The American Board of Otolaryngology, 1924-1999

75 Years of Excellence

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This year marks the 75th anniversary of the founding of the American Board of Otolaryngology (“the Board” or ABO). It has been a productive and innovative 75 years as the Board has strived to elevate the standards of otolaryngology, certify qualified practitioners, protect against unqualified practitioners, and advance the cause of the specialty. Along with American ophthalmologists, otorhinolaryngologists should have considerable pride for the role their specialty has played in introducing board certification to American medicine. The ABO established and maintains a successful certification process that enhances the professional life of its diplomates and provides health care organizations and patients with confirmation of the education, training, and continuing education of practitioners. Otolaryngologists should also be grateful to the ABO for its foresight and tenacity in preserving the specialty’s scope of practice against possible diminishment.

THE BIRTH OF SPECIALIZATION

Specialization within medicine follows the creation of knowledge and the growth of science and technology. It typically occurs as a result of advances in a clinical field or the development of diagnostic or therapeutic technology. As physicians gain expertise in a given area, they begin to exchange information with others interested in the field. Subsequently, they form an organization, meet formally to share ideas and advances, and publish their work. As interested peers learn of the organization, membership in the organization becomes a mark of distinction, more interested physicians join, and a specialty is born.

Ophthalmology and otolaryngology, the first 2 disciplines to emerge as distinct specialties developed in just this fashion. Von Helmholtz developed the ophthalmoscope in 1850, and it was introduced into the United States in 1861. Physicians using this new device and interested in diagnosing and treating diseases of the eye formed the American Ophthalmological Society in 1864 in New York, NY, and the American Journal of Ophthalmology was created in 1884.

Otolaryngology followed a similar course. Physicians interested in the problems of the ears, nose, and throat were spurred by the development in the late 1850s of the otoscope and the laryngoscope. The American Otological Society was organized in 1869, and the American Laryngological Association was formed in 1879.

Many physicians practiced both specialties (eyes, ears, nose, and throat), and they formed a combined society, the American Academy of Ophthalmology and Otolaryngology (the Academy), in 1896. Initially, they published a combined journal, the Annals of Ophthalmology and Otolaryngology, but it subsequently split into the Annals of Ophthalmology and the Annals of Otology, Rhinology and Laryngology.

THE STATE OF MEDICAL EDUCATION

These specialties emerged against a backdrop of an immature and dynamic medical education environment. The earliest medical schools in the United States (dat-
ing to 1765) exposed students to large volumes of clinical material at associated hospitals, but offered little formal teaching or laboratory experience and did not require any college education. Over 400 proprietary medical schools appeared in the 1800s. These were mainly “diploma mills” without university affiliation or access to adequate clinical material. Most had no laboratories or libraries and did not even require high school graduation as a prerequisite for admission.

Attempts at organizing medical education curriculum began in the 19th century. In 1826, the University of Virginia became the first state-supported institution to have a full-time faculty and a prescribed length of study. Later, between 1860 and 1870, Johns Hopkins, Harvard, and other leading schools began to develop core medical curricula, educational prerequisites, and a prescribed length of study. There was, however, still no regulation, no oversight, and no accreditation of schools.1

In 1904, the American Medical Association (AMA) established the Council on Medical Education to evaluate the quality of schools of medicine. The council reported their findings at an AMA meeting, but considered their findings so shocking that they did not publish the results. Instead, they commissioned the Carnegie Foundation for the Advancement of Teaching to conduct an independent survey. The foundation chose Abraham Flexner to perform this task, and when he reported the results in 1910, the impact on medical education, and more importantly on the number and quality of medical schools, was profound. Flexner concluded that the country had too many schools of medicine of poor quality and too many poorly trained physicians. He believed that the United States would be better served with fewer but better schools that in turn would produce better-educated physicians.

The Flexner report, combined with widespread adoption of medical licensure, resulted in the number of medical schools dropping from 161 in 1906, to 131 in 1910, and to 81 schools by 1922.1(pp116-123) Medical licensure had been tried and rejected by a few states in the 1830s, but it was not until the 1870s that it began to be widely accepted and adopted by most states. “Irregular” practitioners fought these licensing laws to be widely accepted and adopted by most states.1

Up to the present, on this continent, there is no recognized portal to the specialty. On the other hand the gates may be said to be many, and yet, mirabile dictu, our towns and villages and even our cities are filled with “specialists” who have entered by no gate whatever, but have simply “climbed over the wall” and are to some extent, at least, to be considered merely as “thieves and robbers.”

The house-surgeon attached for three months to the otolaryngological service of a hospital, the general practitioner who derives his knowledge of the subject from a six weeks’ course in a post-graduate school, and the man who takes a run to Europe immediately after graduation, alike think themselves worthy to be ranked as specialists. It is time we had done with this farcical sort of preparation, if our specialty, worthy as it is of the best, is not to be dragged in the mire as a result of the ignorance of anatomy, diagnosis, and technique displayed by a very large proportion of the rank and file of those who now style themselves “specialists in diseases of the ear, nose and throat.”

We all know the facts, and we deplore them. Now what can be done to face and overcome the difficulties of the situation? We must first decide what constitutes the standard of proper training, then provide for its acquirement, and finally bring such influence to bear on state legislatures as to secure the legal enactment that only specialists provided with this training may practice as such.2

Wishart’s report was published in Laryngoscope in 1913,3 and he recommended 8 steps to achieve the goals he had set. With the exception of the final recommendation (legal enactment of licensing of specialists), all, or variations of them, were eventually adopted. The Academy embraced this initiative and appointed 2 committees—one for ophthalmology and one for otolaryngology. It charged the committees “to induce post graduate institutions of the United States to adopt some manner of uniform curriculum and uniform requirements for admission to Ophthalmic and Otolaryngologic practice.”

The committee for ophthalmology included representatives from the American Ophthalmologic Society, the Section on Ophthalmology of the AMA, and the Academy. By ignoring its original charge and choosing only to offer an examination on completion of unspecified training, this committee avoided the more daunting task of trying to standardize postgraduate education. The committee members presumed that training programs would upgrade their curricula so that their graduates could pass the examination. As a result, the committee was able to form the American Board for Ophthalmic Examinations in May 1916 in Washington, DC. The board offered a trial certifying examination on December 13, 1916, in Memphis, Tenn, to 13 candidates. The American Board of Ophthalmic Examinations was incorporated in 1917, thus becoming the first medical specialty certifying board in the
United States, and it offered the first regular examination on June 7 and 8, 1917, in New York, NY.³

Sharon A. Bryan, who authored the book *Pioneering Specialists, History of the American Academy of Ophthalmology and Otalaryngology* in 1982, observed:

Certainly in the cosmos of American medicine, in the unfolding of American specialty practice, this event marked the beginning of evolutionary changes. The American Board for Ophthalmic Examinations . . . stimulated motivation and means for elevating the quality of those practicing the specialties and, therefore, the quality of care delivered. The influence of the Board traversed the entire circumference of American specialization and was a prime mover toward the highly sophisticated medical specialization that we have in this country today.⁴

The otolaryngologists first constituted their committee in 1915 with representatives from the Academy, the American Laryngological Association, the American Otological Society, the Section on Otalaryngology of the AMA, and the Triological Society. The committee rather easily agreed on recommendations for teaching otalaryngology to undergraduates, and copies of the recommendations were forwarded to the medical faculty of every university and college of medicine, as well as to every state or provincial examining board in the United States and Canada.⁵

Standardization of postgraduate education was a much more difficult undertaking. Meeting in 1916, the committee recognized the controversial nature of the revolutionary process they were contemplating, and convincing the various program directors around the country to voluntarily accept their recommendations was not to come easily. This process, now known as accreditation, consists of determining what constitutes the content of specialty practice, establishing educational standards, and periodic inspections of the training programs to ensure that those standards are being met. Certification is the examination process that follows the period of accredited training culminating in the issuance of a certificate attesting to the fact that an individual has successfully completed this process.

World War I delayed the committee from meeting for 2 years, and it was not until 1919 that another meeting was held. In 1920, the committee (now called the Committee on Education) reported to the Triological Society:

> From Philadelphia, New York, Boston, Chicago, Iowa, Minneapolis and other cities, very encouraging reports have been received as to the influence that is being brought to bear by the members of this committee. If everyone of the members [of the Triological Society] will take a part in the campaign of education, we feel certain that, although you may not be able to work along an absolutely direct line, you will see much advancement in the educational work which concerns the teaching of the man who is going to be a specialist in Otalaryngology.⁶

Although it faced heavy resistance in establishing authority to regulate specialty training, by 1921 the committee had agreed upon a recommended postgraduate curriculum, and by 1923, had proposed that a certifying examination also be given.

In 1920, the ophthalmologists had begun requiring certification by their board for fellowship in the Academic Society.

The board did not forget its responsibility for accrediting programs, and it established standards and began the process of accreditation, still voluntary today on the part of the programs. The ABO continued this activity until 1953, when the Residency Review Committee for Otalaryngology was formed to serve this function. The Residency Review Committee for Otalaryngology is a tripartite committee consisting of 3 otalaryngologists, 1 each from the ABO, the American College of Surgeons, and the AMA, with the secretary of each organization serving as ex officio members. A confederation of residency review committees of all specialties was established in

Harris P. Mosher (Figure), professor of laryngology and otology at Harvard Medical School, was elected the first president of the board, and he served in this capacity from 1924 until 1947.

To elevate the standards of otalaryngology, to familiarize the public with its aims and ideals, to protect the public against irresponsible and unqualified practitioners, to receive applications for examinations in otalaryngology, to conduct examinations of such applicants, to issue certificates of qualification in otalaryngology and to perform such duties as will advance the cause of otalaryngology.
In 1946, the ABO decided to grant credit for training and experience obtained in the military with the amount of credit lower than the numerical system used in the 1930s. In 1944, the Board reluctantly to rescind eligibility to applicants from Canada, Great Britain, Australia, and New Zealand. Effective July 1, 1959, only those who had 3 failures must show evidence of 300 credit hours of training. This requirement was dropped in 1984.

Until 1976, a candidate who failed the examination 4 times was required to serve an additional year of training before reexamination. A similar requirement was established in 1982, mandating that those candidates who had 3 failures must show evidence of 300 credit hours of training. This requirement was dropped in 1984.

The criteria for acceptable candidates for the examination have changed over the years. Doctors of Osteopathy who are otherwise qualified have been accepted since 1971 if they have completed a training program accredited by the Accreditation Council for Graduate Medical Education. Applicants from the United Kingdom, New Zealand, and Australia were eligible from 1982, 1984, and 1986, respectively, and those graduating from approved Canadian programs had been eligible since the beginning. Difficulty in obtaining information from the accreditating agencies in these countries, variations in their training requirements, and adoption of a requirement by the ABO that all candidates beginning training on or after July 1, 1997, must successfully complete 1 year of general surgery and 4 years of otolaryngology caused the Board reluctantly to rescind eligibility to applicants from these foreign countries. Effective July 1, 2000, only those candidates successfully completing the prescribed training in programs accredited by the Accreditation Council For Graduate Medical Education are eligible to take the ABO certifying examination.

EVOLUTION OF THE EXAMINATION

The 1927 certifying examination included a practical component and a written component. By 1940, the examination consisted of 4 parts (written, clinical, oral, and a test on pathology), and lasted 2 to 4 days. Only class III and IV physicians were required to take a written examination. The clinical examination of an actual patient included history taking, physical and functional examina-
Certifying Examination Eligibility Requirements From 1927 to 1999

1927 General Requirements
Class I (physicians who had practiced for 10 years or more): The American Board of Otolaryngology reviewed the applicant's training, published records, case histories, and professional work to determine whether examination would be necessary before awarding a certificate.

Class II (physicians who had practiced 5 to 10 years): The American Board of Otolaryngology reviewed a report of 25 cases observed and treated by the applicant and considered service as an intern or assistant in an ear, nose, and throat hospital or clinic, or service as an associate or an assistant to an otolaryngologist in private practice, to determine if further examination was necessary.

Class III (physicians who had practiced less than 5 years): The American Board of Otolaryngology stipulated that to be considered for examination, these applicants must have:
1. Earned a degree from a medical school of high standing, satisfactory to the Board of Examiners;
2. Performed 1 year of service in an ear, nose, and throat clinic, an internship of 1 year in an ear, nose, and throat hospital, or an assistantship in private practice with a statement of the duties required; and
3. Completed 1 year of special study of otolaryngology under competent instructors or in accepted institutions for graduate teaching and 1 year of clinical hospital experience, preferably in a general hospital.

Applicants who had been in practice for less than one year were not considered for examination.

1943 General Requirements
Option 1. Applicants must have completed:
1. One year of internship;
2. Two years of training in otorhinolaryngology (or 3 years in combined ophthalmology/otorhinolaryngology training with 50% of the training in the combined program in otorhinolaryngology) that must include anatomy, histology, physiology, and pathology; and
3. Three years of specialized practice (or for the combined program, specialized practice for 4 years) that may include the period of training.

Option 2. Applicants must have 5 years of specialized practice.

Option 3. Applicant must have completed a combined program that must include acceptable training in the basic sciences, subject to the approval of the Credentials Committee.

1950 General Requirements
Option 1. Applicants must have completed:
1. One year of internship;
2. Three years of otolaryngology residency (4 years if ophthalmology is included with a minimum of 50% of the training spent in the study of otolaryngology) that may include basic sciences, or a formal course in the basic sciences to fill out the balance of training in otolaryngology for a 3-year period; and
3. One year in specialized practice.

Option 2. Applicants must have completed:
1. Two years of residency (3 years combined program);
2. One year of residency training in surgery or medicine, or an additional year in an approved internship.

Option 3. Applicants must have completed 7 years in specialized practice (otorhinolaryngology or ophthalmology/otorhinolaryngology).

1959 General Requirements
Applicants must have completed 1 year of internship and 4 years of graduate training to include 3 years of otolaryngology and 1 year of surgery, medicine, full-time study in a basic science department of an approved medical school, or 1 year in an approved course of study and training in otolaryngology at a hospital or university center in the United States, Canada, or abroad.

1961 General Requirements
Applicants must have completed 4 years of graduate training to include 3 years of otolaryngology and 1 year of general surgery, which could be taken any time except after the training in otolaryngology. The course of study included anatomy, biochemistry, embryology, microbiology, pathology, physiology, pharmacology, and the communicative sciences including audiology and speech, plus basic principles of surgery.

1999 General Requirements
Applicants must have successfully completed 5 years of graduate training to include 3 years of otolaryngology, 1 year of otolaryngology, general surgery or other acceptable specialty, and 1 year of general surgery. For those applicants beginning training on or after July 1, 1997, the requirement is for 1 year of general surgery and 4 years of otolaryngology.

The general surgery may not be taken after completion of the otolaryngology training. All training must be in programs approved by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada, and must be completed before the date of the examination in any given year. Individuals beginning training on or after July 1, 2000, must receive training in programs approved by the Accreditation Council for Graduate Medical Education.

tions, the use of laboratory and radiography findings, and a discussion of differential diagnoses and treatments. The oral examination was a private test covering all aspects of otolaryngology. Class III examinations included gross pathology, while those for class IV included gross pathology and microscopy. In 1968, the ABO changed the examination slightly to a 3-part format: an oral examination of general medical knowledge and basic science as related to otolaryngology; a clinical examination of a patient; and an evaluation of otolaryngologic abnormalities using microscopic slides or photomicrographs.

In 1969, owing to increased numbers of applicants, it was necessary to administer as many as 3 examinations per year, and this became costly and time consuming. The clinical examination was viewed as being particularly important in determining the candidates' technical ability to examine patients, but it became impossible to find hospitals with appropriate facilities and enough willing patients to accommodate the growing number of candidates. Thus the clinical examination was replaced by oral examination protocols derived from actual cases.

In 1972, the examination format was changed to include a written multiple-choice component plus the oral component. The content of the written part was organized into 5 general areas and included the type of pa-
tient treated, the patient's problem, the part of the body involved, the application of basic science information, and the clinical diagnosis and treatment. The oral examination protocols covered 4 types of problems: diagnosis, treatment, complications, and emergency care. These were organized into 4 areas of the specialty: general otolaryngology, head and neck surgery, otology, and plastic and reconstructive surgery. Additionally, in 1972 the use of the term conditioned to indicate a candidate who had failed the examination the first time was discontinued, and henceforth only the terms pass or fail were used.

By 1979, administering a written and oral examination to all candidates required 70 guest examiners and 25 directors. Concern was mounting over the cost of the examinations. The Board's educational consultants agreed that on the basis of a written examination alone, it would be possible to determine which candidates would pass or fail an oral examination. Since the written and oral scores were combined, it was a simple matter of mathematics to determine what score on the written test would preclude a candidate from failing, even with a very low score on the oral examination. Thus, in 1980, the examination format changed drastically. A written examination was given in the fall. Those who passed with a sufficiently high score were certified solely on the basis of the written examination. Those who failed the written test had to retake it and pass it before continuing with the certification process. Those who passed but did not receive a score sufficiently high to become certified became candidates for an oral examination. Since the written and oral test scores were added, the pass-fail decision was based on this total score.

This method saved the Board money by not incurring travel expenses for a large number of guest examiners, but there were several directors who raised concerns that the oral examination evaluated different aspects of a candidate than did the written examination. Additionally, this examination process was creating 2 classes of diplomates: those who were certified on the basis of the written examination alone, and those who had to take both a written and an oral examination. Some of the former group were indicating on their resumes that they were certified on the basis of the written examination alone. In spite of the concerns of some directors, this examination format was used throughout the 1980s.

Those arguing in favor of this method of examination pointed out that the overall pass rate did not increase appreciably when it was initiated, as had been feared. In fact, the pass rate decreased. From 1960 to 1980, the pass rate varied from 63% to 86%, with most cycles above 75%. From 1980 to 1990, the overall passing scores varied from 63% to 83% with an average of 70.2%.

In 1988, the examination changed again slightly. The microscopes and slides used in the histopathology examination were replaced by photomicrographs used during a 15-minute pathology section of the oral examination.

THE CURRENT EXAMINATION

Administering a valid, fair, and thorough examination is the core function of the ABO; it is performed as a public trust. The entire process must be above reproach with no hint of outside influence on the outcome of the examinations. The ABO has achieved this high level of integrity and maintained it over the years.

Considerable effort is expended to ensure that the examinations are comprehensive, fair, and valid. The directors have studied what other examining boards have done and hired experts in examination construction and administration to assist them. Still, they continually search for ways to improve the examination. Candidates, too nervous to notice during the examination but reflecting on it later, and guest examiners who participate in the process are impressed by the amount of effort that goes into the examination development and the surprisingly smooth logistics of administering an annual oral examination to about 350 candidates using more than 100 examiners over a 2-day period. Many people contribute to this effort, including the examination committee chair, the Board administrative staff, the examination committee members, and the psychometric consultants who spend countless hours ensuring that the examination is relevant, valid, and reproducible for each candidate.

The selection of material for the examination is carefully controlled to ensure that the examination tests what otolaryngologists actually do. In 1997, the Board initiated a scope of practice survey and an extensive investigation into what constitutes an otolaryngologist's practice. The results confirmed that the general requirements established by the ABO and the materials used to test candidates for the past several years are appropriate and reflect the content of the average otolaryngologist's practice.

The written examination questions are carefully selected and drawn up by practicing otolaryngologists who have spent time in classes learning how to avoid ambiguity. These individuals constitute the task force on new materials, and each serves up to 6 years in this capacity. The oral protocols are taken from actual cases submitted by directors or senior examiners. The questions are reviewed and re-reviewed, and the final decision on which ones are used in the examination is determined by the examination committee chair, assisted by the physician directors who serve on the examination committee (the core committee of the Board). Visual materials, though sometimes a cause of complaints by candidates, are designed to illustrate their subject matter as clearly as possible and are continually improved.

The task force on new materials is one source of guest examiners, 40 of whom are needed to assist the directors and senior examiners in conducting the examination. The examiner selection committee reviews the credentials of people wishing to participate in this process and who are recommended for the task. They are chosen on the basis of reputation, contributions to the specialty, geographic location, and subspecialty interest. Guest examiners usually serve for 2 years, and following service of at least 2 years, they are eligible for election as a senior examiner. There are 36 senior examiners, each of whom serves a 5-year term. These important men and women, along with the directors, provide the Board with a cadre of experienced examiners to administer the examination in a uniform fashion. Most new directors of the ABO are selected from the senior examiner group. Directors are elected to a 4-year term, eligible for reelection twice or until age 65 years, whichever comes first.
To ensure uniformity in the administration of the oral examination, all examiners, including the directors, spend a half-day annually being oriented in examination techniques the day before the oral examination. The candidates are provided with written materials outlining the conduct of the examination, and they are briefed again just before the examination. Owing to these rigorous standards, the ABO examination has received outstanding reviews by psychometricians and physicians from outside the Board who have witnessed the process and base their judgments on experience with other certifying examinations.

The ABO director’s continuing desire to improve the examination process led to an educational retreat of the ABO in June 1990. Representatives from the boards of anesthesia, pediatrics, and surgery as well as psychometricians attended the retreat. Following this meeting, the ABO decided to give a written qualifying examination that all candidates must pass before they are eligible to take the oral examination. Unlike with previous examinations, the written and oral scores were not to be combined. The candidates now must pass both the written qualifying and the oral examinations before they can be certified. This method has been used since 1991, and it has resulted in a certification rate averaging 78.8%. This improved success rate compared with the previous 10-year period can be attributed also to improvement in the quality of the physician entering and completing the accredited US otolaryngology training programs over the past decade.

The ABO used psychometric firms to construct and manage the examinations for them from the mid 1970s to the mid 1990s. American College Testing, Iowa City, Iowa, performed this work from 1980 until 1994, when the ABO took direct control of the oral examination preparation. In 1996, they did the same with the written part. Since then, the ABO has directly prepared, assembled, and conducted the entire examination, relying on psychometric consultants only in an advisory capacity. Two or 3 directors plus some Board staff members and locally hired proctors administer the written examination annually in the fall in 4 widely separated geographic locations such as New York, NY; Atlanta, Ga; Chicago, Ill; and San Francisco, Calif. The ABO directors, assisted by ABO administrative staff and approximately 75 carefully selected senior and guest examiners, administer the oral examination annually in the spring. For logistical reasons, this is administered at a single location, usually Chicago.

PROTECTING CERTIFIED PRACTITIONERS

The ABO has important functions in addition to the process of certification. One of these functions is to protect the integrity of the certificate. Certification is and always has been a voluntary activity. However, increasing consumerism and public knowledge of how medicine is, or should be, practiced, along with greater specialization and medical liability, have increased the importance of certification. These trends have forced many agencies, including hospitals and managed care organizations, to insist on evidence of higher qualifications than just a license to practice medicine. Certification by an American Board of Medical Specialties (ABMS) member board has risen in importance to a position just below licensure.

One consequence of this development is that some practitioners who are unwilling or unable to pass the certification process sometimes falsify their credentials or even forge an ABO certificate. This type of individual has always been with us, but the increasing scrutiny of credentialing organizations has spawned a more sophisticated group of them. It is not possible for the ABO to monitor every physician who opens a practice and claims certification. The Board depends on its diplomates, whose legitimate certificate is diminished when unqualified practitioners claim to be certified, to notify the ABO office of their suspicions. It is then a simple matter for the staff to check the records and find out if the person claiming to be certified is a diplomate.

Sometimes practitioners falsely claiming to be certified are discovered when a credentialing agency checks with the ABO. When someone advertises that they are “board certified” when they are not, a letter from the ABO is usually sufficient to cause them to cease this practice. Occasionally, however, a true miscreant tests the resolve of the Board, as one did recently. Having used a forged certificate for several years, this practitioner refused to cease claiming to be certified; after the state board of medicine found him guilty and fined him, the ABO lodged a civil action and recovered damages from him.

The ABO also ensures that otolaryngologists are allowed to practice the full scope of otolaryngology—head and neck surgery for which they are qualified by virtue of their training and education. Occasionally, an organization will attempt to restrict what a well-trained otolaryngologist—head and neck surgeon is permitted to do. If a diplomate of the ABO is denied privileges to perform a procedure for which he or she is qualified, the ABO cannot affirm that the diplomate is qualified to perform a given procedure. The ABO does not possess that information. Validation of training in the performance of a given procedure is the responsibility of the individual and the individual’s training program director. What the ABO can do is inform the organization that the requested privileges are within the training, examination, and scope of practice of an otolaryngologist—head and neck surgeon.

THE ABMS

In 1933, the American Board of Obstetrics and Gynecology (formed in 1930), the American Board of Dermatology and Syphilology (formed in 1932), the American Board for Ophthalmic Examinations (renamed the American Board of Ophthalmology in 1933), and the American Board of Otolaryngology, joined by representatives of the American Hospital Association, the Association of American Medical Colleges, the Federation of State Medical Boards, the Council on Medical Education of the AMA, and the National Board of Medical Examiners, formed a confederation known as the Advisory Board for Medical Specialties, later to become the American Board of Medical Specialties. Within a few years, the ABMS had gained autonomy and by 1937, all boards paid $0.10 to the ABMS for each diplomate certified. Although the ABO ex-
pressed reservations about continuing this practice in 1937, by 1993 the ABO was paying more than $55 per diplomate to the ABMS. The ABMS has now achieved a status of approving the certification standards determined and employed by each member board. While the ABMS was originally intended as a forum to discuss how to improve the certification process without powers of enforcement, the overlap of specialty interests has thrust it into a position of attempting to adjudicate disputes between boards as to the scope of practice.

**TURF BATTLES**

Nearly all plastic surgical procedures within the head and neck before 1920 were developed and performed by otolaryngologists. Sir Harold Gillies, MD, an English otolaryngologist (1882-1960), is acknowledged as the father of modern plastic surgery. Plastic surgery within the head and neck has always been a major part of the practice of otolaryngologists. As plastic surgery practiced on all parts of the body began to develop after World War I, the pathway into general plastic surgery began to be through basic general surgery. Otolaryngologists continued to practice plastic surgery within the head and neck area, but there was a gradual growing apart of the 2 specialties. In 1937, the American Board of Plastic Surgery (ABPS) was formed. A schism developed between the 2 specialties, and by 1950, turf battles (i.e., disagreements over the scope of practice) began developing. These continued to simmer until 1974, when the ABPS attempted to stop the ABO from using the term plastic surgery and lodged a complaint to this effect with the ABMS. The ABPS argued that the term was reserved for use solely by their board and their diplomates. The ABO countered that it was a generic term that described a technique, not a specialty. Many surgical specialties use plastic surgery and are thus entitled to train their residents in it and test for the acquisition of this knowledge. The ABPS preferred the ABO to use rhinoplastic, aesthetic or cosmetic surgery. The ABO elected not to discontinue the use of the term plastic surgery. The ABPS appealed to the ABMS to resolve the dispute and to establish a mechanism for the resolution of disputes between boards then and in the future. The ABMS, lacking the will or the jurisdiction, failed to take a position. Rather than resolve the issue, the boards composed a joint letter divorcing them from responsibility for competence beyond the certification process. This issue was to smolder with occasional flare-ups for more than 20 years.

Four things finally resolved this issue in favor of otolaryngologists. The first was solid training and educational programs that provided otolaryngologists interested in this field with excellent training and rich sources of information. In this regard, the American Academy of Facial Plastic and Reconstructive Surgery led, and continues to lead, the field with excellent educational programs and seminars. Second, fellowships in facial plastic surgery beyond the plastic surgical training required for the primary otolaryngology certificate offer excellent training to augment these educational programs. Third, the ABO and otolaryngologists performing this type of surgery exhibited resolve and perseverance to see this issue through to its conclusion. Finally, owing to frustration with the slow process of trying to secure approval of subcertification at the ABMS, the facial plastic surgeons formed their own board, spent the money to campaign for equivalency of their board with the ABMS, and attained this status in several key states (California, Colorado, Florida, and Oklahoma). Until this time, only ABMS member boards were acknowledged by state licensing boards as representing a given specialty.

This action threatened the sovereignty of the ABMS and forced it to deal with the simmering conflict. After several years of negotiations between the 2 boards, brokered by the ABMS, the issue was resolved when the ABMS approved an agreement in September 1997, and the terms were accepted by the ABO in March 1998. By the terms of the agreement, the subspecialty of facial plastic surgery as practiced by otolaryngologists was changed to plastic surgery within the head and neck; qualified applicants for certification would be accepted from both fields—otolaryngology and plastic surgery; and diplomates of the ABPS as well as otolaryngologists would participate in the certification process. The granting of permission by the ABMS in March 1998 for the ABO to issue a subspecialty certificate in plastic surgery within the head and neck was the culmination of more than 25 years of effort to obtain this official recognition by organized medicine.

An additional turf issue arose with the ABO’s attempt to change its name to “The American Board of Otolaryngology–Head and Neck Surgery.” And in 1980, the American Academy of Otolaryngology (having separated from ophthalmology in 1979) merged with the American Council of Otolaryngology and adopted the name “The American Academy of Otolaryngology–Head and Neck Surgery” to better reflect the scope of practice of many otolaryngologists. One of the major journals of the specialty, the *Archives of Otolaryngology*, sponsored by the AMA, adopted the title *Archives of Otolaryngology–Head and Neck Surgery* in 1986. Three times the proposed name change came before the ABMS assembly and 3 times it was defeated. The ABO, being the second board formed and one of the 4 founding member boards of the ABMS, was understandably rankled by the restraints imposed on them by other boards. This led to adoption of the qualifier, “Serving the Specialty of Otolaryngology–Head and Neck Surgery” under the name “The American Board of Otolaryngology” in 1985.

Another controversy arose in 1986, when the ABO voted to create a new certificate that listed the 6 subspecialties of otolaryngology on the certificate. Those subspecialties (facial plastic and reconstructive surgery, head and neck oncology, laryngobronchoesophagology, otolaryngic allergy-immunology, otology-neurotology, and pediatric otolaryngology) were to be plainly listed on the redesigned certificate. This resulted in the boards of allergy, plastic surgery, and surgery filing a grievance with the ABMS; the ABMS filing a lawsuit against the ABO when it failed to agree to withdraw the certificate; the federal court in Chicago issuing an injunction against using this certificate; and the court directing all concerned to use the 1985 certificate then in circulation. The boards of plastic surgery and surgery then filed a second grievance about

Owing to prolonged negotiations between 1990 and 1997, mediated by the ABMS, the ABO and the ABPS in March 1997 requested permission from the ABMS to change their certificates and received unanimous approval. The ABO certificate approved in 1997 indicates that a person is certified “in Otolaryngology, to include General Otolaryngology, Otology, Facial Plastic Surgery, Head and Neck Surgery, and Pediatric Otolaryngology.” This is essentially the same certificate that caused the lawsuit in 1987, when it was the right idea but the wrong time. Timing is very important, or, said another way, persistence pays.

CONCLUSION

The ABO held a gala 50th anniversary celebration on November 1, 1974 that was attended by 52 directors or former directors and their spouses. W. J. McNally, MD, master of ceremonies and a former director, closed the program with a quote from Keats’ Endymion: “Upon our heels a fresh perfection treads—born of us—but fated to excel us.” As the ABO celebrates its 75th anniversary this year (1999), Keats’ words still ring true.

The record of achievements attained by the dedicated physicians who have served as directors of the ABO and the others who have supported them is admirable. Otolaryngologists–head and neck surgeons take their place among the most highly placed specialists, and they have every reason to be proud of their specialty, their teachers, their certifying board, and the care they render to the patients needing their services.

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