Membership History of the ASSH: 1946–1970

BY J. LEONARD GOLDNER, MD, DSc(hon)

The American Society for Surgery of the Hand (ASSH) was organized in 1946. The Founders held the first Scientific Meeting in 1947. The original qualifications for membership were: (1) clinical experience; (2) recommendation by a member of ASSH; (3) published peer-review articles; (4) presentation of a paper at the Scientific Program of the ASSH. Only a limited number of surgeons met these requirements early in their career. Thus, emphasis was on the category of Associate Members who had all the privileges of the ASSH members except for voting and holding office. Also, as the number of residents taking Hand Fellowships increased, the number of potential members in the ASSH necessarily increased. Since a Certificate of Added Qualification (CAQ) became a requirement for membership, the qualifications for membership in ASSH remained stringent.

Accurate historic information usually depends on either documented written or oral sources or both that reinforce each other or that disagree. Verbal statements or rumors are associated frequently with specific events, but they may or may not be accurate. My personal involvement with the American Society for Surgery of the Hand (ASSH) dates back to 1947 when I attended the initial Scientific Meeting of the Society in Chicago. At that time, I had been discharged from the United States Navy as a medical officer, had begun my Orthopaedic Residency at Duke, and was in Chicago participating in an Instructional Course sponsored by the American Academy of Orthopaedic Surgeons. This course was concerned with upper extremity tendon transfers in poliomyelitis. The first scientific program of the ASSH was held during this Chicago meeting.[1] For the first time, I saw and met several of the active and founding members who either participated in the program or attended the meeting. Previously, I had met Dr. Bunnell in San Francisco at the Mare Island Naval Hospital, which was my last assignment before discharge from the Navy. He visited the Naval Hospital on 4 occasions to not only see patients, but also to do surgical procedures.

From the Division of Orthopaedic Surgery, Duke University Medical Center, Durham, NC.
Address reprint requests to J. Leonard Goldner, MD, DSc(hon), James B. Duke Professor Emeritus, Division of Orthopaedic Surgery, Duke University Medical Center, Box 3706, Durham, NC 27710. E-mail: howar011@mc.duke.edu

1531-0914/03/0301-0008$35.00/0
doi:10.1053/jssh.2003.50007

The Founders

The 35 founding members of the ASSH were selected from military and civilian activities by Dr. Bunnell, Dr. Boyes, and a few members of the

Committee who were responsible for the origin of the Society. The constitution and the by-laws had been presented at the 1946 founders meeting and the first scientific program was presented in 1947. One of the founding members was Dr. Hart, the first Professor of Surgery at Duke. He had been recruited from Johns Hopkins after completing his 9-year residency. Early in his clinical career, and while a resident at Johns Hopkins, Dr. Hart wrote a chapter in the loose-leaf *Lewis Practice of Surgery*.[2] The topics were infections of the hand and treatment of tendon lacerations of the hand. At that time, injuries of the hand usually were treated in the emergency room by a member of the house staff. Dr. Hart as a resident and clinician had taken a special interest in the management of these patients and he included instruction of the house staff about hand problems as part of his regular duties. The literature on hand surgery in 1946 was limited. Kanavel's textbook had been published in 1939,[3] and Dr. Bunnell's textbook *Surgery of the Hand* was published in 1944.[4] The clinical practice of hand reconstruction was limited primarily to Dr. Bunnell on the West Coast, Dr. Sumner Koch in Chicago, and a limited amount of reconstruction by Dr. Marble in Boston.

Not until Surgeon General Norman Kirk, during World War II, appointed a civilian, Dr. Bunnell, to organize Hand Centers in the United States Army was there a concerted effort to improve management of the injured hand and to concentrate on all aspects of hand surgery as a subspecialty of orthopedics, plastic, and general surgery.

Original Membership Requirements for ASSH

The Founders of the ASSH considered that membership in this society should be well defined and have stringent requirements. That concept has continued to the present time. The council of the ASSH considered hand surgery as a subspecialty that required wide clinical experience, special education, clinical or laboratory research, teaching responsibilities, and publications in peer-reviewed journals. When the ASSH founders meeting occurred in 1946, 28 of the 35 founders had experience with war wounds as members of the Armed Services. The civilian founders had varying degrees of experience related to the hand. Only 7 were selected from the nationwide population of surgeons. Thus, very few qualified hand surgeons existed at that time. During the next several years, the education of hand surgeons improved, but very few clinicians met the requirements for membership in the ASSH. This exclusivity did not occur because of the elite attitude of the ASSH members, but rather because of the educational emphasis by those who were treating patients with hand injuries. Both Newmeyer[3] and Hentz[2] implied that the concept of exclusivity rather than inclusivity influenced the limited number of individuals taken into the ASSH from 1947 to 1970. My opinion is that qualifications for membership in the Hand Society had been defined, and for the next 10 years, very few surgeons in orthopedics, plastic, or general surgery met those qualifications. This was particularly true with reference to peer-reviewed publications and presentation of a paper at an annual scientific program of the ASSH.

However, the interest of surgeons of all 3 major disciplines did increase dramatically after the ASSH was formed. This was evident by the fact that in 1950, when the ASSH held the scientific meeting for 2 days before the American Academy of Orthopaedic Surgeons, there were 1,900 surgeons in the audience. In that respect, the ASSH was inclusive. Thus, the interest was present, but the qualifications for membership in the ASSH were met by only a few because the number of fellowships was limited and most residency training programs were not structured to include clinical and didactic training in hand surgery.[5]

The Duke Hand Program

The Duke Program, however, was oriented toward surgical practice, research, peer-review publications, and preparation of papers for scientific meeting presentations. From 1953 to 1969, these individuals associated with the Duke Orthopaedic Division were admitted as full active members of the ASSH: J. Leonard Goldner, 1953; Donald Eyler, 1953 (fellowship at Duke in the Anatomy Department for 1 year); C. E. Irwin, Georgia Warm Springs Foundation (faculty Duke-affiliated program); Frank Stelling, 1962 (Duke-affiliated faculty); Frank Clippinger, 1963 (Duke faculty); Ralph Coonrad, 1968 (Duke-affiliated faculty); Jim Urbaniak, 1972 (Duke faculty).

Later, several additional members were taken in after completion of a fellowship in hand surgery at Duke including James Nunley, Andrew Koman,

Richard Goldner, Don Bright, Jim Roth, and Robin Richards.

Thus, even though by 1950, the interest in hand surgery was great, the number of surgeons meeting the qualifications for ASSH membership was small. If the ASSH had opened membership to all interested surgeons, or if application had been accepted if the surgeon stated an interest in hand surgery by designating this on the stationery, the ASSH would have been overwhelmed by applicants who did not qualify.

Requirements for Membership in the American Society for Surgery of the Hand (ASSH)

The ASSH council was determined to make membership in the ASSH dependent on the credentials that I mentioned earlier (ie, sponsorship by 3 members, treatment of a large number of patients with hand pathology, participation in teaching hand surgery, and by having a manuscript accepted by the scientific committee of the ASSH for the annual program). Also, publications in peer-reviewed journals were required. These credentials, once fulfilled, made certain that members were not just casual entrepreneurs, but were surgeons who were truly interested in getting new information into the field of hand surgery and in educating more hand surgeons.

Personal Credentials for Membership in ASSH

My personal experience and early credentials in hand surgery and education associated with this subspecialty included the following: a 6-month assignment to an upper extremity amputee clinic and to the hand service at the Mare Island Naval Hospital from January 1946 to July 1946. Two years at Georgia Warm Springs Foundation where there were always 150 patients with poliomyelitis, many of whom were treated by upper-extremity reconstruction and tendon transfers. Subsequently, I worked with Professor of Anatomy Joseph Markee at Duke in doing anatomic dissections of the upper extremity; completing biomechanical projects; and teaching both students and residents about the anatomy and function of the upper extremity. Also, I worked with Barnes Woodhall, Chief of Neurosurgery at Duke, who served in the United States Army in Washington, DC, at the Armed Forces Institute of Pathology and Walter Reed Hospital from 1941 to 1946. Once I joined the Duke faculty in 1950, I worked with Dr. Woodhall for several years managing patients with peripheral nerve problems. We cooperated in treating patients with peripheral nerve lesions. After the diagnosis and treatment had been initiated, the patients were then turned over to me for reconstructive surgery when peripheral nerve repair was partially or completely unsuccessful in establishing full function of the hand, elbow, or shoulder.

From 1950 through 1960, my patients with severe hand trauma continued to increase. I was the only surgeon in the Southeast who was doing reconstructive hand surgery. My initial paper, presented to the ASSH in 1952, was entitled, "Deformities of the Hand Incidental to Pathology of the Extensor and Intrinsic Muscle Mechanism." As an example of the requirements for membership, and the somewhat stringent qualifications demanded at that time, my membership application had been in preparation for 3 years. I was sponsored by Dr. Fowler of Nashville, seconded by Dr. Flynn of Boston. My application finally fulfilled these requirements after 3 years: (1) Sponsorship by an active member of the ASSH who could vouch for my ethics, my commitment to hand surgery, and my clinical involvement; (2) letters of recommendation by 2 other members of the ASSH who wrote letters concerned with ethics, their personal knowledge of the volume of my clinical practice, and my commitment to the further development of hand surgery; (3) the manuscript that I have mentioned was presented at the scientific program of the ASSH in 1952; (4) this article was published by a peer-reviewed journal (*Journal of Bone and Joint Surgery* American volume) in 1953.

These requirements for membership as I have listed them were fulfilled. Once the preliminary application was submitted to the membership committee, and after the membership committee had reviewed the qualifications, the application was then submitted to the council that acted as the nominating committee. The chairman of the council presented the applicant information to the total membership and a three-quarters vote of those present was necessary to finalize the acceptance as an active member.

In 1953, when I became a member of the ASSH, there were 4 other surgeons accepted for membership in that year. At that time, there was no set limit for

the number of new members. The emphasis was on qualifications of the applicant. Subsequently, the maximum number of members taken in during a single year was designated as 10. The number was in a motion made by Dr. Riordan when he was president. At that time, the average number of applicants annually accepted varied from 3 to 7. There were a large number of surgeons in the United States and Canada who did not fulfill the qualifications as defined by the ASSH membership credentials.

Educating Surgeons in Hand Surgery

Certain committees and committee Chairmen were working vigorously during the initial 15 years of the existence of the ASSH to establish regional scientific programs, to encourage publications by ASSH members in existing peer-reviewed journals, and by attempting to standardize fellowships in hand surgery. There was no feeling of exclusivity of the ASSH membership as described by Newmeyer.[6] Likewise, there was no effort at inclusivity for mass membership in the ASSH because the members and the membership committee firmly believed that membership in the ASSH should be dependent on achievement and excellence and not on a desire to be designated as a hand surgeon.

From 1957 to 1967, I was chairman of the fellowship committee of the ASSH and also served on the membership committee for two 5-year rotations. The goal of the members of the ASSH and the membership committee was to define fellowship experience and to establish a hand surgery core curriculum for fellows and residents. All fellowship directors were encouraged to answer annual questionnaires about their physical facilities, their fellowship curriculum, the patient volume in their program, and the number of surgical procedures performed. Although specific standardization was not possible at that time because of lack of consensus, the results of the annual questionnaires allowed publication of a fellowship booklet that provided committee members and those applicants who were seeking fellowship with an objective method of judging the curriculum and the facilities in any particular program.[7] The facilities of the fellowship program as they appeared in the booklet served as an implicit standard. The results of the questionnaires allowed fellowship directors to change their description of the program each year. Certain directors altered their fellowship to a preceptorship and other preceptorships improved and progressed to more formal fellowships. As the number of defined fellowships increased annually, the number of graduate fellows also increased. The requirements for membership in the ASSH remained the same. The fact that a limited number of new members were taken in each year was primarily owing to the publication requirement. Also, the acceptance of a paper for the scientific program of the annual meeting of the ASSH was not always certain. Several surgeons who could be described as having a high volume of hand patients and who had participated in some form of fellowship were not honored by ASSH membership until a paper had been read at the annual ASSH meeting, and their article had been published in a peer-reviewed journal.

Associate Members of the ASSH

The delay in acquiring membership in the ASSH was recognized as undesirable by both the members of the ASSH and the applicants. There were 2 options: (1) lower the credentials, which the membership committee, the council, and the members did not select; or (2) provide a category of associate member who would advance to active status once qualifications had been completed. Meanwhile, the associate member was participating in the educational aspects of the ASSH and was listed as a member of the society.

As chairman of the fellowship committee in 1967, I made a motion at the business meeting to alter the original description of associate member as listed in the original by-laws. This motion would allow admission of an unlimited number of associate members and privileges of membership without voting or holding office. This motion stimulated discussion at the initial business meeting. There was no consensus and the motion tabled. During the next year, the members of the fellowship committee attempted to influence the active members to accept this concept. A few members were vehemently opposed because they were concerned about associate members being considered as second class citizens. The American College of Surgeons had adopted the concept of candidate members and that concept had been a success. Finally, in 1970 when I presided over the annual business meeting, the motion was passed, the by-laws were rewritten by Robert McCormack so that associate membership could be admitted and moved to active membership

once they had fulfilled the qualifications. All of the requirements for active membership remained the same.

Fellowship Booklet

The booklet describing fellowship sites sent out in 1969 to 1970 was the result of efforts of the fellowship committee for 12 years. I collated this material annually and sent it to the fellowship directors. The number of fellowship positions had increased, the quality of education in each hand program had improved, more fellows were educated each year, and there were more applicants for the ASSH than could be accommodated for by the 10 annual admissions that the by-laws defined.

The admission requirements in 1970 were referred to as arbitrary.[6,8,9] However, these arbitrary qualifications not only remained in place, but in many ways have become more stringent. Now, a 1-year fellowship at an approved center is required, and a Certificate of Added Qualification (CAQ) also is required.

As a result of my motion in 1969, there was no limitation to the number of associate members included annually. Associate members had all the privileges of active members except voting and holding office. This situation was somewhat irritating to both active members and associate members as the associate members were required to leave the room during a formal business meeting. Although the difference in memberships was discussed many times, the associate members accepted the limitation because they were known as members of the American Society for Surgery of the Hand; and they realized that once they had completed the application requirements, they could move into active membership. This emphasis on increasing the number of associate members resulted in 42 new associate members admitted to the ASSH in 1971. The new associate members received recognition for their advanced training, clinical practice of hand surgery, their teaching, and their community activities. The letters of recommendation indicated that they were providing high-quality care of patients with hand problems. Although the 42 new associate members admitted in 1971 had not fulfilled all of the stringent requirements, they knew they were designated to be active members as soon as these requirements were completed. Thus, there was an incentive to achieve excellence.

The Influence of the Fellowship Committee of the ASSH on the Education of Hand Surgeons

New membership quality was assured by the continued action of the ASSH committee on fellowship review. Each fellowship site was visited by 2 members of the committee and the fellowship curriculum described in the fellowship booklet also was reviewed annually.[4] The Committee did not rate or standardize the fellowship because this necessitated more consensus among the members and the fellowship directors than was achievable. However, because all fellowship directors agreed to answer the submitted questions, the description of the fellowship, as given in the booklet, was an implied standardization. The resident seeking a fellowship, or a practicing physician who wanted a mini-fellowship, could determine the available facilities at a particular medical center or private office and decide whether or not that program director could provide the core curriculum for either a formal fellowship of 1 year or a short experience that would be described as a preceptorship.

Although Hentz,[8] Stern,[9] and Newmeyer[3] all implied that the membership procedure was somewhat casual and might be influenced by a single vote, at no time during my 15 years of service on the fellowship committee, and intermittently on the membership committee, did I observe inappropriate use of voting to block a particular individual's application. The applicants were judged on the required credentials. There was never a casual attitude toward judging the applicants; nor was there a requirement for a unanimous vote for a potential member; nor was there evidence of professional or personal vendetta toward any particular applicant. At times, there were discussions about the behavior of an individual in a particular community; personal opinions were expressed about an applicant that may or may not have been documented by hard facts; and there was occasional evidence of a negative vote that might be interpreted as being related to competition in a specific community. The Membership Committee and the Council were always able to eliminate subjective factors relatively easily; this was particularly true if the objective evidence related to education, clinical practice, teaching, research, and administrative activities were positive and obvious in favor of the applicant. In my opinion, all qualified candidates were taken in as

active members. Occasionally, in retrospect, a candidate was rejected on first application, but this was usually caused by either absence of a published peer-reviewed article or a paper presented at the scientific program of the ASSH.

Comparison of ASSH With American Association of Hand Surgeons

With all this material that I presented as a background, I refer to the article "Together or Apart: A Study of Hand Surgery Professional Organizations."[8] Hentz[8] has given his opinion as to why the 2 organizations should be "together and apart." I concur with his conclusion, but my descriptive terms would be coexistence and cooperation. The difference between the organizations dates back to the history that I have recounted concerning the founding of the ASSH in 1946, and the founding of the American Association of Hand Surgeons (AAHS) in 1970. The former organization was initiated by pioneers in hand surgery, by experienced individuals who at the time of formation of the ASSH were committed to maintaining an organization that had stringent requirements for admission. A high level of academic or educational and clinical requirements would necessarily result in outstanding scientific programs, regional instructional courses, and the development of fellowships that would persist in the future.

The difference in requirements for membership in each organization in 1970 primarily was related to the credentials. The ASSH membership committee required evidence of academic achievement, peer-reviewed articles, 50% of patients treated had hand pathology, and during the early years of the organization, acceptance of a paper for the annual scientific meeting of the ASSH. As time passed, the credentials of the ASSH became more, rather than less, stringent because the applicant was required to complete a 1-year fellowship and acquire the CAQ. Thus, the early requirements of the ASSH of publication, appearance on an annual program, and commitment to hand surgery were substituted for by obligatory fellowship, CAQ, and other positive data listed on the individual's curriculum vitae. Thus, the comparative qualifications for membership in the ASSH as compared with the AASH were different in the beginning and that difference persists.

Hentz[2] mentions the difference in numbers of subspecialty surgeons in the ASSH. These numbers must be based on the difference in total numbers of orthopedic surgeons versus plastic surgeons in the United States. Hentz[2] commented that 70% of the ASSH are orthopedic hand trained and 25% are plastic hand, and 5% are general surgery. At the present time, there are approximately 25,000 orthopedic surgeons, of which 1,400 are members of the ASSH; there are 3,000 plastic surgeons of which 650 are members of the ASSH.

Thus, there is a 1 to 5 ratio for plastic surgeons and a 1 to 18 ratio for orthopedic surgeons.

Hentz[2] also speculated that if the original abstracts of the papers presented at the ASSH had been referred to a plastic surgery journal rather than to the *Journal of Plastic Surgery*, the membership ratios and the influence of the activities of the organizations may have been different. I doubt that speculation. The likelihood of the original founders selecting a plastic surgery journal for publication of the ASSH abstracts rather than the *Journal of Bone and Joint Surgery* was slim. Although Bunnell was a general surgeon, he organized the hand units in the army hospitals in conjunction with the orthopedic services or occasionally with the plastic surgery service. Also, in San Francisco, he worked frequently with orthopedic surgeons and he visited the Orthopaedic Hand Service at the Oakland Naval Hospital and Mare Island Naval Hospital. Also, he was a close friend and a patient of Dr. Mayer, an orthopedic surgeon from New York who did original work on the gliding of tendons. Mayer operated on Bunnell's nonunion of the femoral neck. The "if only" comment by Hentz[2] is an interesting speculation, but an unlikely occurrence. Furthermore, the *Journal of Bone and Joint Surgery* was the official publication for the abstracts of the ASSH in the early years of the ASSH and under the direction of Dr. Boyes as associate editor. I was subsequently assigned that position when Dr. Boyes became editor of the *Hand Journal*. The *Journal of Bone and Joint Surgery* was the designated journal for publication of the ASSH abstracts until the ASSH initiated the *Journal of American Society for Surgery of the Hand*.

Growth of the Membership of the ASSH

Because the number of founding members of the ASSH was small, and the number of surgeons throughout the United States who had an interest in hand surgery was limited, the membership grew

slowly because of the requirements for membership. These were based on objective evidence of academic achievement.

I attended the business meetings and was involved with the membership committee from 1953 to 1969 and at no time was an applicant rejected by a single negative vote. Applicants were rejected when their credentials were inadequate.

In addition to the credentials that I have mentioned already, the applicant had letters of recommendation with reference to ethics and pattern of practice and evidence that there was a recognized special interest in clinical or laboratory research relative to hand surgery. Unfortunately, in the mid-1960s, the membership committee guidelines specified that no more than 10 new members could be admitted annually. This was based on the low number of individuals taken in annually because only a low number qualified. As the number of fellowships increased, and as chairman of the fellowship committee, I realized that the number of applicants would increase annually, I recommended to the Executive Committee in 1967 that we initiate the broader view of associate membership and that the number of 10 new members each year be altered. Both recommendations were taken under consideration, but were not actually accepted until 1970. My recommendation was that the associate membership receive special attention because the pattern had been successful already in the American College of Surgeons. I recommended that surgeons with documented interest in hand surgery, who had completed a fellowship, who had performed clinical research or laboratory research, and who were qualified in every way except for publications, be admitted promptly as associate members and then recommended for active membership as soon as their final requirements were fulfilled. I presided when this motion was passed (1970). Also, the number of new members taken in annually was part of a by-laws change. However, in 1969, Dr. Posch of Detroit had an associate who was number 11 on the list of 10 to be admitted to the ASSH in 1970. Thus, this individual's name would not be read as a new active member at the 1970 meeting. I advised Dr. Posch that his associate would definitely be on the list in 1971 because of the change in the by-laws. However, Dr. Posch was upset by this delay and warned me that if this associate of his was not admitted to the ASSH in 1970, and despite Dr. Posch's objection to the action of his associate, "a new Hand Society would be formed." Ray Curtis, president of the ASSH in 1970 to 1971, arranged a meeting with the individuals who were forming the "new society." I spoke with the Ray Curtis both before and after the meeting that he had with this group and at no time did the threat of a new organization influence the required credentials for active membership in the ASSH. Completion of a fellowship and other similar requirements eventually substituted for publication credentials. At that time and currently, the AAHS has less restrictive membership requirements than the ASSH. Also, the AAHS includes hand therapists; from an educational standpoint, fewer opportunities for members to participate in structured courses exist during the year. However, both organizations cooperate, coexist, and attempt to fulfill a similar mission. The fact that 14 of the 16 presidents of the AAHS are members of both organizations indicates that certain surgeons have the commendable desire to participate in the educational activities of both organizations.

From a political standpoint, both organizations should act through joint committees and for certain policy concepts they should speak with one voice. The goal of the members of each group, regardless of the variations in credentials for membership, is quality patient care.

References

1. Bell JL. American Society for Surgery of the Hand—25 Years (1945-1970). Chicago, IL, 1970:7-47.
2. Hart D, Lewis DD. Surgery of the Hand (Lewis Practice of Surgery). Dean Lewis, Ed. Hagerstown, MD, W. F. Prior, 1930.
3. Kanavel AB. Infections of the Hand: A Guide to the Surgical Treatment of Acute and Chronic Suppurative Processes in the Fingers, Hand, and Forearm. Lea & Febiger, Philadelphia, PA, 1939.
4. Bunnell S. Surgery of the Hand. Philadelphia, PA, J. B. Lippincott Company, 1944.
5. Goldner JL. American Society for Surgery of the Hand. Presidential Address, Proceedings of the American Society for Surgery of the Hand. JBJS 1970; 52:1061-1065.
6. Newmeyer WL III. The American Society for Surgery of the Hand: The First Fifty Years. New York, NY, Churchill Livingstone, 1995, 1-203.
7. Goldner JL. Chairman of the Fellowship Committee, American Society for Surgery of the Hand, Information Booklet of Hand Surgery Available Training Programs, Durham, NC, 1969-1970:1-68.
8. Hentz VR. Together or Apart: A Study of Hand Surgery Professional Organization. J Hand Surg 2001;1:217-223.
9. Stern PJ. ASSH Membership: A Historical Perspective. ASSH News 2000;4.