Interaction of Pediatric Urology with Pediatric Surgery

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"In many communities the relative domains of the urologist and the pediatric surgeon are unsettled and often give rise to considerable acrimony. While many pediatric surgeons can doubtless remove a kidney as expeditiously as the urologist, the problems are usually not that simple; and for one of my grandchildren with a serious urologic condition, I certainly would want the urologic study and treatment carried out by a urologist experienced in pediatric urology rather than by any pediatric surgeon I know of, most of whom know little or nothing of urological instrumental diagnosis and treatment. It is up to the urologist to demonstrate that he can render the required service more competently than can the pediatric surgeon". **Meredith Campbell** (Valentine Lecture, 1963 [3])

Pediatric surgeons as teachers of pediatric urologists

I begin by reminding our readers that the original pediatric urologists in America were trained overseas. The training was given not only by a urologist, David Innes Williams, but also by pediatric surgeons Herbert Eckstein, Herbert Johnston, and Barry O'Donnell. It was Herbie Johnston, for the Society of Paediatric Urological Surgeons, who invited the Pediatric Section of the American Academy of Pediatrics and our Society for Pediatric Urology to help sponsor a pediatric meeting in Liverpool, England in 1973. Herbert Eckstein had been one of the founders of the SPUS, an organization that had its start at a dinner party at David Williams' house in Hampstead, London in 1963. That founding party was attended by Herbert Johnston, Richard Mogg, John Mitchell, Herbert Eckstein, John Scott, Barry O'Donnell and Jean Cendron. Yearly meetings have been held since the founding.

Specialization

By starting with the origins of pediatric surgery, we can learn how the relations, at times strained, between the pediatric surgeons and the pediatric urologists developed.

As long ago as 1853, a New York surgeon named John Watson expressed surprise that, among the many divisions of surgery, a special department for the surgical diseases of children had not been formed. "The industrial instinct of modern practitioners is proverbial; it shows itself in almost every conceivable form; it attaches itself to almost every department of the profession, and evinces astonishing ingenuity in striking out new paths to notoriety and wealth; and hence the wonder that it should, up to the present moment, have wholly overlooked so promising a field as the surgical pathology of childhood" [1].

In Hugh Cabot's 1911 presidential address, he said: "A department of medicine becomes a specialty when our knowledge of the diseases of this department becomes so far developed that it requires the whole time of any individual to keep abreast of the accumulating knowledge, and still have time to devote to the study of the problems presented" [2].

We should note here that once a subspecialty is started, however informally, it develops and expands as it matures and takes possession of a territory adjacent to and often overlapping that of other specialties. It is defended by its own experts, who tend to exclude outsiders. At first the subspecialty is preoccupied with clinical problems. Only later does it incorporate academic pursuits and embrace research. As the subspecialty develops, those privileged to be

on the inside appear to set up barriers to the generalists. They enjoy their turf for its intellectual stimulus as well as its advantages in practice. Also they rightly believe they can give better care by limiting the field. One consequence of such specialization is a demand for documentation of their special training and for certification as a subspecialist.

Pediatric surgery

It was left for William E. Ladd of Harvard to get Pediatric Surgery started as a subspecialty of Surgery when he established an independent service for the surgical management of infants and children at Boston's Children's Hospital. Advances since that time have been rapid.

Further evidence of subspecialization appeared in 1948, the Surgical Section in the American Academy of Pediatrics was founded when the pediatric surgeons cast their lot with the pediatricians rather than with the American College of Surgeons, even though they were required to be certified in general surgery by the American Board of Surgery. In 1955, C. Everett Koop requested certification in pediatric surgery from the ABS. Approval was granted by both the ABS and the AAP, but withheld by the American Board of Medical Specialties ("crosses specialities", "starts a flood"), so that the ABS stopped its efforts. A definition of Pediatric Surgery was needed. It was the Board's suggestion that recognition be obtained through the Surgical Section of the AAP. Another tack was taken by the pediatric surgeons by defining the subspecialty through publication of specialty articles in the new **Journal of Pediatric Surgery**, founded in 1964. This proved to be a major break for independence.

Recognition by the American College of Surgeons was obtained in 1967 when Pediatric Surgery was first listed in the ACS Directory. At the same time, the College established an Advisory Council for Pediatric Surgery.

The need for an organization independent of pediatrics and surgery was recognized if the goal of certification was to be reached. So in 1970, the American Pediatric Surgical Association was organized, which added considerable stature to the struggling specialty. The AAP Surgical Section published a list of available fellowships and residencies. A Surgical Section Committee on Postgraduate Education and Residency Training was appointed and "Special Requirements for Residency Training in General Pediatric Surgery" were published. This committee then inspected and approved 11 training programs.

The ABS finally approved certification in Pediatric Surgery and the next year the ABMS approved a "Special Certification in Pediatric Surgery". The first examination was held in 1975. The lessons learned have not been wasted on pediatric urologic organizations seeking similar recognition.

Fragmentation of both pediatrics and surgery is occurring. Already, neonatology and pediatric intensive care are encroaching on pediatric surgery, but, to quote Sir Denis Browne, "it is the aim of Pediatric Surgery to set a standard, not to seek a monopoly" [(4)]. This admonition applies to fledgling pediatric urology as well.

Pediatric urology

After World War I, there was increasing interest in Pediatric Urology. It gradually became obvious that a new subspecialty was imminent and that the time had come for starting communication among those urologists who had a special interest in the problems of children. The upshot was a meeting in Chicago in 1951 of eight urologists for exchange of information and ideas. The founding of the Society for Pediatric Urology clearly marks the beginning of Pediatric Urology as a branch of Urology. Since that time, the subspecialty has grown to be practiced by over 300 pediatric urologists. The growth of the new subspecialty was bolstered by the diagnosis of reflux, a disorder that was becoming recognized as a common and reversible disorder. David Innes Williams identifies reflux as "the take-off point... for pediatric urology as a specialty" because it was a disease diagnosed by urological, not by surgical, techniques. Certification in the subspecialty, however, has yet to be granted.

Conflicts

As new and effective operations for children were developed and as third party payers were organized, conflicts appeared over the distribution of pediatric patients between pediatric surgeons and general uro-

logists. The friction was only increased by the advent of the subspecialists, the pediatric urologists. As early as 1958, John Lattimer wrote Harry Spence: "we should have some discussion about the problem of the Pediatric Surgeons who are invading our field so energetically".

Victor Politano, eleven years later, wrote to Rubin Flocks as President of the American Board of Urology about the need for support of the subspecialty by the national organizations in the training of residents: "The problem is that pediatric surgeons are invading a field which, in the main, they are poorly trained to handle properly. If this concept is incorrect, then our whole concept of training for urology is also incorrect and improper". He felt that "there seems to be a lack of concern by both the American Urological Association and the American Board of Urology because pediatric urology seems to constitute a relatively small percentage of the urologic practice". The AUA and ABU should be interested in protecting members of the organization from outside invasion, and "on whether or not pediatric surgeons are going to be permitted to do pediatric urology in institutions or hospitals where a Board-approved urologic residency exists".

An example of the conflict was pointed out at the Coordinating Council, AUA in 1971, that in the American Academy of Pediatrics, the pediatric surgical section had its own training program certification and that one of the requirements was a rotation through urology. The favorable aspect was that this made it possible to insist that all the urology patients be on the urology service. Otherwise, the urologists could withdraw the rotation and thereby destroy the accreditation of the program.

The position was later summarized by Dr. Hinman in response to a question to the SPU by a chairman of a training program: "....It is my opinion that Pediatric Urology should be taught only by surgeons who are not only technically qualified to operate on children but who have the basic knowledge of all aspects of Urology, an important tenet of the SPU. Training supervised by surgeons not so qualified would be of much less value to their residents as they sought Board Certification".

Similarly, Ralph Straffon as Chairman of the Advisory Council for Urology of the ACS wrote:
"The basic training of a pediatric surgeon, as stated, is a general surgical training program followed by two years of pediatric surgery. It was the consensus of nearly everyone in attendance that this training would prepare a pediatric surgeon to do any general surgical procedure on children and, in particular, train individuals in the management of the various congenital anomalies associated with the gastrointestinal tract.

The thoracic surgeons, neurosurgeons, and urologic surgeons, present as invited consultants, felt that this was not adequate training to perform procedures in their particular fields of specialization.

The training that best prepares an individual to do pediatric urologic surgery is a full three-year program in urology which meets the American Board of Urology requirements, followed by additional training in pediatric urology. The length of the training in pediatric urology to fill the need in this area".

For the Committee on Urology of the American Academy of Pediatrics as well as the SPU, the problem was how to liberalize the practice requirements for membership in the SPU while not at the same time opening the membership doors to pediatric surgeons. The by-laws of the prospective Section for Urology within the American Academy of Pediatrics stipulated that members be limited to urologists and pediatric surgeons who spend more than 50 % of their professional time in pediatric urology or related teaching and research.

Hardy Hendren was the pediatric surgeon at the Massachusetts General Hospital who subspecialized in pediatric urology and in fact trained others in that area. In 1969 he applied for membership in the SPU and was informed that the application has been acted upon favorably pending membership in the American Urological Association. Soon thereafter, Dr. Hendren was admitted to the AUA as a regular member.

However, the concerns for encroachment by pediatric surgeons had continued. It was not clear how to handle such invidiuals as Pediatric Surgeons who would obviously make contributions to the meetings of the Society, but who would not meet the qualifications completely. It was clear that Dr. Hendren had made his way into the AUA, but there seemed to be no way to get around the requirement of the SPU (overlooked in 1970 when his application was approved with the proviso of AUA membership) that he be Board-eligible.

The upshot was that, in 1974, Hardy Hendren was recommended for honorary membership. Significantly, the SPU by-laws were amended in 1985, omitting the requirement for Board certification.

Dr. Hendren at that time summarized his own views: "It is my belief that pediatric urology should be done by surgeons who have a strong and continuing interest in the field. Obviously this implies the need for training in pediatric urology during residency and active practice of pediatric urology after that. Much of it is technically very difficult surgery and if it is poorly done the results are disastrous as you well know. The large number of children who have had urinary diversion throughout the world bespeak this point. I do not think that pediatric surgeons should dabble in the occasional urologic case, nor do I think that the majority of urologists should tackle the complex cases so often presenting in infants and children. I think this field needs people who devote a major part of their time to it. I believe that the input to this field can be from either urology or pediatric surgery. In fact there are very few pediatric surgeons who have directed much attention to pediatric urology. Similarly, when we look at the large numbers of urologists in the United States, there are only a relatively small number who have become much involved with pediatric work". He went on to say that most of his effort had been directed toward residents who will become urologists, not pediatric surgeons.

In 1972, the possibility arose that the American Board of Surgery would incorporate major urologic operations in their requirements for pediatric surgeons. The following year, Alan Perlmutter reported to the SPU Executive Committee on "the decision of the American Board of Surgery not to include major urologic surgical procedures as a part of pediatric training. This has great implications as far as urologists having available pediatric urologic material. It is far from a 'fait accompli', but it seems to be on the drawing board". Fortunately for the two subspecialties, such major urologic procedures were not included in the ABS requirements, which remain distinct from those of the urological boards.

Arrival at a resolution

The two subspecialties now coexist with almost no friction at the organizational level. Locally, the division of cases depends, as it should, mainly on the relative capability of the subspecialist, whether pediatric urologist or pediatric surgeon.

References

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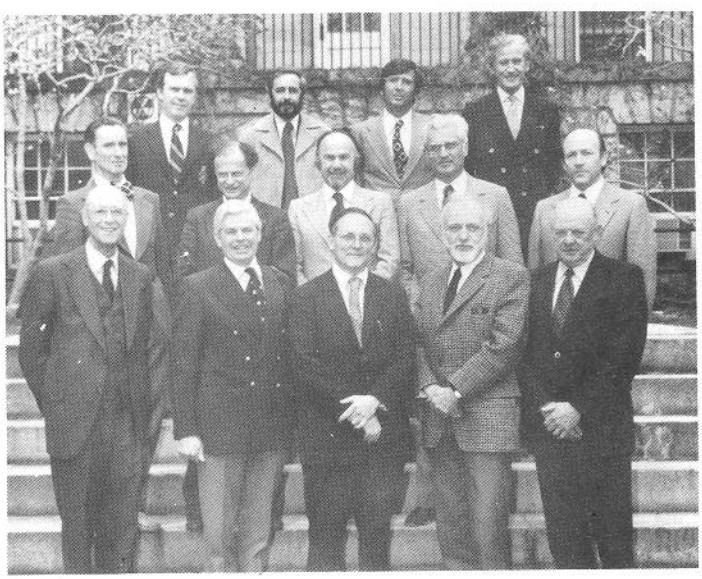

SPUS Meeting Boston, 1976

Back row (right to left):
JES Scott, R Gosalbez, G Monfort, R Jeffs
Middle row: J Cukier, M Bettex, SJ Cohen, HB Eckstein, K Parkkulainen
Front row: RA Mogg, J Cendron, H Hendren, DI Williams, NJ Bakker