PRESIDENT'S ADDRESS
OBSTETRICS AND GYNECOLOGY AS A UNITED SPECIALTY*

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DURING the past twenty-five or more years, there have been steadily progressive changes in educational standards, and in methods of training in the specialties. For example, practically all except the youngest members of this Association were not able to have the advantages of present-day facilities for intensive training in obstetrics and gynecology because, until comparatively recently, opportunities for this were so limited in number. Formerly, as most of us recall, one served his general internship as now, but training in obstetrics and gynecology was usually obtained by apprenticeship to a recognized and outstanding specialist. After more or less prolonged assistantship, one was allowed more responsibilities and wider latitude in his work, still under the close supervision of his preceptor. Hospital staff promotions followed gradually, and presently one became recognized, and rightly so, as a trained specialist.

Time has not lessened the value of this type of training in a specialty, and many men are following this course even now. More intensive methods have partly superseded this, however, and to this end internships and residencies in the specialties are now being developed to a high degree of efficiency.

By the older method, young men were inevitably influenced by the personal views and medical activities of their preceptors. Lines of specialization were not sharply drawn. Gynecology was often a small portion of the work of some distinguished surgeon; another might find that gynecology constituted the major portion of his practice with obstetrics filling a minor place, or the reverse might be true. Younger men were prone, naturally, to follow the example of their masters, and thus the traditions were carried on. Many general surgeons whom we know and revere were trained in this manner to include gynecologic surgery in their work and nothing can detract from the brilliance of their performance of this in many instances.

During the past few years, however, multitudes of new discoveries in all fields of medicine have tended to limit the special activities of physicians within fairly sharply defined borders. On this and other accounts, we are obliged to face the facts of changing times and methods. All of us appreciate, as never before, the breadth and

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importance of the fields of obstetrics and gynecology, while their interrelationship becomes daily more apparent.

The subject chosen for presentation in this address was not singled out in a controversial spirit. Quite the contrary, it was selected for the express purpose of analyzing these definite transitions and trends in the teaching and practice of obstetrics and gynecology, which are becoming more and more widely established on this Continent. I refer particularly to the growing tendency to combine obstetrics and gynecology as a unified specialty in teaching institutions, in hospitals, and other practice. In Europe, this has been a customary and accepted combination for many years. In this country, however, one still hears a certain amount of persistent opposition to the logical suggestion that midwifery bears so close a relationship to diseases of women that they should be taught and practiced together.

By those not favoring this combination, childbearing seems to be regarded as a simple and normal function, which can be adequately supervised by any general practitioner. They grant that obstetrics is one of the most important branches of medicine, but have failed to appreciate that its importance has developed obstetric practice to an extent fully equal to that of any other major specialty. Gynecology is viewed by the same commentators as a mere branch of general surgery, free from any particular influence resulting from improvement in obstetric art, even though many gynecologic ailments are directly the result of poor obstetric care.

The more modern conception is that obstetrics with its multitudinous possibilities for trouble constitutes a major branch of medicine, and that diseases peculiar to women are inseparably associated with their childbearing functions. During recent years this idea has steadily gained more general acceptance on this Continent, although it still meets with sufficient antagonism to warrant a thoughtful analysis of the present situation, both pro and con.

TEACHING COMBINATIONS IN NORTH AMERICA

Accordingly, I inflicted another questionnaire on the deans of the seventy-five four-year medical schools approved by the American Medical Association in this country and Canada. Replies were received from seventy-four deans and I gratefully acknowledge my obligation to them for their generous coöperation in this study. So general a response clearly manifests their active interest in this moot question.

These replies show that the teaching of obstetrics and gynecology from a combined chair is carried out in forty-five, or approximately

60.8 per cent, of the approved medical schools of North America. It develops further that twenty-three, or 31 per cent, have separate chairs for each, and it is significant that gynecology is combined with general surgery in only five, or 6.7 per cent of our approved schools. In one school gynecology is divided between the surgical and the obstetric departments.

CURRENT OPINIONS FAVORING UNIFICATION

In contrast to these latter groups, the attitude of the American Board of Obstetrics and Gynecology, as well as the findings of the White House Conference, have definitely advocated the unification of obstetrics and gynecology for undergraduate and graduate teaching, and for practice.

Two years ago, Dr. Louis E. Phaneuf, in his presidential address before this Association, took for his subject "The Undergraduate Teaching of Gynecology." He discussed many of the points which I have in mind at this moment, but his theme dealt more with undergraduate education than with graduate training in the specialty. He expressed his firm conviction that the ideal way to teach gynecology to the undergraduate was from a combined chair of obstetrics and gynecology. He said that where this was not yet possible, "the teacher of obstetrics should have fundamental training in gynecology as the teacher of gynecology should have in obstetrics, if the best results are to be obtained," and he further stated, "For purposes of teaching and giving the patient the best care, the department of gynecology in large hospitals should be separated from general surgery and should function as a unit or as a part of a woman's clinic." This is sound logic, and applies equally well to the teaching and training of resident house officers and other graduate students.

Six years ago, Dr. Walter T. Dannreuther chose as the subject for his presidential address before this Association "The Qualifications of the Specialist." He called attention to the fact that the medical profession has been afflicted with numberless irresponsible self-styled specialists. He said, "The term 'specialist' implies that the individual so designated has had superior training and has assimilated knowledge from a multitude of opportunities, and the public is just beginning to display an interest in the qualifications he really possesses and to question his authority for so classifying himself." This summarizes admirably the reasons which caused the twelve major specialties in medicine to organize certifying Boards. As you well know, these Boards investigate carefully the special training and practice of applicants for certification as specialists, and then conduct rigid exam-

GYNECOLOGY AND OBSTETRICS IN THE MEDICAL SCHOOLS OF THE UNITED STATES AND CANADA

(FOUR YEAR—"GRADE A" SCHOOLS)
TOTAL INQUIRIES TO—REPLIES 74

ANALYSIS OF TEACHING PLANS

CHAIRS	TOTAL	PERCENTS.	DURATION OF COMBINATION	PRESENT ARRANGEMENT SATISFACTORY	ARRANGEMENT UNSATISFACTORY	CONTEMPLATING CHANGES	DEPARTMENT HEADS: FULL TIME	DEPARTMENT HEADS: PART TIME	DEPARTMENT HEADS: CLINICAL	HOUSE-STAFF TRAINING IN OBSTETRICS-GYNECOLOGY: SERVICE	OBST-GYN COMBINED OR HAVING INTER-ROTATION	OBST-GYN SEPARATED: NO INTER-ROTATION	OBST-GYN SEPARATED PARTIAL INTER-ROTATION	OBST-GYN AND SURGERY INTER-ROTATION	GYN. SURGERY INTER-ROTATION WITHOUT OBST.	NO ANSWER	UNDERGRADUATE TEACHING: OBSTETRICS-GYNECOLOGY REQUIRED SUBJECTS
GYNECOLOGY AND OBST. COMBINED	45	60.8	WITHIN LAST 10 YRS: 16 WITHIN LAST 20 YRS: 7 LONGER THAN 20 YRS: 23	42 (NO ANSWER 3)	1	0	10	20	14	RESIDENT	45						45
							OBST. PART TIME & GYN CLINICAL: 1			ASST. RESIDENT	45						
										INTERNE	45						
GYNECOLOGY AND OBST. SEPARATE	23	31.		15	8	COMBINATION WITH OBST. PLANNED: 5 COMBINATION WITH OBST. UNDER DISCUSSION: 1 OPINIONS DIVIDED: 1 NO PLANS: 1	1	8	7	RESIDENT	4	13	1		4	1	23
							OBST. PART TIME, GYN CLINICAL: 5 OBST. FULL TIME, GYN. PART TIME: 1 OBST. FULL TIME, GYN. CLINICAL: 1			ASST. RESIDENT	3	12	1		3	4	
										INTERNE	11	3			7	2	
GYNECOLOGY AND SURGERY COMBINED	5	6.7	WITHIN LAST 10 YRS: 1 LONGER THAN 20 YRS: 2 NO ANSWER: 2	5	0	0	0	2	3	RESIDENT		2		1	1	1	5
										ASST. RESIDENT				2	3		
										INTERNE		1		1	3		
GYNECOLOGY COMBINED PARTLY WITH SURGERY, & PARTLY WITH OBSTETRICS	1	1.3		1			1 (MODIFIED)			RESIDENT		1					1
										ASST. RESIDENT		1					
										INTERNE				1			
TOTAL	74			63	9	8	12	30	24	RESIDENT	49	16	1	1	5	2	74
										ASST. RESIDENT	48	13	1	2	6	4	
										INTERNE	56	4			10	3	

inations to ascertain the extent of their special proficiency before granting certificates. As Dr. Dannreuther said, "The chief purposes of our Board (like the others) are not restrictive but educational: to encourage and induce potential specialists in obstetrics and gynecology to prepare themselves thoroughly, to persuade medical schools and hospitals to provide adequate facilities for special training, and to put the stamp of approval on qualified specialists." He further said, "The departmental integration and fusion of obstetrics and gynecology is not only desirable but highly essential, because the skillful practice of one is dependent upon a thorough knowledge of the other. It must be conceded that the large Frauenkliniks abroad are far better equipped to produce specialists than our own institutions, although the available clinical material is no greater."

From its beginning the American Board of Obstetrics and Gynecology has insisted that a fundamentally thorough knowledge of both branches is essential, regardless of whether a physician elects to practice one or the other, or both. Therefore, the examinations include both subjects, with especial emphasis on this interrelationship.

In this connection it would have been of interest, had it been possible, to inquire into the arrangements in the many general hospitals of this continent having obstetrical and gynecological departments, because it is in them that many men receive their graduate training in the specialty. Nevertheless, it is likely that the methods provided for undergraduate instruction in the medical schools are a fair index of graduate training facilities, and of practice in general. Each of these schools has its affiliated hospital, and non-teaching hospitals are apt to emulate the example of the others.

COMMENTS ELICITED BY QUESTIONNAIRE

My questionnaire and the comments it elicited developed many interesting facts.

There seems to be no serious argument over the fact that the childbearing function and diseases of women overlap and interlock so closely that there can be no sharp line of demarcation between them. However, in an attempt to divorce the two in one of these teaching institutions, patients with pelvic disorders are still claimed by the surgical division unless their illness is clearly the result of some obstetric experience or calamity. In the latter event they are conceded to the obstetric and gynecologic division, considered in this particular institution as being "combined." Thus a retrodisplacement of the uterus with symptoms in a nulligravida, which is seldom a surgical problem,

is viewed as a case for the general surgeon, whereas a similar condition following pregnancy is assigned to the obstetrician-gynecologist.

In still another important teaching institution, in which it is strongly asserted that gynecology is properly a branch of general surgery, assignment of cases is based upon the rule that all women with pelvic disorders who have not previously been patients in the obstetrical division are to be admitted to the surgical-gynecologic service. Only if they have ever been patients on the obstetric service may they return to this department for gynecologic treatment. Thus, a woman with an ectopic pregnancy is not an obstetric case unless previously she had been a patient in the obstetric department. Both services receive and treat cases of ectopic pregnancy according to this ruling. Indeed, they go even further than this in this hospital. A patient with a fibromyoma or an ovarian cyst applying for admission is likewise questioned as to previous admissions. If she has had a baby or even an abortion treated there at some previous time her tumor becomes mysteriously related to obstetrics and she is admitted to and operated on in the maternity division.

At this same institution, the internes, assistant residents, and residents in gynecology may serve periods of time varying from one to four or five years without ever seeing an obstetric case, without any personal insight into the later effects of some of their pelvic surgery when pregnancy occurs, and without any arrangement whereby they may routinely rotate or have exchange services with men from the obstetric division, if they should wish thus to broaden their knowledge.

Is it necessary to reiterate, at this point, that both in teaching and in practice an attempt to create a dividing line between obstetrics and gynecology is impossible, and at times becomes almost ridiculous? Furthermore, gynecology does not bear an inseparable and constant relationship to surgery. In a recent publication I took occasion to say, "Gynecology . . . includes not only local or genital diseases of women, but general and associated glandular dysfunctions. By far the greatest bulk of gynecologic practice is non-operative, and this, too, should serve . . . to controvert the suggestion that this specialty should be considered a subdivision or branch of general surgery. Office treatments of ambulatory patients predominate greatly in numbers and probably in variety of purposes over hospital admissions and major operations for gynecologic disorders."

OPPOSITION TO UNIFICATION

Having expressed some very definite opinions as to the propriety of combining obstetrics and gynecology, it is proper to consider the

other side of the question and to examine the arguments offered against such a union.

The first of these is, "The obstetrician-gynecologist cannot cope with emergencies of abdominal surgery as efficiently as can the general surgeon. He must be trained in and practice general surgery to be a safe gynecologist in the abdominal cavity. Some of the emergencies mentioned were intestinal obstruction and tumor growths of the gastro-intestinal tract, as well as cholecystitis and cholelithiasis. But is this true of the properly trained obstetrician-gynecologist? It is granted that a competent gynecologist must have had good training in abdominal surgery even though these emergencies are distinctly a minor part of his work, but it should also be remembered that the inter-relationship of obstetric matters is by no means a minor, but rather is a constant part of his gynecologic work.

It was interesting to note what constituted "adequate training in gynecology" in the opinion of this particular critic, whose own department is a subdivision of general surgery in his school of medicine. He has a small corps of internes and assistant residents, headed by a chief resident. While his department is rated as a subdivision of surgery, his men are appointed directly to this gynecologic subdivision, do not rotate through or serve in the general surgical department, and receive their entire training in the gynecologic operating rooms and wards. Their training under his direction is no broader or more inclusive, or better suited to fit them for the general surgical emergencies mentioned, than that of any similar but truly gynecologic service combined with obstetrics. Moreover, there is an entire lack of obstetric experience or training for these men, and I question the likelihood of their seeing any more general surgical emergencies than are met in any average obstetric-gynecologic service.

Let us continue with the quotation. Amplifying his argument, this same authority said, "For example, suppose a gynecologist were to operate for a large fibromyoma of the uterus, and found a gall bladder full of stones." Insisting that such a man's operative ability must perforce be limited, he demanded to know what this operator would do. Would he remove the uterus, and meanwhile summon a surgeon to stand by to remove the gall bladder, or would he be so remiss toward the patient as to remove only the uterus and leave the gall bladder because of his lack of general surgical ability? Apparently in the vehemence of his argument it did not occur to him to question the soundness of judgment of any surgeon who would subject his patient to a hysterectomy for fibroids, at the same time throwing in a cholecystectomy for good measure.

Another comment makes one ask what possible benefit in the way of general surgical training or experience can follow the subordination of gynecology as a division of general surgery in an institution from which the dean writes as follows: "Female urology forms part of the work of our Department of Gynecology. Administratively the Department of Gynecology is considered to be a sub-department of Surgery. As a matter of fact it is largely autonomous. I doubt if the Professor of Surgery ever sets foot in the gynecologic operating suite."

Still another objection offered to the combination of obstetrics and gynecology is that "men trained in obstetrics and gynecology sooner or later drift into the practice of one or the other, seldom continuing with both. The majority, as they grow older, major in gynecology, dropping their obstetric work because of its arduous nature." I do not believe that this is true of the obstetrician-gynecologists trained by modern methods in the combined specialty. Even if it is so, they are better gynecologists and better teachers for having had their broad fundamental training and experience in these closely related branches.

A third argument was, "A man cannot operate on scheduled cases in the morning if he has been up all night with an obstetric case." In a recent paper, Stander dismissed this adequately by the comment that "all doctors specializing as obstetricians and gynecologists, have connections with hospitals, most of them first class, thanks to the efforts of the American College of Surgeons and the American Medical Association. Good hospitals with trained resident staffs are decreasing the necessity of all night vigils with every patient in labor."

It was startling to have the dean of another of these five schools write, "I think that we need more conservative obstetrics and think that this cannot be obtained by combining obstetrics and gynecology."

The dean of the one school in which gynecology is divided between the surgical and the obstetric departments says, "Possibly the most important reason why gynecology is retained in part by the surgical service is the fact that it is felt that the general surgeon will continue to do the major portion of operative obstetrics for many years to come, if not indefinitely."

If there are other reasons against a combination of obstetrics and gynecology as a united specialty, they have not been given me. The relative worth of such arguments should be obvious.

EFFECTS OF UNIFICATION

Let us clearly understand what is meant by the unification of ob-

stetrics and gynecology. It does not mean that one trained in the specialty of obstetrics and gynecology must practice both, but first that he will be better qualified in either branch because of his knowledge of the other. The time will soon come, in all probability, when all those who have been thus broadly trained will practice not merely one or the other, but both, because of the fascinatingly engrossing interrelationship of the two. It does not mean that any one can fairly contend that the general surgeon is unqualified or unfitted to do female pelvic surgery. The results of numerous brilliant surgeons, many of them Fellows of this Association now and in the past, refute such an implication or conclusion.

It does mean that there is a growing appreciation that the teaching of undergraduate medical students, and the training of graduate students, are best accomplished when obstetrics and gynecology are correlated by being departmentally united. Properly to teach the younger men who will succeed us, those giving the instruction should have a background of wide experience in both branches, and preferably should practice what they teach. Needless to say, both obstetrics and gynecology are non-elective subjects for undergraduate students, being "required" subjects in all American schools. The combination also means that patients requiring the solution of either gynecologic or obstetric problems will receive the greatest benefit if they are in the hands of men having this breadth of background.

Fundamentally and basically, therefore, the problem becomes one of training. Those who have had adequate education in the combined specialty should be similarly training the potential specialists. They can best do their teaching of the younger men while these are serving as internes, assistant residents, and residents on combined hospital services. In institutions with medical school affiliations, these same trained men should be teaching obstetrics and gynecology and the elements of their interrelationship to the undergraduate.

Let us see how this applies in the three different groups of schools. In the hospitals of all of the forty-five schools having combined chairs the residents, assistant residents, and internes are given a well rounded and balanced service in the combined specialty.

In contrast to this, in the twenty-three having separate chairs, residents alternate or rotate through both services in only four, and through obstetrics, gynecology, and surgery in only four more. There is a partial rotation in one other. At thirteen of these institutions the residents serve either in gynecology or in obstetrics, but not in both, so that their training here is presumably deficient in one or the other.

The assistant residents fare about the same, as is shown in the accompanying chart, but internes are required more generally to serve in both departments.

In those in which the chair of gynecology is combined with that of surgery the residents rotate between surgery and gynecology in only one, and between surgery, gynecology, and obstetrics in only one other. The assistant residents and internes have generally similar facilities, the importance of related obstetric training apparently being minimized.

Graduate training in obstetrics and gynecology presents two distinct aspects. There are many men who do not intend actually to specialize in this work but whose interest impels them to seek something more than the limited experience derived from an average rotating internship. Still others may have been in practice a few years, and wish to improve themselves in special work. One problem, therefore, concerns itself with the matter of providing graduate training for limited periods of time for these men. The other is that of providing training facilities for those planning to specialize in obstetrics and gynecology.

Many hospitals offer special internships for men who have completed a general rotating internship there or elsewhere. These services are usually for one year, and in many of these four men are appointed. This provides ideal training for a man who does not intend to specialize, but who plans to engage in general practice with special attention to obstetrics and gynecology. It is also a good foundation for those who propose to work up more slowly to specialization through the medium of dispensary and assistant staff attending positions in a department of obstetrics and gynecology of some general hospital.

If these same institutions could arrange assistant internships, externships, or voluntary assistantships for periods of three or four months, perhaps with a registration fee, they would probably be crowded with applicants. Such positions would be in great demand among general practitioners anxious to improve their knowledge and to bring themselves up to date from time to time. Unfortunately such opportunities are not generally available.

Assistant residencies, and residencies of one year each, as now provided, are usually obtained by promotion from the internships. For example, two of four internes are chosen to become the assistant residents, and one of these in turn is appointed to the residency for the ensuing year. At the majority of hospitals with such services, salaries as well as maintenance are paid to some of these men.

Certain hospitals in this country do not provide so complete a course of training, but absorb the assistant residents or even the internes who fail to obtain the promotion, or who wish to acquire other viewpoints by going elsewhere. For example, many general and some special hospitals with residencies and assistant residencies, prefer to have these men come to them from other clinics after their special internship of one year.

Thus, a variety of facilities for special training in obstetrics and gynecology are available in this country. Recently, a Committee on Graduate Education of the American Board of Obstetrics and Gynecology undertook to survey and list the institutions having services such as these. Its findings were published in the *American Journal of Obstetrics and Gynecology* (issue of April, 1936), and should be consulted by those seeking such appointments.

To return to my original theme, I agree emphatically with Dr. Phaneuf that undergraduate teaching of obstetrics and gynecology should be from a combined chair. I reiterate the suggestion that graduate training is best given in a combined hospital service, and that the only compromise with this can be where provision is made for rotation of internes, resident assistants, and junior staff assistants between the two services. Even this is not as satisfactory as to give them their practical training under one head or director who is able from personal experience to correlate the teaching in the two branches. I subscribe wholeheartedly to the viewpoint of the American Board of Obstetrics and Gynecology that even those men who wish to practice or teach only one of these two branches are not adequately qualified to do so without a thorough training and experience in the fundamentals of both. I repeat that modern gynecology is not being well taught when its precepts come from a chair of general surgery, with the chair of obstetrics entirely alienated from the subject. The teaching of obstetrics and of gynecology suffers when their chairs are separated.

CHANGES IN TEACHING METHODS

If these concepts which I have presented are valid, how then may the situation be corrected in those institutions naturally resistant to revision of their long standing traditions, yet inclined to conform with the current trends and to improve their methods of undergraduate as well as graduate teaching of our specialty?

I have no desire to appear in the rôle, alliteratively described by the late Barton Cooke Hirst, as that of a "non-teacher trying to teach teachers how to teach." It is quite possible, however, to acquire a

viewpoint unaffected by local conditions or political expediencies, and to envision the matter entirely from the standpoint of results. Moreover, what is now being said about teaching institutions applies equally well to hospitals without teaching affiliations. The latter predominate numerically, and render an important service to the women of this country, incidentally providing training for many future specialists and practitioners in obstetrics and gynecology. I have ventured, therefore, to formulate certain ideas and to offer certain suggestions on this account, but not on this account alone.

In the position with which I have been honored for several years, namely that of secretary of the American Board of Obstetrics and Gynecology, I have received an extraordinary number of communications on this very subject. The deans of two medical schools and the secretaries of a number of hospital staffs have addressed the Board to the effect that they have taken cognizance of the Board's demands that candidates for certification must have a specified minimum training in both obstetrics and gynecology. They have recognized that the logical way to provide this is by an integration of these departments. In some instances, this requirement of the Board may have had only a minor influence upon their decision, their altered viewpoint being initiated by the very force of the plan's own logic.

From these conferences a simple plan of procedure seems naturally to have evolved itself. It is not an official suggestion of the Board, because the Board is merely an examining body and has never undertaken to interfere with or direct the policies of any group or institution. The Board does no more than establish certain minimum standards of education and training as a basis for admission to its examinations.

The dean of one school of medicine wrote some time ago that the trustees wished to reorganize their departments of obstetrics and gynecology, combining the chairs into one, and asked if we had any suggestions to make as to how the new department should be organized and conducted. He said in effect that he dreaded the repercussions, and the disappointments of some who would be adversely affected by the change, but that they were all convinced of the wisdom of the move. His letter came at about the same time that one of a similar nature was received from another dean of a school in which one chair had been vacated by the death of the incumbent. During the same period, others were received which related to the reorganization and combination of departments in three hospitals without teaching or medical school affiliations. After considerable correspondence, and even some personal conferences, certain facts developed. At the outset, it was clear that in all such institutions a general upheaval is undesirable. Those

nen who have supported them faithfully for years should not be slighted, but obviously should be retained and absorbed wherever possible in any such reorganization.

The principal difficulty seemed to be that of the choice of a director for any new department of obstetrics and gynecology. In one instance the importation of a man from elsewhere solved their problem; in another, they appointed the senior man who limited his work almost entirely to gynecology, although he had had excellent training in obstetrics; in the institution in which a vacancy was created by death, the occupant of the other chair was given the new combined post; in still another, the younger of the two men was selected solely because he had had a broader training and was better equipped.

Under these heads, holding the newly combined chair or staff position, it was suggested that a professorship or senior staff position in obstetrics and similarly one in gynecology be created, subordinate to the head of the combined department, with respective groups of associates and assistants being given lesser positions so that the whole formed a strong pyramid with a broad base. No dismissals were necessary, no demotions were required, and no restrictions of duties or privileges needed to be imposed. Indeed, the activities of all department members, previously restricted by the limits of their department, were immediately broadened in scope and interest, according to an individual's ability. A new administrative head of the combined department having been appointed, his greatest responsibility became that of coördinating the work of the two groups as rapidly as possible. Such a reorganization must necessarily be developed gradually. In certain instances it involved additional graduate training for some of the department members themselves. A gradual fusion with the least possible, but occasionally necessary, elimination or restraint of those unable to adapt themselves was infinitely wiser than an abrupt and sweeping change in any of these institutions.

The most important reform of all was that whereby the resident house officers and students were compelled to weave their activities into the work of the two groups without any imaginary or arbitrary dividing line, so that instruction and training in gynecology and obstetrics were integrated by clinical precept and management of cases.

TYPES OF PROFESSORSHIPS

In the questionnaire, due notice was taken of the material or financial side of this question as this is of considerable importance to all schools which must function usually with less than adequate endow-

ments. Reference to the chart shows that the part-time professorship plan predominates in North American schools.

Full-time professorships are those under which the incumbent is paid a salary and gives his entire time to the position he holds; part-time professors receive a lesser salary as reimbursement for their school activities but are allowed the privilege of a limited amount of consultation and other "private" work. The professorship designated here as "clinical" is that under which the school pays no salary, and the incumbent's entire livelihood comes from his clinical or "private" practice.

The first of these is a fairly recent innovation about which certain objections have been raised. It has been said that the full-time professor, by being cloistered, is forced out of touch and out of sympathy with the general medical profession. Local jealousies seem prone to develop and the school's hospital and special services suffer not only from non-support but often from active opposition from the local profession. This is especially true in those places where private patients are admitted to the care of a full-time specialist, the institution taking the patient's medical fee. The profession objects that such an institution is actively competing in the practice of medicine with the physicians of that community.

Capable men who take these positions must make considerable financial sacrifices because their earning powers in ordinary private practice are usually considerably more than the salaries which their institutions can afford to pay them. Consequently, such men are relatively few in number, not easily found, and their institutions impose a constant hardship on them at the same time that they expect and receive the intense loyalty of these men.

The third or "clinical" type of professorship is one which is often dictated by necessity. An outstanding man in a school's community, supporting himself entirely by his clinical practice, may have been chosen outright or may have worked up to the professorship through promotions. His compensation for his school work is the prestige of the position, and the consultation work which may come later from the students he has taught and trained. His personal interests usually come first, because he is no more than human, and his school work is often secondary to the demands of his practice. In the selection of such men the school is ordinarily limited in choice to practitioners in the school's immediate vicinity.

The part-time professorship seems to be an ideal compromise between these other two plans. This survey demonstrates that it is the most widely favored plan at the present time. From the standpoint of the

school it is more economical than the full-time professorship. It is less restrictive and more broadening in opportunities for the individual, and generally more inviting to any capable man than either of the others. Under this plan, men may be attracted to come to a school from elsewhere if that is desired, or local men find it possible to discontinue the routine and relatively unimportant parts of their private work in order to give more time to the school.

Incidentally, it may be remarked that under either the full-time or part-time plan, the unification of the departments of obstetrics and gynecology is, obviously, an economical move insofar as salaries and other administrative expenses are concerned.

GENERAL

This entire transition which has been discussed is still going on. In those places where it is complete, the general surgeon no longer fears or finds that the gynecologist wishes to invade his domain, obviously with less skill than that possessed by the general surgeon. In fact, indiscreet excursions into general surgery by the gynecologist constitute another valid reason against the policy of including gynecology in the department of general surgery. Obstetrics and gynecology is a field of sufficient breadth to test the skill, engross the entire interest, and require the full attention of any one man. Working in such a broad specialty he will have no inclination or time, even in the unlikely event that he possesses the ability, to invade the field of general surgery.

Furthermore, in the course of due time, it should be found that the obstetrician-gynecologist will have less and less occasion to object that the general surgeon in his institution continues to undertake female pelvic surgery. Comparison of results between the two departments should take care of this situation, and if they fail to prove his advantage something is wrong with the gynecologist.

Criticism, to justify itself, should be constructive. What then shall be the constructive thought which should accompany the criticism in this address?

It is obvious that specialization in any field of medicine can be improved by higher educational standards and better training facilities, to the end that our sick populace will benefit when the help of a specialist is needed, whatever the nature of his affiliations. For the protection of the public, if there are to be specialists in the several branches of medicine, let us make certain that they are well trained and not merely self-styled ones. What this country needs is not more but better specialists. Adequate training through the medium of hospital

residencies or of staff assistantships for prolonged periods of time are the only reasonable solutions to this.

Our particular problem in this march of progress is specialization in obstetrics and gynecology. I am convinced that our answer is to be found in the unification of obstetrics and gynecology into one specialty for the purposes of teaching of students, clinical training of one's assistants, and actual practice for oneself, all to the immediate advantage of the patients for whom we are caring.