state legislatures.

AMA President Dwight L. Wilbur, M.D., urged the AMA's House of Delegates to adopt its Board of Trustees' nine-point program for the elimination of the osteopathic profession. The program was little more than a sophisticated version of the nearly ten-year-old program that had enticed some 2,500 D.O.s in California down the road to oblivion. The AMA hoped that the osteopathic profession had learned little from the experience in California and that osteopathic physicians could be persuaded to serve as pall bearers at their own funerals. Indeed, the AMA cherished the idea that osteopathic physicians were anxious to join it, in spite of its dwindling and antiquated power.

It would take many years before the AMA would understand and accept that the "osteopathic problem" would not go away, that the osteopathic profession would not allow itself to be absorbed by another branch of medicine, and that osteopathy would continue to grow. Ultimately, the AMA would learn that to attack osteopathic physicians was to attack the

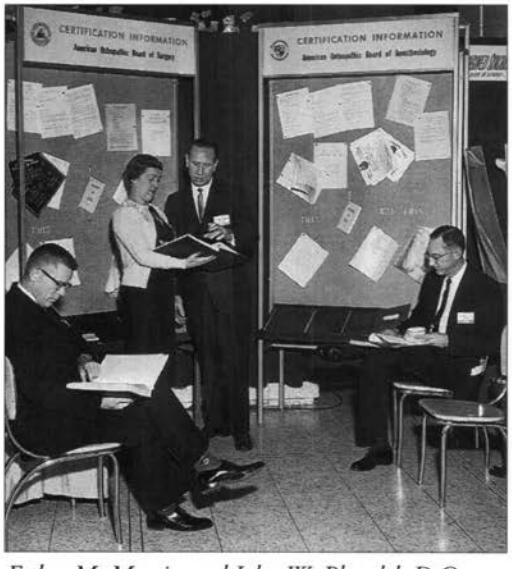
millions of patients who, by choice, sought their care.

The osteopathic profession had a mandate from its patients and that mandate had to be defended. It was the responsibility of the profession to maintain its identity and integrity in public service to the people who had given it strength. The profession would accomplish this over the next decades; it could do no less.

Bright Spots

Despite the serious challenges and setbacks in the 1960s, the ACOS continued to grow and experience new firsts. By the end of the decade, the ACOS had four subspecialty sections, or disciplines: surgical urology, cardiothoracic surgery, neurosurgery, and proctology. The Sixties also marked the first time a woman in the osteopathic profession—Betty Jo White, D.O., of Grove City, Pennsylvania—completed a surgical residency. Prior to that time, only one other woman—Margaret Jones, D.O., FACOS—practiced surgery, but her training, which preceded the establishment of formal residencies, had been informal.

Educational opportunities at the ACA continued to be strengthened and to reflect the growth of attending specialty groups. In 1968, the Academy of Osteopathic Directors of Medical Education met at the convention for the first time. In addition, a President's reception, which was held the day before the conference's formal opening, was inaugurated.



Esther M. Martin and John W. Phardel, D.O., stand before Annual Clinical Assembly exhibit booths that provide information on certification by the American Osteopathic Board of Surgery and American Osteopathic Board of Anesthesiology (circa 1960s).

The 1960s also saw the release of two redesigned and improved the ACOS publications. In 1960, a new membership directory format was introduced that included a short history of the College, lists of officers, committee appointments, bylaws, clinical assemblies, in memoriams, and the Code of Ethics. Alphabetical listings of Members and alphabetical and geographical listings of Candidates also were included. Designed as a desk reference, the handsome publication became the prototype for directories up through the present day.

ACOS NEWS

Vol. 1 No. 1 AMERICAN COLLEGE OF OSTEOPATHIC SURGEONS April, 1962

Florida 1962 Host Annual Clinical Assembly

The AMERICANA HOTEL, Bal Harbour, Miami Beach, Florida, will host the Thirty-Fifth Annual Clinical Assembly of the American College of Osteopathic Surgeons and the organizations and sections participating with it in the 1962 edition of what has become known as an outstanding convention of the Osteopathic profession. Although its programs are geared to the understanding of and for dissemination of the latest information to the Members and Candidates of each specialty organization taking part in the meeting, many general practitioners in recent years have found much of benefit to them by their attendance at the scientific sessions.

The convention facilities at the Americana Hotel are unsurpassed. The huge Grand Ballroom may be divided by flexible sound-proof partitions to house several meetings and the industrial and the scientific exhibits as well. Consequently, a large exhibit area surrounding a convenient Coffee Lounge will be placed in the Grand Ballroom, around the periphery of which adequate meeting rooms will be produced to accommodate the program sessions of the American College of Osteopathic Surgeans, the American Osteopathic Hospital Association, and the American Osteopathic College of Anesthesiologists. As well, banquets of some of the organizations will be held in these ballrooms. The Registration Desk will be placed adjacent to the exhibits area on the lobby side of the Grand Ballroom.

All of the program and teaching sessions scheduled for the American Osteopathic College of Radiology will be held in the beautiful Medallion Room. The Caribbean suite will be divided into two functional rooms, the Bermuda and the Barbados, to be occupied by the American Osteopathic Academy of Orthopedics and the Urological Section of the American College of Osteopathic Surgeons for their meetings and program sessions. These arrangements have been made in order to hold all of the meetings on the ballroom side of the lobby of the Americana Hotel.

Luxuriously appointed rooms, suites, and lanai apartments have been reserved in sufficient numbers to accommodate almost all of the Members and Candidates expected to attend the 1962 meeting. Other handsome cooperating ocean-front hotels stand ready to augment the housing facilities of the Americana by caring for the overflow.

Locationwise, the Americana is ideally secluded for the "business on hand," and yet only minutes away from all of the exciting attractions Miami Beach and the entire Gold Coast has to offer. For work and play the Americana offers the best of everything; several fine restaurants in the hotel stand ready to serve you fine foods at reasonable prices.

Sports activities of every variety associated with a warm climate are available for your entertainment and relaxation: golfing, sailing, fishing, water skiing, and hunting are a few of the sports in which you may engage. Cruise trips of a day, a week, or a fortnight may be arranged to the nearby Bahamas, the islands of the Caribbean or South American ports and return; consult your travel agent for particulars.

The last week in October is usually one of the nicest times of the year in Southeastern Florida. Ordinarily, the temperature is just right, neither too hot nor too cold, and sunshine every day can almost be guaranteed. Place attendance at the Thirty-Fifth Annual Clinical Assembly at the top of your list of things to do in 1962. Many will make it part of a family vacation.

NEW COLLEGE PUBLICATION INTRODUCED TO SURGEONS

Subscribers in A. C. O. S. Group Life Insurance Program are reminded that there is NO GRACE PERIOD for payment of premiums next due May 1, 1962.

This is the first issue of a brand new publication of the American College of Osteopathic Surgeons — ACOS NEWS. Plans in recent years to publish the BULLETIN six times or even four times annually, have failed of attainment. "MR. CLIPS" was an abortive effort to get more news to the Members and Candidates of the College; only three issues were published in 1959.

The members of the Board of Governors and the staff of the Administrative Office have tried to devise means and to recruit personnel to furnish the Members and Candidates of the College with information more regularly concerning the activities of the organization, of its services, and of the duties and responsibilities discharged by its committees. ACOS NEWS will not completely replace the BULLETIN of the American College of Osteopathic Surgeons; a preconvention and postconvention issue may be expected. This new news medium, like the BULLETIN, will not contain scientific articles but may be considered rather in the category of a "house organ." Articles will be brief and concise, and confined to two to four pages depending upon the amount of material available and the urgency for dissemination of the information which subsequent numbers may contain.

What would you like to read about or learn more about through the pages of ACOS NEWS? Would you like more "personals" relating to interesting professional and other honors and attainments of the Members and Candidates? Would you like to know, for example, that other colleagues enjoyed a happy and satisfying experience similar to that of President-Elect Emmett Binkert, when more than three thousand people inspected the new facilities of Carson City Hospital, an institution which he founded and has seen develop into the largest (82) beds and finest hospital in the area which it serves.

We will "work like beavers" to produce what you like. Criticisms, comments and suggestions are solicited; even more important, send us news for publication about yourself, your family, your colleagues in the American College of Osteopathic Surgeons.

The first issue of the ACOS News.

Two years later, the first issue of the *ACOS News* made its debut. Although smaller than its precursor, *The Bulletin,* it was published monthly and thereby furnished Members and Candidates with information on a more regular basis.

The decade also saw the first publication of *Orthopod,* published by the American Osteopathic Academy of Orthopedics (AOAO) and distributed at the 1966 ACA in honor of the AOAO's twenty-fifth anniversary. *Orthopod* provided an overview of the organization's first quarter century of existence.

Training Programs Expand and Become More Sophisticated

For the first time, in 1963, the ACOS offered a postgraduate course for surgical residents. The well-attended two-week course, which was the brainchild of J. Natcher Stewart, D.O., was held in Arlington, Texas, and offered 100 hours of study in the basic sciences related to surgical practice and advanced clinical surgery.

Also for the first time, in 1965, the ACOS conducted a new teaching course in surgery, which allowed participants to observe surgical techniques in operating rooms. Surgery in each of the difficult cases chosen for the course was performed by some of the most well-respected osteopathic surgeons in the profession. Case histories were discussed by the residents. A discussion of the pathologies of the cases followed, along with a presentation of slides prepared by pathologists. Special observation stands also were constructed.

In 1969, the ACOS held its First Inquisitional Forum. Participants included surgeons who prepared papers based on their own surgical experiences, and

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- ***1964**—The ACOS and the AOA hold a joint conference on ethics during which they propose changes to the AOA's Code of Ethics in an effort to tighten compliance. The two groups also pass a resolution requiring hospitals to adhere to the Code in order to maintain their accreditation.*
- ***1964**—Surgical departments in osteopathic hospitals begin to take a stronger stand against the division of fees.*
- ***1964**—The ACOS recommends to the AOA Committee on Hospitals and the AOA Bureau of Professional Affairs that a four-year residency be required in general surgery and orthopedic surgery. The measure will go into effect January 1, 1967.*
- ***1965**—For the first time, the ACOS conducts a teaching course in surgery that allows participants to observe surgical techniques in operating rooms. A hospital inspectors' school also is established.*
- ***1966**—The American Osteopathic Academy of Orthopedics (AOAO) is organized.* Orthopod, *an AOAO publication, makes its debut.*
- ***1966**—The ACOS and the AOA hold a joint meeting to iron out additional modifications to the Code of Ethics; the ACOS proposes the addition of Item 4, which prohibits fee splitting under all circumstances.*

internists, pathologists, radiologists, and anesthesiologists, who served as critics. The forum was one of the most valuable and sophisticated educational opportunities of its kind. Although future inquisitions were held, none would match the quality of the very first session. The forums were discontinued in 1972.

The mid-1960s also saw great strides in the development of osteopathic residency programs. In 1964, the ACOS recommended to the AOA Committee on Hospitals and the AOA Bureau of Professional Affairs* that a four-year residency be required in general surgery and orthopedic surgery. This requirement was approved and went into effect January 1, 1967. The evaluation of residency programs concurrent with the AOA Committee on Hospitals' inspections also was approved, with interim surveys being conducted by specialty college evaluating committees, which could request the elimination of programs that were inconsistent with effective teaching. In addition, inspection teams were created to inspect multiple specialty training programs. To train inspectors, AOA for the first time in 1965 held a hospital inspectors school, which continues to the present. That same year, the AOA recommended that exchange, or "out-rotation," programs be established among hospitals in certain training areas in order to strengthen these programs.

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* *The AOA Committee on Hospitals also was known as the AOA Bureau of Hospitals. Today, it is known as the Bureau of Healthcare Facilities Accreditation, which is under the auspices of the AOA Department of Educational Affairs. The AOA Bureau of Professional Affairs now is called the Bureau of Professional Education.*

- ***1966**—The AOA challenges the ACOS's right as an affiliate to act independently and to take steps to suspend College members for Code of Ethics' violations.*
- ***1966**—The ACOS agrees to a moratorium on additional interpretations of the AOA Code of Ethics to maintain the peace between the organizations.*
- ***December 12, 1966**—ACOS President Theodore F. Classen, D.O., issues a message to Members threatening those who engage in fee splitting with suspension of their membership.*
- ***1968**—The Academy of Osteopathic Directors of Medical Education meets for the first time at the ACA.*
- ***January 1968**—The AOA Committee on Ethics proposes a resolution attacking Item 4 of the Code of Ethics and requests that the ACOS reinstate nine physicians whom the College suspended for ethical violations.*
- ***July 1968**—The AOA House of Delegates passes a resolution requiring the ACOS to reinstate its suspended members without prejudice by October 1. The College decides to put the matter before its membership during the ACA, which does not meet until after the deadline.*

Leaders of Note



Howard C. Baldwin, D.O.

Dr. Baldwin assumed the ACOS presidency in 1962, a critical year for the College, which had just suffered a substantial loss in members and training facilities as a result of the merger of the California Medical Society and the California Osteopathic Association. Through strength, skill, and determination, Dr. Baldwin kept the ACOS on track. In recognition for his years of service as a member and chairman of the College's evaluating committee, and for his support of excellence in education and training, he was awarded the Orel F. Martin Medal in 1975.

Howard R. Graney, D.O.



Like his predecessor and mentor, J.P. Schwartz, D.O., one of the College's founding members, Dr. Graney has given unselfishly his time and energy to support the growth of the ACOS. In the late 1950s, he served on the College's Rules and Regulations Committee, which updated bylaws, rules, and regulations to improve the functioning of the ACOS. A strong opponent of fee splitting and an avid proponent of quality education programs, he received the 1977 Orel F. Martin Medal. Dr. Graney also is credited for his invaluable contributions to the development of this ACOS history.



Paul R. Koogler, D.O.

As a member of the ACOS Ethics Committee, Dr. Koogler devoted his time and energy to the battle against fee splitting. Later, in 1966, while serving as ACOS president, he guided the planning of the 4th Annual Postgraduate Course, which resulted in the creation of an ACOS–American Osteopathic College of Radiology joint curriculum. He received the Orel F. Martin Medal in 1972.

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Esther F. Martin

Like her husband, Orel F. Martin, D.O., the College's first permanent secretary/treasurer, Mrs. Martin was tireless in her devotion to the organization. Mrs. Martin maintained the professional affairs of the College during her husband's long illness and become ACOS executive secretary upon his passing. She worked for the College until 1960, when she was named corresponding secretary of the AOBS. In 1958, she was made an honorary member of the College and the award of Fellow was bestowed upon her. In 1978, she received the ACOS's most prestigious award, the Orel F. Martin Metal, in recognition of her many accomplishments on behalf of the College and the profession.

Howard J. McAnally, D.O.

Dr. McAnally nobly served as president of the ACOS in 1957 and as College secretary during the tumultuous years 1960 to 1969. In 1969, the ACOS bestowed upon him the Orel F. Martin Medal in recognition of his many years of service to the College and osteopathic profession.





J. Donald Sheets, D.O.

Among his many contributions, Dr. Sheets served on the College's Rules and Regulations Committee, which in the late-1950s undertook the Herculean task of updating bylaws, rules, and regulations to improve the functioning of ACOS. Dr. Sheets served as College president in 1956 and was a staunch supporter of the College's stance on fee splitting. He received the Orel F. Martin Medal in 1971.

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C. Robert Starks, D.O.

As chairman of the ACOS Ethics Committee, Dr. Starks was a major force in the College's fight against unethical billing practices among Members and the profession. An ACOS Fellow, secretary (1973), and Orel F. Martin Medal recipient (1973), he also was a founding member of the American Osteopathic Academy of Orthopedics (AOAO), and the first and only two-term president of the AOA. His impressive credentials underscored the integrity of the ACOS Ethics Committee, to which he brought high professional standards and an abiding sense of fairness.

James O. Watson, D.O.



Dr. Watson chaired the Special Reference Committee that examined the effect of *Lilly* v. *IRS* on the profession and helped the College develop its stance against fee splitting. A dedicated board member, he served as president in 1953 and received the Orel F. Martin Medal in 1970. Dr. Watson, who was instrumental in obtaining full practice rights for osteopathic physicians in Ohio, was a member and past chairman of the Federal Health Programs in Washington, D.C. (1941-1960). He received numerous honors and awards over the years and was named honorary president of the Ohio Osteopathic Association in 1972, the only individual to be so honored.

- ***October 15, 1968**—The AOA sends the ACOS a letter notifying it that its affiliation has been rescinded. The AOA establishes a new affiliate to replace the College: the American Osteopathic College of Surgeons (AOCS).*
- ***November 1968**—Six ACOS members bring suit in Tarrant County, Texas, district court against the AOA to prevent the disaffiliation of the College and the formation of the AOCS. A temporary restraining order is granted.*
- ***January 1969**—The AOA Board of Trustees passes a resolution calling for binding arbitration to resolve the issue of ethics and whether the ACOS has the right to sanction its own members. The ACOS Board of Governors approves the resolution in February.*
- ***1969**—The ACOS holds its First Inquisitional Forum. Inquisitional forums will continue to be held until 1972.*
- ***July 1969**—The American Medical Association (AMA) opens its doors to osteopathic physicians.*
- ***July 1969**—American Arbitration Association arbitrators rule in favor of the ACOS.*

Chapter 5: Into the Light

1970–1979

Whereas the 1960s marked a period of turmoil and change for the American College of Osteopathic Surgeons (ACOS), the 1970s was a time for strengthening the foundation upon which the College was founded. The dark days of the Sixties had passed, days that had been filled with conflicts over unethical billing practices, the College's right to discipline its own membership, and the desertion of its California members. Thus, once again, the ACOS was able to channel all of its energies into its primary mission: the development of osteopathic surgical training programs.

The ACOS raised the quality of surgical education by instituting three new concepts—in-service examinations for residents, self-evaluation examinations for practitioners, and required continuing medical education (CME) for the entire profession. The great strides made through these programs contributed to increased recognition by the allopathic community and federal government of osteopathic medicine as a legitimate, independent branch of medicine.

In great part, this change in perception was the result of the vision, hard work, and commitment of a number of surgeons who

then, as now, are regarded as giants in the field of osteopathic surgical training. As they passed the mantle of responsibility for training from one generation to the next, osteopathic surgery enjoyed a period of tremendous growth and maturity and witnessed many firsts. Among them: the introduction of In-depth Reviews; the founding of the American Osteopathic Board of Orthopedic Surgery (AOBOS); the participation of the American College of Osteopathic Pathologists (ACOP) at the Annual Clinical Assembly (ACA); the inauguration of the Distinguished Osteopathic Surgeon Award; the use of computers for exam analysis and CME tracking; the purchase of a building in Coral Gables, Fla., to house the College; and the first paid advertisement and article on medical writing techniques in the *ACOS News.*

Residency Exams and Self-examinations

As part of its ongoing effort to improve training standards, the ACOS initiated an in-service exam for residents. The goal of the exam, which was conducted in 1970 by the Professional Examination Service (PES), the prestigious New York testing firm specializing in examinations for the health professions, was to identify any weaknesses in the four-year programs then in place so they could be strengthened, where appropriate. Eventually, this and other types of evaluations of residency training led to the lengthening of surgical residencies to an internship plus four years of residency training.*

In the 1970s, the ACOS also initiated a series of self-examinations for surgeons in practice. Their purpose was threefold: 1) to help osteopathic surgeons gauge their strengths and weaknesses so they could identify any additional training they needed; 2) to identify the need for new CME

* *In-service examinations for residents are again being conducted by the ACOS. The first exam in recent years was given in early 1994, and was constructed by College volunteers, with the technical support of the National Board of Osteopathic Medical Examiners (NBOME).*

ACOS Chronology

- ***1970****—The ACOS conducts its first in-service exam to provide data on the educational weaknesses of surgical residencies.*
- ***1971****—The ACOS conducts its first self-examination to help osteopathic surgeons gauge their strengths and weaknesses, and to identify subject areas for future continuing medical education (CME) programs.*

programs and strengthen existing ones to meet physicians' needs and thereby improve patient care; and 3) to serve as the basis upon which mandatory continuing medical education could be developed. Exam results were solely for the physicians' own knowledge, not for comparison with other surgeons.

PES assisted with the development of the first exam, which was conducted in 1971. A special committee of eleven members, chaired by Nicholas G. Palmarozzi, D.O., and assisted by thirty other College members representing various specialties, compiled 178 questions, which PES experts analyzed. An additional 122 questions were acquired from the PES Library Bank.

> "As surgeons, we must realize that education is the key that will open the door to better surgical care as well as enhance our image when we walk through to face the future."
>
> *—J. Natcher Stewart, D.O., from his 1971 inaugural address*

More than half of the Members of the College took the first exam, which had 300 multiple-choice questions. Exam fees were $30 for Members, $50 for nonmembers, and $10 for residents. Participating physicians received graded answer sheets and a 200-page follow-up syllabus designed to serve as an educational aid.

In 1973, after an in-depth analysis of the test results, the special test construction committee released its results, which revealed that:

- surgeons who had taken the exam shortly after they completed their residencies had higher grades;
- the scope of the residents' training correlated well with the content areas of the self-examination test;
- the high scores of young surgeons, who had not been in practice long enough to learn by trial and error, indicated that they had planned programs of learning; and
- surgeons in partnerships in clinical practices averaged higher scores, presumably because they benefited from collegial interaction, which was unavailable to sole practitioners.

A second self-exam was given in June 1974.* The National Board of Osteopathic Medical Examiners (NBOME) replaced PES as test administrator. NBOME was less expensive to use, and it had a bank of questions utilized for state osteopathic medical licensure boards that were more specifically related to the College's needs. NBOME submitted the 1974 exam results to the University of Iowa, where for the first time the ACOS had purchased computer time for statistical analysis. Some 223 surgeons took the exam, and an additional 200 were urged to complete it in order to make the exam results and analysis more meaningful.

A third self-exam was offered in 1979. It included 200 questions in basic science and 200 questions in general surgery. Specialty exams in orthopedics and urology were completed and sent to specialists in those disciplines at a later date.

Analyses of the self-examination results were used to strengthen the College's annual postgraduate programs, which had been instituted in 1963. Training received at these popular but intensive programs was accepted by states requiring postgraduate education for licensure renewal.

"It is our fervent hope that the emotion of this moment in your lives will instill in you the courage and the ambition to carry the message of this College and what it stands for to our society with dignity and honor, unswerving in principle and ethics, always alert to the dangers which may threaten its life by those who place personal achievement ahead of unselfish contributions, and ever mindful of the opportunities that you have to ensure the continued growth and status of this College and osteopathic profession."

—John W. Phardel, D.O., from his charge to new members at the ACOS Ceremonial Conclave during the 1972 ACA

Continuing Education

Another great stride in osteopathic surgical education occurred in 1972, when the ACOS succeeded in making continuing medical education mandatory throughout the profession.

Credit for this milestone must be given to Ellis Siefer, D.O., a longtime and vocal proponent of continuing education. Dr. Siefer, who helped plan and direct the annual postgraduate surgical education programs, envisioned

* *That year, the ACOS Committee on Continuing Medical Education approved the revised exam for ten CME credits.*

community hospitals as hubs of training.

"We charge our community hospitals with the duty of being the center of continuing medical education," he told his colleagues during his inaugural address as president in 1971. "It is one thing to establish training programs for interns and residents and another thing to establish a meaningful program at your hospital that will upgrade the practicing physicians' knowledge and, in doing so, improve patient care."

Dr. Siefer's ardent belief in the value of continuing medical education led him to draft a plan to nationalize and make such education mandatory for membership in the ACOS and the American Osteopathic Association (AOA). In 1972, he was invited by the various specialty colleges attending the annual AOA convention to discuss his plan in greater detail. Although thirteen osteopathic divisional (state) societies and the American College of General Practitioners in Osteopathic Medicine and Surgery* already had CME requirements in place, this marked the first time a policy had been proposed making the requirements mandatory for AOA membership. Specifically, the policy would require that all D.O.s complete fifty hours of postgraduate medical education each year or 150 hours every three years. The ACOS would require that 120 of those hours be in surgical subjects if members were to retain their College membership. The AOA House of Delegates approved the measure in July 1972.

The following year, the AOA Board approved changes in the ACOS bylaws regarding continuing education. The AOA had already set up a committee, chaired by Donald Siehl, D.O., to give the CME program shape and substance. The categories for continuing education credits were established as well as procedures for documenting them.** These new policies were outlined in the May 1973 *ACOS News*. Keeping abreast of the technological advances of the day, the AOA also devised a new computerized filing system to maintain the CME records.

That same year, fifty CME credits were required for the first time, and

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* *Today it is known as the American College of Osteopathic Family Physicians.*

** *The ACOS had its own CME committee, which was chaired by R. William Bradway, D.O. Then, the parameters for continuing medical education were different for AOA and ACOS members. The College required that of the 150 hours of CME credits, 120 be related to surgery. Each specialty college had to assure that its members fulfilled these requisites.*

ACOS members received twenty CME credits if they registered for the entire ACA, the same number of hours of osteopathic CME* annually required by the ACOS. All AOA members were given personal identification numbers, which were entered on computer and recorded on their membership cards, to keep track of credit for all AOA-approved programs.

Three years later, an ACOS survey revealed that 75 percent of the ACOS membership had completed the necessary CME requirements. It was estimated that the remaining 25 percent could complete a major portion of their remaining requirements at the ACA. (The first three-year period in which members had to obtain the credits was to end December 31, 1976.)

In the years to come, Members would have greater and more specialized opportunities to earn CME credits, thanks to the evolving sophistication and scope of College continuing education offerings. These courses not only mirrored the movement toward specialization within the profession but served as signposts for technological advances and changes in healthcare delivery services.

An Educational Renaissance

The College's renewed emphasis on education in the 1970s was built upon a positive confluence of events that had been unfolding since the 1960s. That decade witnessed increased recognition of osteopathic medicine as a legitimate, independent branch of medicine. The American Medical Association (AMA), for example, had begun accepting osteopathic training in satisfaction of its membership eligibility requirements; a few allopathic hospitals had begun giving privileges to osteopathic surgeons; and the federal government had recognized osteopathic physicians as having legitimate training for reimbursement under the then-new Medicare and Medicaid programs. In short, the ACOS's commitment to surgical training programs was having a positive effect not only on patient care but on the improved stature of the entire osteopathic profession.

Residency exams, self-examinations, a mandatory continuing education requirement—all three ushered in an educational renaissance in the 1970s. And it was during this period that the giants in the field of osteopathic surgical training made their greatest contributions to the College and the profession. These renowned surgeons and educators included Charles L. Ballinger, D.O.; R. William Bradway, D.O.; J. Richard Costin, D.O.; John Fetzer, D.O.; Arthur M. Flack, D.O.;

* *Now referred to as AOA Category 1-A CME.*

Charles R. Hetzler, D.O.; P. Robert Lombardo, D.O.; Nicholas G. Palmarozzi, D.O.; John W. Phardel, D.O.; Richard P. Rounce, D.O.; Ellis Siefer, D.O.; Donald Siehl, D.O.; J. Natcher Stewart, D.O.; Paul W. Trimmer, D.O.; and John P. Wood, D.O.

Their tireless work and commitment to excellence were responsible for the ever-improving quality of the annual postgraduate surgical training programs, the Inquisitional Forums, the In-depth Reviews* introduced in



Many of the ACOS leaders who led the College's education renaissance are pictured here, in a photo taken at the past presidents–Board of Governors luncheon held at the 1970 Annual Clinical Assembly. Seated, left to right: Paul R. Koogler, D.O.; Charles R. Hetzler, D.O.; Ellis Siefer, D.O.; P. Robert Lombardo, D.O.; Albert C. Johnson, D.O.; James O. Watson, D.O.; Karnig Tomajan, D.O.; Howard A. Graney, D.O.; and Paul W. Trimmer, D.O. Standing, left to right: Donald Siehl, D.O., Charles L. Ballinger, D.O.; Arthur M. Flack, Jr., D.O.; C. Robert Starks, D.O.; Richard A. Michael, D.O.; C. Denton Heasley, D.O.; Theodore F. Classen, D.O.; J. Natcher Stewart, D.O.; Clois H. Guthrie, D.O.; Robert C. Erwin, D.O.; William J. Davis, D.O.; and Howard C. Baldwin, D.O.

* *The In-depth Review was instituted by the ACOS Committee on Graduate and Postgraduate Education as a means for general surgery Members to earn CME credits over the course of a weekend of rigorous study.*

1975, and the ACA. The educational programs they designed were multidisciplinary in nature, for these visionaries believed that truly successful training allowed disciplines to learn from and share with one another. This idea, born in the College's earliest days, would continue throughout the decade and into the 1980s and 1990s.

For example, the American Osteopathic College of Radiology (AOCR) met with the ACOS at the ACA from 1946 until 1986 and participated in numerous other annual postgraduate courses held other times during the year. The American Osteopathic Hospital Association (AOHA) also met (until 1973) at the ACA, as did the American College of Osteopathic Anesthesiologists (from 1950–1986) and the Association of Osteopathic Directors of Medical Education (from 1965–1968 and 1978–1979). The American Osteopathic College of Pathologists (AOCP) joined the annual meeting in 1974–1976 and 1981–1983, adding even greater depth to the panels and sessions. Today, in addition to the ACOS, the ACA includes the American Osteopathic Academy of Orthopedics (AOAO) and the American Osteopathic College of Proctology (AOCPr).



ACOS Members participate in a surgical anatomy course held at the Kirksville College of Osteopathic Medicine.

Over the years, other ACOS programs also have successfully drawn in the various specialties. The Inquisitional Forums, which were inaugurated in 1969, included surgeons who prepared papers based on their own surgical experiences, and internists, pathologists, radiologists, and anesthesiologists who served as critics. The annual postgraduate courses attracted OB/GYNs, pediatricians, and radiologists in addition to general, thoracic, urologic, pediatric, vascular, gynecologic, cardiovascular, and plastic surgeons. Other examples abound.

In addition to creating multidisciplinary programs, the educational lead-

ers of the 1970s were dedicated to designing programs that reflected the latest and best in osteopathic surgery and medical technology, a practice that continues today. A glance at the ACA course titles from the 1970s to the early 1990s (see pages 70–71) reveals both the procedures Members wanted to learn to upgrade their skills—like microsurgery of the hand in 1975 and ultrasound and its use in infertility in 1985—and the predominant medical problems and diseases—like AIDS in 1994.

As the mantle for surgical training passed from one generation to the next in the early 1980s, educational programs began to shift partially their emphases to address some of the most pressing socioeconomic issues of the day (as also are reflected in the listings on pages 70–71): the growing impact of government and third-party payers on the delivery of medical services; rising healthcare costs; informed consent and physician liability; second opinions; medical ethics; and healthcare reform. These issues would continue to grow in importance and ultimately compelled the ACOS to move to the Washington, D.C., area in 1986 so it could better represent the interests of its members and be in closer proximity to federal legislators and regulators as well as other medical groups helping to shape the nation's healthcare policy (see Chapter 6).*

Finally, it is important to note how, in the 1970s, the ACOS established several prestigious awards to honor the work of the great leaders of the College, the programs they planned and directed, and their numerous educational achievements.

College Recognition Awards

In 1972, the ACOS Board of Governors established the Distinguished Osteopathic Surgeon Award, which is given annually to a gifted surgeon, teacher, and researcher in recognition of his or her outstanding accomplishments and leadership in the field of surgery. Following the death of Charles L. Ballinger, D.O., in 1974, this award has been presented in his memory, and many of the College's education leaders are among its proud recipients.

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* *Until this time, the ACOS staff offices were based in Coral Gables, Florida, where, in 1979, the ACOS purchased its own building. Previously, the College had been headquartered in a cramped room in the home of Dr. and Mrs. Orel F. Martin.*

ACA Course Topics—A Sampling

1970

Hospital costs and the industrial engineer
Present day indications for surgery in tuberculosis and fungus infections
The problem of residency training with orthovoltage therapy
Use of EMG in evaluating disc syndrome and manipulative therapy
Anesthesia for the burn patient
Foreign bodies in the bladder
Emergency room management of the neurosurgical patient
Single dose caudal analgesia in obstetrics
Traumatic A-V fistula—Diagnosis and treatment

1975

Maintaining quality standards
Ethrane vs. forane anesthesia
Nonpolluting rain control
Principles of mechanical ventilation
Bypass surgery for morbid obesity
Introduction to microsurgery of the hand
Current uses of power tools
Radiation therapy: Has anything changed?
Federal health programs and legislation affecting the physician today

1980

Transsexual surgery
EEA stapling device in low lying rectal lesions
Nutritional basis and treatment of cardiovascular disease
Technical advances in management of colon polyps and cancer
Hypnotic anesthesia in Harrington Rodding and cerebral angiography
Genitourinary ultrasound, computed tomography plus nuclear medicine
Potpourri of treatments and appliances in an orthopedic sports medicine program
Legal relationship of anesthesiologist to surgeon
Clinical use of computer in intensive care unit and operating room

***Course Topics** continues on page 71*

***Course Topics** continued from page 70*

1985

How changes in healthcare delivery affect the osteopathic physician
Marketing ambulatory care services in a competitive environment
Pain control and nerve block techniques
Pharmacological erection program
Indication/techniques for pericardial window and pericardectomy
Computerized tomography and MRI in the diagnosis of brain tumors
Anal rape: Legal and forensic considerations
Ultrasound and its use in infertility
E.C.T. in nuclear cardiology

1990

Balloon dilations
Basic pedicle screw fixation
The roles of CT, MRI, and ultrasound in staging carcinoma of the prostate
Advanced and new treatments of prostatic cancer
Neurosurgical application of lasers
Subcutaneous tissue expansion and polyurethane implants in breast reconstruction
Cervical spine trauma in the community hospital
The threat of medical malpractice lawsuits/asset protection
Office management

1994

Preparing your surgical practice for managed care
HIV-1 and the healthcare worker
ACOS female surgeons forum
John Gibbon and the evolution of cardiopulmonary bypass
Complications of laparoscopic hernia repair
Scheuermann's disease
Development of ambulatory surgicenters
State-of-the-art skin care regimen
Future of urology in America: Changing policies and practices

In 1981, the ACOS created the Resident Achievement Award* to recognize outstanding residents in the surgical specialties of general surgery, general vascular surgery, neurological surgery, orthopedic surgery, plastic and reconstructive surgery, cardiothoracic and vascular surgery, and urological surgery. Five years later, the Robert C. Erwin Literary Achievement Award was instituted. Named in honor of the College's former executive director, Robert C. Erwin, D.O., who made invaluable contributions to osteopathic residency training and the ACOS, the award is presented annually to residents who have written outstanding scientific manuscripts. In 1993, the R. Lynn Powell Writing Award was initiated in the memory of R. Lynn Powell, D.O. Dr. Powell, who passed away in 1991, had been a member and the chairman of the ACOS In-depth Review Committee. The award recognizes the best paper on endoscopic surgery.

Development of the American Osteopathic Board of Orthopedic Surgery

In 1979, the AOBOS was established to certify osteopathic orthopedists. Prior to that time, certification was the responsibility of the American Osteopathic Board of Surgery (AOBS). As the number of osteopathic surgical specialists grew, however, so did the work load of the AOBS. Accordingly, the creation of a new board was proposed. Today, some thirty to thirty-five new applicants apply for board certification each year.

The relationship between the ACOS and orthopedic osteopathic physicians had always been a strong and healthy one. In fact, throughout the

* *The Resident Achievement Award currently is sponsored by the Merck Human Health Division.*

- ***1971***—*ACOS President Ellis Siefer, D.O., is invited to the American Osteopathic Association (AOA) annual convention to discuss his plan for making continuing medical education mandatory throughout the profession.*
- ***1972***—*The College succeeds in having the AOA adopt a policy making continuing medical education mandatory to retain membership.*
- ***1972***—*The ACOS Board of Governors establishes the Distinguished Osteopathic Surgeon Award.*
- ***1973***—*The American Osteopathic Board of Orthopedic Surgery (AOBOS) is established to certify osteopathic orthopedists.*
- ***1973***—*The American Osteopathic Association (AOA) Board approves changes in the ACOS bylaws regarding continuing education requirements.*

years, and especially from the 1950s forward, the College's leadership was primarily composed of general surgeons and orthopedists. As early ACOS members, orthopedic surgeons created their own study group and for a time considered becoming a College Discipline. That study group eventually grew to become the American Osteopathic Academy of Orthopedics (AOAO), an AOA-recognized specialty affiliate offering its own well-attended mid-year meeting and publications, including the *Orthopod.* The AOAO also meets annually at the ACA.

In the Courts

In 1974, AOA won a major court victory that all osteopathic physicians would celebrate: The California Supreme Court ruled unanimously to overturn a 1962 state voters' referendum preventing osteopathic graduates from becoming licensed in California. As a result of the voters' action, the California Osteopathic Board of Examiners was disbanded, and the College of Osteopathic Physicians and Surgeons, Los Angeles, was converted to an allopathic medical school. The state medical board of examiners, upon receipt of $65 per applicant, granted some 2,500 unearned M.D. degrees to D.O.s in the state, with the concurrence of the California Medical Association and the California Osteopathic Association. In response, the AOA chartered a new group, the Osteopathic Physicians and Surgeons of California, for D.O.s who chose to retain their osteopathic degrees and identities. However, only a small number chose to maintain their osteopathic identity.

After the California Supreme Court ruling providing for the licensing of D.O.s in California to resume, an osteopathic medical board was re-established in California to issue licenses again to graduates of accredited colleges

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- *1973—CME credits are required for the first time. The AOA computerizes its continuing medical education records. All AOA members are given personal identification numbers, which are entered on computer and recorded on their membership cards, to keep track of CME credit for AOA-approved programs.*
- *1973—ACOS members receive twenty CME credits if they register for the entire Annual Clinical Assembly (ACA).*
- *1973—The* ACOS News *continues to gain a wide audience and runs its first paid advertisement and article on medical writing techniques.*
- *1973—A special ACOS committee releases its in-depth analysis of self-examination results.*
- ***June 15, 1974**—ACOS Executive Director Charles P. Ballinger, D.O., passes away.*

of osteopathic medicine. The AOA, the accrediting body, immediately set about encouraging the establishment of a college of osteopathic medicine in California—a process accelerated by an attempt in 1976 by a group of physicians to set up a school called the Santa Ana School of Osteopathic Medicine. The institution was to be a two-year college that conferred a Doctor of Osteopathy degree on students who had begun, but had not completed, for whatever reason, their careers in allopathic, osteopathic, chiropractic, podiatric, or optometric schools. Not meeting established educational standards, this school never received AOA accreditation.

Although the long-awaited state supreme court victory was, in ACOS President Paul W. Trimmer's words, "a great day in the history of osteopathy," much had to be done in the ensuing years to rebuild the strength of the profession and training programs in California. This was especially true of the urological and neurosurgery sections, two of the specialties that had suffered most as a result of the desertion from osteopathic medicine in the 1960s by D.O.s in that state. The small number of urologists remaining in the profession after the California desertion were located in Philadelphia and Detroit. Today, the College's urological section is recovered and once again vibrant and expanding. The neurosurgery discipline also is expanding, but at a slower pace.

Another court victory for osteopathic physicians occurred in 1977, when as a result of several court cases, the AOHA prevailed in getting member hospitals to require physicians to institute, handle, and have patients sign informed consent forms for surgical procedures. The need for the forms was—as it would continue to be—a pressing one, due to an alarming rise in the number of malpractice suits.

- *1974—A second self-examination is given.*
- *1974—The California Supreme Court rules unanimously to overturn the state referendum preventing osteopathic graduates from becoming licensed as D.O.s in California.*
- *1974—The American College of Pathologists (ACOP) joins the ACA for the first time.*
- *1975—The ACOS Committee on Graduate and Postgraduate Education institutes In-depth Reviews.*
- *1976—A group of physicians attempts to establish a school called the Santa Ana School of Osteopathic Medicine; the AOA does not accredit the institution.*
- *1976—An ACOS survey reveals that 75 percent of all Members have completed the AOA's CME requirements.*
- *1977—The American Osteopathic Hospital Association (AOHA) prevails in getting member hospitals to require physicians to have patients sign informed consent forms for surgical procedures.*
- *1979—A third self-examination is given.*
- *1979—The ACOS purchases a headquarters office building in Coral Gables, Florida.*

Leaders of Note

Charles L. Ballinger, D.O.



One of the true giants in osteopathic surgery, Dr. Ballinger devotedly served the College first as president (1951) and then as secretary (1953 to 1960). In 1960, he became the first executive director, a position he held until his death in 1974. Dr. Ballinger, known lovingly as "Bally," also was called "The Great Communicator" for his ability to keep the Board and membership apprised of important events and information. Revered as an astute politician, he also was a great motivator, providing the energy and enthusiasm so crucial to the development of the College's educational programs. For his dedication, he was awarded the Orel F. Martin Medal in 1968. The Distinguished Osteopathic Surgeon Award is given each year in his honor.



R. William Bradway, D.O.

Dr. Bradway co-chaired the first Continuing Surgical Education Committee, which established the highly successful in-depth weekend courses—today's In-depth Review Seminars—through which Members earned CME credit. A long-time governor, he served as ACOS secretary in 1987 and president in 1989. He received the Distinguished Osteopathic Surgeon Award in 1979.

J. Richard Costin, D.O.



An outstanding leader and accomplished surgeon, Dr. Costin helped create and coordinate the Surgical Inquisitional Forum, one of the most sophisticated and valuable educational experiences of its kind. Throughout the years he has served the College as a governor, Executive Committee member, member of the Evaluating and Membership committees, secretary (1981), president (1978), and ACOS representative to the White House Conference on Children and Youth. He received the Orel F. Martin Medal in 1988 and the Distinguished Osteopathic Surgeon Award in 1989.

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John A. Fetzer, D.O.



Dr. Fetzer, a talented surgeon, teacher, and researcher, was the first recipient of the Distinguished Osteopathic Surgeon Award (1972). In 1965, he performed the first open heart surgery in the osteopathic profession and six years later developed the open heart program at Chicago Osteopathic Hospital and Medical Center. Throughout his years of service to the ACOS, he has worked to keep surgical training abreast of new aspects of diagnosis and treatment and to strengthen multidisciplinary programs. He served as ACOS president in 1979 and was a member of the American Osteopathic Board of Surgery. In 1983, he received the prestigious Orel F. Martin Medal for his lifetime achievements.



Arthur M. Flack, Jr., D.O.

Dr. Flack served as president in 1965 and actively supported the development of postgraduate training opportunities. The 1974 recipient of the Orel F. Martin Medal, he was recognized for his excellence as a teacher and surgeon by the College to which he had devotedly served.

Wanda L. Highsmith



Mrs. Highsmith joined the ACOS administrative staff in 1960, when the College still had its headquarters in Coral Gables, Florida. Known affectionately as the "Chief of Staff," she is credited with the smooth operation of the College for which she served as senior assistant executive director/meetings manager until her retirement in 1994. Mrs. Highsmith was made an honorary Fellow of the ACOS in 1993.



J. Paul Leonard, D.O.

Dr. Leonard was a founder and long-time secretary of the American Osteopathic Academy of Orthopedics (AOAO) and a distinguished orthopedic surgeon at the Detroit Osteopathic Hospital. In recognition of his many years of service to the AOAO and profession, he was awarded the Orel F. Martin Medal in 1976.

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P. Robert Lombardo, D.O.

Dr. Lombardo has played a key role in the planning and coordination of the ACOS annual postgraduate courses. A gifted surgeon and teacher, he received the Distinguished Osteopathic Surgeon Award in 1980 and the prestigious Orel F. Martin Medal in 1991. He served as College president in 1975 and as secretary in 1978 and 1979.



Milton K. Miller, D.O.

A renowned surgeon and revered teacher, Dr. Miller was a noted participant in ACOS educational seminars. Reflective of his efforts to improve education and training, he helped develop a 1979 course on surgical stapling and the In-depth Review on colon surgery offered in 1984. To honor his contributions to the College, he received the 1981 Distinguished Osteopathic Surgeon Award and the highest College honor of all, the Orel F. Martin Medal, in 1985.



Nicholas G. Palmarozzi, D.O.

Dr. Palmarozzi was a major force in the development of the self-examinations introduced in the 1970s, which were designed to help Members gauge the clinical areas in which they needed additional training. He received the 1978 Distinguished Osteopathic Surgeon Award in recognition of his outstanding skill as a surgeon and his service to the College. Four years later, he became the ACOS secretary.

John W. Phardel, D.O.

Dr. Phardel was awarded the Distinguished Osteopathic Surgeon Award in 1977 for his untiring efforts to teach surgical residents the art and science of surgery and for inspiring colleagues to continue their training and strive for excellence. An ACOS Fellow, he has authored numerous scientific papers and is a founding member of the American Trauma Society.



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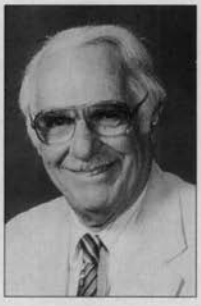
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Richard P. Rounce, D.O.

Regarded as an excellent physician and a humanitarian, Dr. Rounce was a strong proponent for the creation of high standards of excellence in education and training. Through his chairmanship of the Postgraduate Education Committee, he helped plan and coordinate successful annual programs, some of which included the participation of other specialty groups. Dr. Rounce served as president in 1977 and secretary in 1980. He received the Distinguished Osteopathic Surgeon Award in 1985.

Ellis Siefer, D.O.



Dr. Siefer was one of the primary architects and promoters of the College's rigorous and encompassing continuing medical education program. An ACOS president (1972) and secretary (1975), Dr. Siefer received the Distinguished Osteopathic Surgeon Award in 1975 and the Orel F. Martin Medal in 1987 in recognition of his lasting achievements, which have strengthened the College and the profession. One such achievement is his authorship of this history of the ACOS.



Donald Siehl, D.O.

As chairman of the AOA committee that formulated the requirements for the profession's continuing medical education program, Dr. Siehl's leadership helped establish the program's strong foundation. Dr. Stewart was a renowned orthopedist who worked to establish close relations between orthopedists and general surgeons and served as a consultant to the board that established the American Osteopathic Board of Orthopedic Surgery. He served as ACOS president in 1976 and, later, as president of the AOA and executive secretary of the AOAO. In 1983, he received the Distinguished Osteopathic Surgeon Award and in 1986 received the Orel F. Martin Medal for his many years of invaluable and distinguished service.

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David Silverman, D.O.

Dr. Silverman, a gifted osteopathic physician who is widely acclaimed for his surgical skills, helped found osteopathic hospitals in Cherry Hills, New Jersey, and Philadelphia, Pennsylvania. The College acknowledged his many contributions to the osteopathic surgical profession in 1974, when it bestowed upon him the Distinguished Osteopathic Surgeon Award.

J. Natcher Stewart, D.O.



Dr. Stewart is, in the eyes of many, the single most outstanding force in the creation of innovative, multidisciplinary teaching programs for Members, Candidates, and ACA participants. The founder of the annual postgraduate seminars and an ACOS Fellow, Dr. Stewart served as president in 1971 and secretary in 1974. He also was instrumental in developing the self-examinations administered in the 1970s. To honor his many years of service to the ACOS, he was awarded the Distinguished Osteopathic Surgeon Award in 1973 and the Orel F. Martin Medal in 1979.



Paul W. Trimmer, D.O.

Dr. Trimmer has always been an enthusiastic supporter of continuing medical education for osteopathic physicians and has worked diligently to develop AOA CME program requirements. He assumed the ACOS presidency in 1974 and was credited with keeping the organization running smoothly following the death of its beloved executive director, Charles L. Ballinger, D.O. In acknowledgment of his many contributions to the ACOS, he was awarded the Orel F. Martin Medal in 1989.

John P. Wood, D.O.



Throughout his years of service to the ACOS, Dr. Wood has worked with devotion and enthusiasm to further the education and training of osteopathic physicians. Founder and first president of the American Osteopathic Academy of Sports Medicine, he was elected a Life Member of the ACOS in 1968. The College recognized his many contributions in 1984, when it bestowed upon him its highest honor, the Orel F. Martin Medal.

Chapter 6: Entering the Political Arena

1980–1994

The 1980s marked a fundamental change in the traditional doctor-patient relationship and the beginning of the doctor/patient/third-party-payer triad. As the leadership of the American College of Osteopathic Surgeons (ACOS) had wisely predicted, the practice of medicine would be forever changed by the bureaucratic governmental regulations and procedures that proliferated during the decade; it would undergo yet other changes in the 1990s and beyond as health system reform once again took center stage on Capitol Hill and managed care delivery networks dominated the private sector.

To lend its voice and perspective to the national debate and to preserve the practice rights of osteopathic surgeons, the College relocated its headquarters to the Washington, D.C., area. From its new vantage point, it quickly launched a governmental affairs program that included hiring a legislative affairs consultant, monitoring federal legislative and regulatory proposals, and participating in coalitions with other healthcare organizations. The ACOS also worked with other osteopathic specialty groups to stem the closing of osteopathic hospitals around the country due to shortened patient lengths of stay and reductions in reimbursement for care.

At the same time that the College moved into the political arena, the role of specialties took on greater meaning within the ACOS. Interdisciplinary education continued to improve, and the Board of Governors was expanded to include representatives of each of the surgical specialties comprising the membership. These governance changes, coupled with bylaws amendments that ensured the smooth running of the College and the Annual Clinical Assembly (ACA), were only two of the many highlights of the 1980s and 1990s. Others include the establishment of the ACOS Auxiliary, the Student Osteopathic Surgical Association (SOSA), the Residency Program Directors Seminars, the Young Surgeons Committee, and the Federation of Osteopathic Specialty Organizations (FOSO); the development of more comprehensive training standards to elevate the quality of surgical residency programs; revisions to the ACOS Fellow requirements; and the creation of the Robert J. Sherman Memorial Fund.

The Political Arena

Long before the 1960s, when the U.S. Congress wrote the federal Medicare program into amendments to the Social Security Act, ACOS leaders had predicted that the time would come when the federal government would begin to regulate the practice of medicine. As deliberations on the proposal for the Medicare program proceeded, osteopathic surgeons got a taste of what these regulations would mean.

In the House version of the bill to establish Medicare, osteopathic physicians were excluded from the definition of "physicians" who would be eligible for reimbursement for medical services to the elderly. Fortunately, however, ACOS Executive Director Charles L. Ballinger, D.O., learned of the exclusion, won an invitation to testify before a Senate committee, and provided inclusive language that eventually was written into law.

By the 1980s, the federal regulation of medicine had begun in earnest, with a steady

> "We have seen agencies decide where there are too many hospital beds; where and when a new radiation therapy unit might be; which institution might be allowed to have a CAT scanner or a new cardiac surgical team. No longer can a group of doctors with a dream and a mortgage start a new hospital that will grow into a 400- or 500-bed institution."
>
> *—From the 1980 inaugural address of ACOS President C.W. Elliott, D.O.*

flow of Medicare amendments aimed at cutting the program's skyrocketing costs and improving availability and quality. Some amendments were quickly adopted by insurance companies as "prudent business decisions." These included standardizing and limiting fees for medical services; setting "global fees" to cover pre-, intra-, and postoperative phases of surgical treatment; requiring second opinions; and defining what was "medically necessary" and, thus, eligible for reimbursement.

Other governmental initiatives followed. To counter claims that government bureaucrats were deciding what was medically necessary, one federal legislative amendment established Professional Standards Review Organizations (now called PROs) composed of doctors and nurses to monitor hospital admissions and rule on reimbursement claims. Another Medicare amendment established prospective payment systems that encouraged outpatient care and shorter hospital stays. (The latter notion resulted in numerous hospital closings, especially small allopathic and osteopathic institutions.)

Additional Medicare amendments addressed physician business practices by prohibiting "self-referrals" by physicians to diagnostic laboratories in which they had a financial interest. Yet other amendments raised reimbursement rates for primary care physicians at the expense of specialists (including surgeons) in an effort to encourage more physicians to specialize in primary care, increase their availability, and stem patients' growing reliance on more costly specialists for basic healthcare.

Osteopathic physicians fared no better or worse than their M.D. counterparts as a result of these changes in the Medicare program. Nevertheless, the changes have had far-reaching consequences. The goal of cutting costs, while trying to preserve quality and increase access, has been adopted by the health insurance industry and has surfaced in healthcare delivery reform proposals in dozens of states. In 1993 and 1994, they appeared in a spate of

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ACOS Chronology

- ***1980s**—Federal regulation of medicine begins in earnest with a steady flow of Medicare amendments aimed at cutting the program's skyrocketing costs, expanding access, and ensuring quality.*
- ***1980s**—The ACOS launches a government affairs program that includes responding to proposed legislation and regulations and allying itself with other osteopathic and allopathic specialty colleges to speak with one voice in Washington, D.C.*

"The method in which we have practiced osteopathic medicine from the inception of this profession does not work any more. No longer do we have just a physician-patient relationship that has to be established in order for us to practice our art and our skills. It is now a triad. It is going to be patient-physician-lawyer, or patient-physician-third party payor á la Blue Cross/Blue Shield, Medicaid, or Medicare. There will always be a third party involved. It has even evolved to the point where it is patient-physician-labor union or patient-physician-business or industry triad. There will always be a third party to interfere with the relationship that we have established over the years with our patients. We can no longer practice medicine the way we would like to practice. Even if it satisfies the patient, we cannot do it."

—From remarks made by William G. Anderson, D.O., FACOS, president of the Michigan Association of Osteopathic Physicians and Surgeons in 1982 and president-elect of the AOA in 1994

federal legislative proposals that aimed, in some fashion or another, to provide basic healthcare coverage to the entire populace similar to the way Medicare provides for the elderly. This idea is not a new one. For seven decades and through fourteen presidencies, measures have been introduced in Congress that would mandate minimum and universal healthcare benefits, or at least make basic benefits accessible to more Americans.

Through all of these changes, the ACOS did not stand still. The College's leaders quickly and wisely understood the need to monitor proposed laws and regulations to ensure that osteopathic surgical care would be available to those who wanted and needed it. As a result, the ACOS launched in the 1980s a government affairs program that included monitoring federal legislation and regulatory proposals, responding with official statements to proposals, and allying itself with other osteopathic and allopathic medical specialty colleges and the American Osteopathic Association (AOA) to speak with one voice in Washington, D.C.

The theme of "unity of the osteopathic profession" began appearing in major speeches delivered at the ACA. College Members also were admonished to do what they could on a local and state level to reduce legislative and regulatory interference in their medical practices, to push for increased funding for graduate medical education programs, and to protect their right to provide quality patient care.

Osteopathic medical practice rights were then, as they are now, threatened in

the majority of states. Clinical privileges could be denied based solely on where a D.O. received his or her training. In 1993, the ACOS developed model state legislation that would prohibit health facilities subject to state licensure from discriminating against physicians solely on the basis of their osteopathic training. ACOS Members were urged to become involved in local and state medical societies to influence the enactment of this legislation to protect all D.O.s from discrimination on hospital staffs and in HMOs.

In the 1980s, the College took two bold steps down the path of greater political sophistication.

The first step, in 1985, was to relocate the national headquarters from Coral Gables, Florida, to Washington, D.C., and subsequently, in 1986, to Alexandria, Virginia, a Washington, D.C., suburb. There, the College could lend its voice to the national healthcare debate and be in close proximity to lawmakers and other related medical groups.* The move was recommended by The Public Sector, an outside consulting firm, and supported in interviews and surveys by former ACOS presidents and the membership.

The second step, in 1988, was to hire Stephan E. Lawton, J.D.,** a former chief counsel of the U.S. House Ways and Means Health Subcommittee, as a governmental affairs consultant to monitor the myriad health policies under federal government consideration.



The ACOS building in Alexandria, Virginia.

* *In 1985, the ACOS had just retired the mortgage on its Coral Gables, Florida, office building for which it had been offered double the original purchase price. The College first sublet space from the American Association of Colleges of Osteopathic Medicine in Washington, D.C., directly across from the U.S. Capitol and U.S. Senate offices. On June 28, 1988, it purchased a headquarters building in Alexandria, Virginia, a Washington, D.C., suburb ten minutes from National Airport and seven blocks from Amtrak and the Metropolitan Washington subway.*

** *Mr. Lawton, a partner in the law firm of Hogan and Hartson, continues to consult with the College and is the author of the "Legislative Update" column that appears monthly in the* ACOS News.

"Our future in the American healthcare system lies in our individual and collective ability to manage the dramatic changes in healthcare with a view toward opportunity—not vulnerability.

"When asked how he came to be such a great hockey player, Wayne Gretsky responded, 'I skate to where the puck is going to be, not to where it has been.' In like manner, we must use our creativity, intelligence, knowledge, and leadership abilities to skate to where healthcare is going, not to where it has been."

—Outgoing ACOS President F. Kenneth Shockley, D.O., at the 1993 ACA

That year, from its new vantage point, the ACOS joined a coalition of more than 150 national organizations lobbying for congressional support to reduce cuts in health programs as outlined in President Ronald Reagan's 1988 budget.

The following year, the College's Strategic Planning Committee, chaired by R. William Bradway, D.O., recommended that the College make healthcare legislation and regulations two of its highest priorities. As a result, and with the support of the ACOS Government Affairs Committee, chaired by John H. Sloan, D.O., a law firm associate was assigned by Mr. Lawton to report all significant legislative and regulatory initiatives of the federal government to the Board of Governors on a regular basis. The



Stephan E. Lawton, J.D., governmental affairs consultant to the ACOS.

"We are besieged alphabetically by DRGs, IPPs, PPOs, PROs, PSROs, and CEMPROCs. If [the government] succeeds, medicine will no longer be an art and science but, rather, a business, and we will become businessmen rather than physicians, engaged in public relations, advertising, maybe even eagle stamps and bargains offered to the public on everything from hemorrhoidectomies to thoracotomies!"

—Richard P. Rounce, D.O., from the charge to new members delivered at the 1984 ACA

ACOS saw such efforts as dovetailing with the legislative efforts of the AOA.

Mr. Lawton's services proved invaluable in the 1980s, and continue to be in the 1990s, as public and private sector pressures continue to prompt health system reforms on a state and national level.

A Drop in Hospital Census

The 1980s brought changes not only to osteopathic physicians but to osteopathic hospitals. The days when osteopathic physicians could only practice in osteopathic hospitals were long gone. Although this signaled progress in the acceptance of the osteopathic profession by the public and allopathic medicine, the closure of osteopathic hospitals and the decline in number of D.O.s utilizing the remaining osteopathic facilities continued to be a problem, especially in terms of osteopathic training opportunities. The number of available osteopathic internships was simply not keeping up with the need, especially with the opening of more colleges of osteopathic medicine and the resulting increase in the number of graduates. The situation was so grave, in fact, that ACOS President Daniel L. Wisely, D.O., predicted in his 1983 inaugural address that by 1990 osteopathic medical schools would have 1,000 graduates for whom internships would be unavailable unless new programs were implemented.

> "From 1984 to 1989, thirty-eight osteopathic hospitals closed, representing twenty-six percent of the membership of the American Osteopathic Hospital Association. ... [U]nless osteopathic hospitals become more competitive, they will continue to fall victim to this trend and close."
>
> *—Stephan E. Lawton, J.D., ACOS government affairs consultant, writing in the September 1989* ACOS News

A number of osteopathic facilities closed during the decade because of declining occupancy.* This was due to increases in ambulatory care treat-

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* *Hospital closings had a detrimental effect on the American Osteopathic Hospital Association (AOHA), whose membership dropped from 149 in 1984 to 106 in 1990. Although AOHA was financially stable, there was some concern that its present membership would not be able to sustain the group. The American Hospital Association (AHA) offered to make AOHA a part of its organization while allowing it to maintain its osteopathic distinctiveness. Although a large number of member hospitals considered the alternative—one-third of AOHA members also belonged to AHA—the proposal was subsequently defeated.*

ment, shortened lengths of stay, and lower third-party payments, which made it difficult, if not impossible, for smaller hospitals to sustain themselves financially. Many of the closures were hospitals of fifty beds or less, primarily located in rural areas, characteristics common to many osteopathic hospitals.

Another important reason for the closings was competition from allopathic hospitals. In San Antonio, Texas, for example, after general practitioners were offered medical staff privileges in all of the city's major hospitals, the San Antonio Osteopathic Hospital suffered a major loss of referring physicians and closed.

According to Harold A. Beckwith, D.O., who wrote about the closing in 1982, in an issue of the *ACOS News,* "most of the general practitioners thought that this was a great opportunity for them to become active in the medical practices in the major hospitals of this city. But it was actually a destruction of identity of the osteopathic physicians in this city."

In 1982, ACOS published "Osteopathic Hospitals," a report that examined the decrease in census, which was out of proportion to allopathic hospitals. The report, prepared by former ACOS President C.W. Elliott, D.O., Kirk H. Herick, D.O., president of the American College of General Practitioners in Osteopathic Medicine and Surgery (ACGP)—today's American College of Osteopathic Family Physicians—and Michael Dooley, president of the American Osteopathic Hospital Association (AOHA), examined several key questions:

- How can the use of osteopathic hospitals by D.O.s be improved?
- Would giving hospital medical staff privileges to osteopathic general practitioners increase utilization and still assure quality care?
- Should accreditation standards be revised or other steps taken to strengthen departments of general practice in osteopathic hospitals, and would this increase the G.P.s' allegiance to these institutions?

- ***1980s**—A large number of osteopathic hospitals close due to declining occupancy. Later in the decade, ACOS participates in a number of "summit conferences" to address the reasons for these closures.*
- ***1982**—ACOS publishes "Osteopathic Hospitals," a report that examines the decrease in hospital census.*
- ***1983**—The Young Surgeons Committee is inaugurated.*

- Given the projected growth of the osteopathic profession, what can osteopathic hospitals and other D.O. organizations do to encourage the loyalty of the hospitals' medical staff to such facilities?

- What are the two largest single obstacles to loyalty, commitment, and use of osteopathic hospitals, and what can be done by hospital governing boards and administration to overcome them?

- What three things can medical staff members, governing board members, or administrators of osteopathic hospitals do today to encourage the utilization of osteopathic hospitals, other than recruit new physicians?

In 1984, the AOHA created a task force in cooperation with the ACOS, the ACGP, and the American College of Osteopathic Internists to identify means to encourage "more loyalty" to osteopathic hospitals. A white paper was published, which identified twelve reasons why some D.O.s no longer used the osteopathic facilities. They are:

1) disrespect by one physician for another, usually a general practitioner for a specialist;

2) poor communication, or lack of communication, between general practitioners and specialists;

3) inadequate facilities (some osteopathic hospitals weren't sufficiently equipped to meet physicians' needs and desires);

4) limited medical staff privileges, usually for general practitioners;

5) the perception that a hospital was run by a physician or a small clique of physicians, who controlled privileging and staff memberships;

6) insufficient depth and breadth of expertise among medical staff members to allow for comprehensive referrals;

7) competition (another hospital appeared to be more inviting, for whatever reason);

8) perceived prestige by some osteopathic physicians in associating with M.D.s and nonosteopathic hospitals;

9) board members and administrators who side with one group of physicians over another;

10) lack of financial support for new physicians establishing practices;

11) AOA accreditation standards that impose onerous responsibilities on medical staff; and

12) lack of pride and loyalty on the part of some D.O.s to the profession generally and to its hospitals specifically.

Unfortunately, some of the problems identified in the 1982 and 1984 reports still exist today. Of particular concern is the fact that the number of students graduating from colleges of osteopathic medicine is increasing while the number of residency training positions within the profession is decreasing. The decrease has been noticed by federal governmental agencies and legislators, who are growing less inclined to recognize D.O.s as distinct from M.D.s. The problem is further compounded by today's almost universal acceptance of osteopathic physicians in allopathic hospitals. As a higher percentage of students train in allopathic facilities, which each year are opening their doors wider to graduates of osteopathic medical schools, and as these physicians are recruited to allopathic medical staffs, their allegiance to the osteopathic profession becomes weaker.

The ACOS has taken a number of steps to address the issue over the last decade, however. In the late 1980s, for example, the College participated in several "summit conferences," along with all AOA affiliates. These conferences were designed to analyze the problems facing osteopathic hospitals

and their medical staffs, and to identify and commit to ways to solve them.

Of all the pressing problems identified, the ACOS was most concerned with the loss of the osteopathic surgeon's referral base and the perception among the public and referring physicians, especially osteopathic general practitioners, that osteopathic hospitals did not provide the same level of specialized care that other hospitals could offer. To address these issues, the College identified the need to strengthen its relationship with the ACGP and to encourage general practitioners back into the referral networks and the organizational structure of osteopathic hospitals.

> "Some say the osteopathic colleges should screen applicants more carefully and select only those who are truly motivated to become D.O.s. Well, we all know how that process goes. Others are convinced that the loyalty of the student in our colleges is lost somewhere during the four years of college, either by inferior curricula or role models, lack of exposure to specialists in teaching clinical subjects, or in not having adequate clinical facilities to train the student in the third and fourth years, hence, the need to go to allopathic hospitals for clinical training. And having competed well in those years, over fifty percent of these students will enter allopathic graduate training, where they will come to know the allopathic profession better than the osteopathic profession. They are then welcomed to medical staff privileges and no longer need the osteopathic hospital. It is clear where the work needs to be done in this scenario. Otherwise our profession will wither and die."
>
> *—From an October 1989* ACOS News *editorial by R. William Bradway, D.O., FACOS*

A Stronger, More Representative Whole

The role of the specialties took on greater meaning within ACOS during the decade, not just as it related to the development and improvement of interdisciplinary education programs, but as it related to the College's governance.

Specifically, in 1989, the Board of Governors was expanded to include representatives of each of the various surgical specialties. Proportional representation for each specialty was instituted, as well as for a "members-at-large" category, which included all orthopedic surgeons and several other groups of surgical specialists who did not qualify to have their own representative based on the small size of their membership.*

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* *The subspecialty surgical disciplines that comprised the ACOS wanted more representation on the Board of Governors. The general surgeons, who were proportionately* *(continued on page 92)*

> "The Governors shall be elected to represent the surgical disciplines on a proportional basis. For the purpose of determining the number of governors to be elected, an annual census shall be conducted of the voting membership of ACOS by the Executive Director.
>
> "Proportional representation shall be determined by the Board of Governors based on the number of voting members of ACOS designated as belonging to each specific surgical discipline. The census date for determination of proportional representation on the Board of Governors shall be January 1 of each year. Final designation of discipline assignment shall be at the discretion of the Board of Governors. If the total number of the Board of Governors would exceed twenty (20) persons, reapportionment shall be instituted."
>
> *—Article VII, Section 3, of today's ACOS Bylaws*

According to a 1988 written agreement made with the leadership of the American Osteopathic Academy of Orthopedics (AOAO), orthopedic surgeons who belonged to the ACOS were not to be organized into an "orthopedic surgery discipline," but could be participants in an "at-large discipline" of the College. The AOAO wanted to preserve its role as the principal advocate for osteopathic orthopedic surgery.

Changes to the governing Board brought other changes to the College. The terms of Governors were staggered to prevent terms of office from ending at the same time and disrupting the continuity and smooth functioning of the College. They also were limited to three consecutive terms, to provide opportunities for more Members to participate in College governance.

Disciplines were allowed to continue to establish their own bylaws and dues, as long as the bylaws were in conformance with the ACOS bylaws.

(continued from page 91) the largest group in numbers, had always dominated the Board. As the subspecialties grew, it was felt that they should have more representation. Then, as now, the ACOS disciplines were organized according to the following categories: general surgery, neurological surgery, plastic and reconstructive surgery, urological, and cardiothoracic and vascular surgery.

- ***1983**—The ACOS Auxiliary is established.*
- ***1984**—The American Osteopathic Hospital Association (AOHA) creates a task force in cooperation with the ACOS and other specialty groups to identify how to inspire more loyalty to osteopathic hospitals.*
- ***1985**—Guy D. Beaumont, Jr., becomes the College's first lay Executive Director.*
- ***1986**—The ACOS relocates its national headquarters to Washington, D.C.*
- ***Mid-1980s**—The ACOS Residency Program Directors School is created.*

The ACOS staff took over many of the administrative functions for the majority of the disciplines. These included management of seminars and conferences, meeting promotion, secretarial support, dues billing and collection, and financial accounting and reporting.

Highlights

The 1980s and 1990s saw numerous events that contributed to the rich history of the ACOS. Several of these have been mentioned previously, such as the relocation of the College to Washington, D.C., and the reorganization of the Board of Governors to represent more fully all of the specialty disciplines. Other events include:

- **The improvement of educational standards to strengthen the quality of surgical residency training programs,** and the establishment of a mandate for training programs to affiliate with graduate medical education consortia.

- **The establishment in 1983 of the ACOS Auxiliary,** to promote and support the objectives of the College. The Auxiliary has awarded thousands of dollars in scholarships to surgical residents seeking additional training in clinical fellowships. Nearly 80 percent of the organization's annual $20 dues are used for scholarships and financial grants to the College, including grants to help defray the cost of publishing the College's annual membership directory and this history of the ACOS.

- **The establishment in 1983 of the Young Surgeons Committee,** to serve as a forum in which surgeons aged 45 or younger can exchange ideas and concerns and make recommendations to the Board of Governors.

- **The establishment in the mid-1980s of a Residency Program Directors School** to assist directors of surgical training programs and all others interested in surgical education to improve their training programs. Hosted by the Residency/Fellowship Evalua-



A Residency Program Directors School in progress.

tion Committee, the Residency Program Directors Seminars are held annually in conjunction with the ACA or In-depth Review seminars.

- **The establishment in 1989 of the Student Osteopathic Surgical Association.** The SOSA was organized in 1988, when several osteopathic students organized local chapters. In 1989, these individual chapters joined together to form a national organization. Today, virtually every osteopathic school has a chapter, and there are presently more than 1,000 members nationwide. Through its annual meetings and workshops, members receive hands-on experience in surgical techinques and other fundamentals, and information about internships and surgical residencies. During meetings held in conjunction with the ACA, SOSA members have the opportunity to gain insights into surgery as a career from ACOS members. SOSA members also may participate in a preceptorship program created in 1992, which is designed to expose them to office and hospital-based surgical practices and principles under the guidance of ACOS members.

- **The formation in 1990 of the Federation of Osteopathic Specialty Organizations (FOSO).** This group had its roots in a 1986 attempt by the Osteopathic College of Ophthalmology and Otorhinolaryngology, the American College of Osteopathic Obstetricians and Gynecologists, the American Osteopathic College of Proctology, the AOAO, and the ACOS to form a coalition of osteopathic surgical specialists. Representatives from the five associations had met at that year's AOA annual business meeting and decided to organize the coalition so specialists would have a greater impact on how the AOA responded to issues of common concern to the specialty groups. Specifically, the representatives were concerned with issues like discrimination in the granting of hospital privileges to osteopathic specialists, tort reform, availability and cost of professional liability insurance, and federal funding for graduate medical education.

  Although the AOA bylaws permit all AOA practice affiliates to have a voting member to represent the respective specialties in the AOA House of Delegates, FOSO continues to serve as a forum for specialty affiliates to discuss issues of mutual interest that are brought before the AOA for deliberation.

> "Despite our defeat, ACOS should not give up its goal to gain a vote in the AOA political process. Whether it takes one year or five, we must continue to work with the AOA mechanisms that are currently available to us. To succeed, we also will have to be more involved in AOA politics. We must caucus and form alliances not only with other specialty groups, but also with state osteopathic organizations. We must convince the state delegates that the profession will benefit from inclusion of specialty groups in AOA's political process."
>
> *—From a September 1991 editorial by ACOS President Norman Rose, D.O., FACOS, following the recent defeat by AOA of a resolution to revise its bylaws to permit all AOA affiliates a voting member to represent their specialties in the AOA House of Delegates. A bylaw revision was finally adopted in 1993, and today, the ACOS has one voting delegate in the AOA House of Delegates.*

- **The creation in 1990 of the Robert J. Sherman Memorial Fund,** in honor of Robert J. Sherman, D.O., a skilled surgeon and teacher who served as Secretary/Treasurer of the Urological Discipline. The fund awards a $500 cash prize to the winner of the most outstanding urological paper delivered at the ACA.

- **Revisions to the ACOS Fellow application process** by the Board of Governors in March 1993 provided Members with more opportunities to earn the title of "Fellow in the American College of Osteopathic Surgeons (FACOS)" and removed politics from the decision-making process for awarding the title to ACOS Members. The new system recognizes that practice settings differ and that members have unique professional interests and talents to contribute to the profession.

- **The introduction in 1993 of a new site visitor's manual for ACOS evaluation and AOA approval of surgical training programs.** Developed to ensure an objective review process for determining whether residency programs comply with basic training standards, the *Site Visitor's Manual* and *Site Visitor's Workbook for Review of Surgical Residencies* provide the site visitor with information on planning the training program evaluation, conducting interviews, and reviewing charts for preparation of a written report for the Residency/Fellowship Evaluation Committee, which determines whether to recommend that the program be approved.

- *1987—The ACOS joins a coalition of more than 150 national organizations lobbying for congressional support to restore cuts made in healthcare programs as outlined in President Ronald Reagan's 1988 budget.*
- *1987—The ACOS hires attorney Stephan E. Lawton, former chief counsel of the U.S. House of Representatives' Ways and Means subcommittee on health, as a governmental affairs consultant to monitor governmental, legislative, and regulatory initiatives.*
- *1988—The ACOS Strategic Planning Committee ranks federal healthcare legislation and regulations as two of the College's highest priorities.*
- *1989—The ACOS Board of Governors is reorganized to provide for proportionate representation of each surgical discipline in the College.*

Finally, it is important to note the Board's decision in 1985 to hire Guy D. Beaumont, Jr., as the College's first lay executive director. Mr. Beaumont took over the reigns from the retiring Robert C. Erwin, D.O., FACOS, at the same time as the ACOS was to relocate to the Washington, D.C., area.



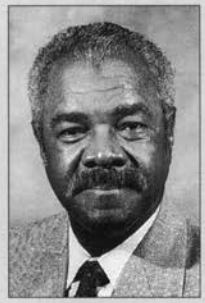
Guy D. Beaumont, Jr. (left), succeeds Robert C. Erwin, D.O., as the College's first lay executive director.

Mr. Beaumont formerly was employed at the American Medical Association (AMA), from 1972–1980, where he worked with county, state, and national medical associations on federal legislative and regulatory issues of interest to medicine. Eventually, he became assistant director of the AMA's Columbus, Ohio, regional office, where he coordinated activities with state medical societies and later returned to the Chicago headquarters and helped to staff the AMA's Interspecialty Advisory Board. In 1980, he joined the American College of Emergency Physicians, where he served four years as associate executive director.

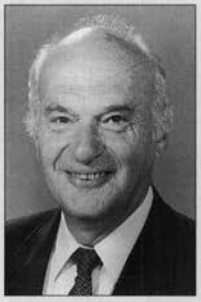
- ***1989**—The Student Osteopathic Surgical Association is established.*
- ***1990**—The Robert J. Sherman Memorial Fund is established.*
- ***1990**—The Federation of Osteopathic Specialty Organizations (FOSO) is formed.*
- ***1993**—The ACOS develops model state legislation to prohibit health facilities subject to state licensure from discriminating against physicians on the basis of their osteopathic training.*
- ***1993**—The ACOS Board of Governors revises the Fellow application process.*
- ***1993**—A new site visitor's manual for ACOS evaluation of surgical training programs seeking AOA approval is introduced.*

Leaders of Note

William G. Anderson, D.O.



Dr. Anderson, who received the Orel F. Martin Medal in 1994, is a recognized leader in osteopathic healthcare. President of the American Osteopathic Association (AOA) in 1994, he also has served on various AOA committees and as president of county and state osteopathic associations in Michigan. He is a College Fellow as well as Diplomate of the American Osteopathic Board of Surgery (AOBS).



Jerome L. Axelrod, D.O.

Former chair of the AOBS and the College's General Surgery Discipline, Dr. Axelrod received the coveted Distinguished Osteopathic Surgeon Award in 1988 in recognition of his outstanding accomplishments and leadership in the field of surgery. A gifted and inspiring teacher, he was named Teacher of the Year in 1982 and 1983 by the University of Health Sciences College of Osteopathic Medicine. In 1986, he received the Outstanding Faculty Award from the Ohio University College of Osteopathic Medicine, where he was appointed head of the surgery section in 1993.

Theodore F. Classen, D.O.



An active member of the College since 1949, Dr. Classen received the title of Fellow in 1949 and became a Life Member in 1982. Elected to the Board of Governors in 1961, he served as president in 1967 and championed the College's fight against unethical billing practices. Dr. Classen, a founder of the Brentwood Hospital in suburban Cleveland, Ohio, also organized a free-standing ambulatory care center in 1977, at a time when the concept of outpatient medical services was just being accepted. A recognized leader in the osteopathic medical profession, he has served on numerous professional and governmental committees over the years, including a U.S. Surgeon General's advisory committee. In honor of his many years of service to the College and the profession, he was awarded the Orel F. Martin Medal in 1993.

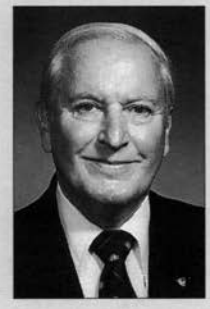
Leaders of Note continues on Page 99

Leaders of Note continued from Page 98

C.W. Elliott, D.O.



During his many years of service to the ACOS, Dr. Elliott has served as chairman of the Postgraduate Education Committee, president of the Cardiothoracic and Vascular Surgery Discipline, chairman of the Residency/Fellowship Evaluation Committee, and long-time governor on the ACOS Board of Governors. When he became president in 1981, he wisely predicted the incursion of government in the practice of medicine and admonished members to do what they could to work cooperatively to reduce rising medical costs. During his term, Dr. Elliott also worked with other national osteopathic organizations to stem osteopathic hospital closings. In addition, he helped improve communications between the membership and the Board of Governors by publishing committee reports and including reports from College presidents in the *ACOS News.* A talented surgeon, Dr. Elliott received the Distinguished Osteopathic Surgeon Award in 1984. In 1990, the ACOS awarded him the Orel F. Martin Medal.



Robert C. Erwin, D.O.

Tireless in his devotion to ACOS, Dr. Erwin served as president in 1970 and executive director from 1977 to 1985. As executive director, he helped oversee the continued development of osteopathic training programs and the College's entree into the political arena on issues such as rising medical costs and government regulation of medical practices. An ACOS Fellow, Dr. Erwin received the prestigious Distinguished Surgeon Award in 1976 and the Orel F. Martin Award in 1982. The Robert C. Erwin Literary Achievement Award was established in 1986 in recognition of his many contributions to ACOS and residency training. Dr. Erwin also has served as chairman of the AOBS and president of the Pennsylvania Osteopathic Medical Association.

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Leonard H. Finkelstein, D.O.

An active participant in numerous local, state, and national organizations, Dr. Finkelstein has devoted many additional hours to the ACOS as chairman of the Urological Discipline and as a member of the Professors of Surgery, and Scientific Exhibits and Poster Sessions committees, among others. His teaching, speaking, and writing skills have garnered him many awards, including the Distinguished Osteopathic Surgeon Award in 1992. Dr. Finkelstein also has served as president and chairman of the board of trustees of the Osteopathic Medical Center in Philadelphia, Pennsylvania, and is president of the Philadelphia College of Osteopathic Medicine.

John H. Finley, D.O.



As ACOS president in 1990, Dr. Finley stressed the importance of unity among osteopathic physicians and V.A.L.U.E. ("V" for vision, "A" for accountability, "L" for loyalty, "U" for unity, and "E" for enthusiasm). During his term, he worked with allied groups to address the issue of osteopathic hospital closings and helped strengthen the College's relationship with the American College of General Practitioners in Osteopathic Medicine and Surgery (ACGP). Dr. Finley, winner of the 1991 Distinguished Osteopathic Surgeon Award, is an ACOS Fellow who has served as chairman of the General Surgery Discipline and as a member of the Residency/Fellowship Evaluation and Strategic Planning committees. He also represents the ACOS on the AOA Committee on Hospital Accreditation, for which he serves as chairman.



Charles V. Gemma, D.O.

Dr. Gemma, who has touched the lives of hundreds of medical students, received the Distinguished Osteopathic Surgeon Award in 1994 and the Outstanding Faculty Award (1991 and 1993) presented by medical students at Ohio University-College of Osteopathic Medicine. A gifted surgeon, he was certified by the AOBS in 1974 and has served in various medical staff positions and on numerous committees at Brentwood Hospital.

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Arnold Gerber, D.O.



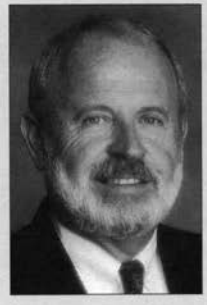
For more than thirty years, Dr. Gerber has been an avid supporter of the ACOS and the osteopathic profession. He joined the College in 1950 and became a Fellow in 1958. Throughout the 1960s and 1970s, he was a member and chairman of numerous committees and was elected to the Board of Governors. He became ACOS secretary in 1983 and president two years later. As president, Dr. Gerber wrote many thoughtful articles for the *ACOS News.* He also worked diligently with the Bylaws Committee to draft bylaw amendments that ensured the proportional representation of the specialties on the Board. A former president of the AOAO, Dr. Gerber is an acclaimed surgeon and teacher. He received the Distinguished Osteopathic Surgeon Award in 1987.



Robert O. Hinkle, D.O.

An ACOS member since 1947, Dr. Hinkle became a Fellow in 1964 and the recipient of the Distinguished Osteopathic Surgeon Award in 1986. A brilliant surgeon and teacher, his contributions to the osteopathic profession were many. They include research efforts for the initial use of penicillin and other antibiotics; his influence in the establishment of the first nuclear medicine laboratory in Oklahoma, which he directed; and tireless sabbaticals at the Mayo Clinic surgery department, the nuclear medicine division of the University of Michigan, and the Atomic Energy Commission.

Peter E. Johnston, D.O.



A respected leader and avid supporter of the osteopathic profession and orthopedic surgery, Dr. Johnston also is known for his high ethical standards and outstanding surgical ability. In recognition of his years of service, he was awarded the Distinguished Osteopathic Surgeon Award in 1993. Dr. Johnson served as chairman of the American Osteopathic Board of Orthopedic Surgery (AOBOS) from 1980 through 1990 and helped improve the quality of its certification examination. He is a dedicated teacher who has earned the respect of his peers for the quality of the orthopedic training programs he has established at Doctors Hospital in Columbus, Ohio.

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Paul Peter Koro, D.O.



Elected as a Fellow in 1984, Dr. Koro has served the College on the Board of Governors and the Membership and Residency/Fellowship Evaluation committees. In 1987, he became chairman of the Cardiothoracic and Vascular Surgery Discipline; two years later, he became ACOS secretary (1989). When Dr. Koro became president in 1992, he charged Members to "recreate" the image of the physician as a competent and dedicated professional and to fight for recognition of osteopathic contributions to the healthcare needs of the nation. During his term, the College improved residency training standards, devised a new long-term strategic plan, continued to push for specialty respresentation in the AOA House of Delegates, and submitted a detailed commentary on the proposed Medicare Fee Schedule to HCFA.



Paul T. Lloyd, D.O.

A gifted and well-respected surgeon and teacher, Dr. Lloyd received the Orel F. Martin Medal in 1981 in recognition of his devotion to the osteopathic profession and the practice of radiology. Dr. Lloyd was a founding member and the first president of the American Osteopathic College of Radiology, and was the organizational force behind the AOBS. In 1937, he was elected to Associate Membership, and in 1944 became a College Fellow. In 1957, he was granted Life Membership.

Edward A. Loniewski, D.O.



Symbolic of the close ties between the College and orthopedists, Edward A. Loniewski, former president of the AOAO (1978), became ACOS secretary in 1986 and president in 1988. During his term as president, he stressed the importance of unity among osteopathic physicians in the face of healthcare reforms and oversaw the expansion of the College's Board of Governors to include representation from various specialties. In the 1970s, he served on an ACOS advisory committee charged to make recommendations on how to better represent and meet the growing demands of specialties at the ACA. A Fellow and Diplomate of the AOBOS, Dr. Loniewski is a skilled orthopedic surgeon and excellent educator, and was the main force in establishing the orthopedic department of Botsford Hospital in Michigan. In recognition of his many contributions to the College and the profession, he received the Orel F. Martin Medal in 1992.

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***Leaders of Note** continued from Page 102*



Sydney P. Ross, D.O.

Dr. Ross served as ACOS secretary in 1984 and as ACOS president in 1986, the year the College relocated to Washington, D.C., as part of its legislative strategy. A long-time ACOS member and governor, he also chaired the Executive Committee that recommended changing the College's bylaws to accommodate representation on the Board of Governors by the various disciplines. In the 1970s, Dr. Ross chaired the Cardiothoracic and Vascular Surgery Discipline and helped devise the third self-evaluation exam for practitioners. In recognition of his surgical and teaching skills, he was named Distinguished Osteopathic Surgeon in 1990. Two years later, he was named Distinguished Practitioner in Osteopathic Medicine by the National Academies of Practice, an interdisciplinary healthcare professional organization that advises government institutions and the public. Dr. Ross is dean of the Kirksville College of Osteopathic Medicine, a position he assumed in 1989.

Daniel L. Wisely, D.O.



As ACOS president in 1983, Dr. Wisely alerted ACOS members to the lack of training opportunities for graduates of osteopathic medical schools and the financial difficulties small osteopathic hospitals faced because of inadequate Medicare reimbursement rates. He also oversaw the inauguration of the Young Surgeons Committee, which served as an important communications link between young osteopathic physicians and College leaders who were older and more established. A well-respected surgeon and highly regarded teacher, Dr. Wisely twice has been named Clinical Teacher of the Year at the Philadelphia College of Osteopathic Medicine. He received the College's coveted Distinguished Osteopathic Surgeons Award in 1982.

Chapter 7: Epilogue

What does the future hold for the American College of Osteopathic Surgeons, its members, and the profession?

In some ways, the question is a difficult one to answer. The challenges facing osteopathic surgeons today are great, and there is much uncertainty about how health system reforms and other changes in the delivery of medical services will affect the science and art of medicine. Two things are certain, however: Change is inevitable, and the ACOS will greet it as an opportunity to further achieve the highest standards for surgical care.

This certainly has been the case throughout the College's sixty-nine years of existence. From its humble beginnings in 1926 to the wide recognition for its surgical leadership in 1994, it has met challenge after challenge head on, guided by the foresight, strength, and vision of its leaders and the unwavering support of its members.

The previous decades have been filled with numerous firsts and achievements, such as the development of stringent educational standards for surgical training programs and mandatory continuing education requirements; the establishment of the Annual

Clinical Assembly (ACA); and the reorganization of the Board of Governors to better represent the membership and meet its professional needs.

The years also have witnessed numerous battles in which the ACOS has fought to stop unethical surgical practices such as fee splitting, protect the rights of osteopathic surgeons to care for their patients nationwide, and gain recognition for the osteopathic profession from the allopathic community and the federal government.

Time and again, the College has prevailed through its determination, persistence, and belief in its mission. And with each battle, the ACOS has grown stronger, more sophisticated, and better able to deal with the challenges that lie ahead; challenges that will require it to continue to be vigilant, sensitive, creative and, more importantly, adaptable.

For in the words of Charles Darwin, "It is not the strongest of the species that survives, nor the most intelligent, but rather the one that is the most adaptable to change."

"The future of this great profession belongs to you."
—Jerome L. Axelrod, D.O., from his charge to new members at the 1989 ACA

Appendix

ACOS Presidents: 1926–Present

1926-1928	George M. Laughlin
1929	Harry L. Collins
1929-1931	W. Curtis Brigham
1932	Orel F. Martin
1933	Edward G. Drew
1934	George J. Conley
1935	Albert C. Johnson
1936	Herbert C. Wallace
1937	John P. Schwartz
1938	Orrin O. Bashline
1939	Howard E. Lamb
1940	Edward B. Jones
1941	Ralph P. Baker
1942	C. Denton Heasley
1943	Andrew R.M. Gordon
1944	Richard A. Sheppard
1944-1946	George C. Widney
1947	H. Willard Sterrett
1948	Edward T. Abbott
1949	Frank A. Dilatush
1950	J. Gordon Hatfield
1951	Charles L. Ballinger
1952	Lucius B. Faires
1953	James O. Watson
1954	James M. Eaton
1955	J. Willoughby Howe
1956	J. Donald Sheets
1957	Harold J. McAnally
1958	Karnig Tomajan
1959	Howard A. Graney
1960	Milton V. Gafney
1961	Ernest G. Bashor
1961	Karnig Tomajan
1962	Howard C. Baldwin
1963	Emmett Binkert
1964	Clois H. Guthrie
1965	Arthur M. Flack, Jr.
1966	Paul R. Koogler
1967	Theodore F. Classen
1968	Richard A. Michael
1969	Charles H. Brimfield
1970	Robert C. Erwin
1971	J. Natcher Stewart
1972	Ellis Siefer
1973	Charles R. Hetzler
1974	Paul W. Trimmer
1975	P. Robert Lombardo
1976	Donald Siehl
1977	Richard P. Rounce
1978	J. Richard Costin
1979	John A. Fetzer
1980	Albert S. Reibstein
1981	C.W. Elliott
1982	Michael A. Longo
1983	Daniel L. Wisely
1984	Samuel V. Origlio
1985	Arnold Gerber
1986	Sydney P. Ross
1987	Walter L. Wilson
1988	Edward A. Loniewski
1989	R. William Bradway
1990	John H. Finley
1991	Norman Rose
1992	Paul Peter Koro
1993	F. Kenneth Shockley
1994	Bernard I. Zeliger
1995	John P. Smith, Jr.
1996	David K. Smith

ACOS Secretaries: 1926–Present

1926	S.D. Zaph
1927-1930	Orel F. Martin
1930-1940	Albert C. Johnson
1940-1953	Orel F. Martin
1953-1960	Charles L. Ballinger
1960-1969	Harold J. McAnally
1970	Charles H. Brimfield
1970	Clois H. Guthrie
1971	Richard A. Michael
1972	Gordon S. Beckwith
1973	C. Robert Starks
1974	J. Natcher Stewart
1975	Ellis Siefer
1976-1977	Charles R. Hetzler
1978-1979	P. Robert Lombardo
1980	Richard P. Rounce
1981	J. Richard Costin
1982	Nicholas G. Palmarozzi
1983	Arnold Gerber
1984	Sydney P. Ross
1985	Walter L. Wilson
1986	Edward A. Loniewski
1987	R. William Bradway
1988	Norman Rose
1989	Paul P. Koro
1990	F. Kenneth Shockley
1991	Bernard I. Zeliger
1992	David W. Smith
1993	John P. Smith, Jr.
1994	Peter V. Kilburn
1995	Richard A. Smialek

Orel F. Martin Medal Winners: 1956–Present

1956	John P. Schwartz
1957	Harry L. Collins
1960	Howard E. Lamb
1961	James M. Eaton
1962	Albert C. Johnson
1965	Edward G. Drew
1967	C. Denton Heasley
1968	Charles L. Ballinger
1969	Harold J. McAnally
1970	James O. Watson
1971	J. Donald Sheets
1972	Paul R. Koogler
1973	C. Robert Starks
1974	Arthur M. Flack, Jr.
1975	Howard C. Baldwin
1976	J. Paul Leonard
1977	Howard A. Graney
1978	Mrs. Esther F. Martin
1979	J. Natcher Stewart
1981	Paul T. Lloyd
1982	Robert C. Erwin
1983	John A. Fetzer
1984	John P. Wood
1985	Milton K. Miller
1986	Donald Siehl
1987	Ellis Siefer
1988	J. Richard Costin
1989	Paul W. Trimmer
1990	C.W. Elliott
1991	P. Robert Lombardo
1992	Edward A. Loniewski
1993	Theodore F. Classen
1994	William G. Anderson

Distinguished Osteopathic Surgeon Award Winners: 1972–Present

1972	John A. Fetzer
1973	J. Natcher Stewart
1974	David Silverman
1975	Ellis Siefer
1976	Robert C. Erwin
1977	John W. Phardel
1978	Nicholas G. Palmarozzi
1979	R. William Bradway
1980	P. Robert Lombardo
1981	Milton K. Miller
1982	Daniel L. Wisely
1983	Donald Siehl
1984	C.W. Elliott
1985	Richard P. Rounce
1986	Robert O. Hinkle
1987	Arnold Gerber
1988	Jerome L. Axelrod
1989	J. Richard Costin
1990	Sydney P. Ross
1991	John H. Finley
1992	Leonard H. Finkelstein
1993	Peter E. Johnson
1994	Charles V. Gemma