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Presidential Address

The President's Address

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Every member of this association who has served you as president has begun his address by expressing in some manner the impact upon himself resulting from this great honor. I assure you that this emotional thrust has affected me as deeply as any of my predecessors. In an organization of this size, the simple rules of the gamblers game create very strong odds against any of us achieving this distinction. Even more, in our association there are so many really outstanding members that in all reason the chance of election is diminished still more. Therefore, I find that I cannot express myself adequately. Nothing could have come as a greater surprise. No reward, no honor that I know of would mean so much to me.

After the excitement and the congratulations have subsided, grim reality comes forward with a shock. The presidency is tied to a genuine obligation, an address. This is a simple task for some, and quite the opposite for others. I judge myself to be numbered among the latter. The ingredient which lends greater flavor is this—the president has a captive audience of several hundred of the most important surgeons in the world. This imposes a real responsibility, the time of these men must not be entirely wasted.

If one seeks recourse to reviewing the presidential addresses of his predecessors, he will find that one of two general trends are evident. A learned discussion of a clinical problem of particular interest to the speaker constitutes one approach. The other avenue is usually a philosophical treatise, often relating to the education of a surgeon. I have sought such recourse but my apprehensions over this assignment were not allayed. The presidential addresses given before this association have been of a high order and I recommend them to you to refresh your memories and to remind you that they make good reading indeed. But, comforting to this essayist they were not! To make things worse, Gibbon[1] was careful to point out specifically the momentous accomplishments of some who preceded him in this office. These references alone were enough to cause me to seek a way out. But no honorable course was open, so here we

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are, and you are the unfortunate listeners.

Then the desire to retreat begins in earnest for the exasperating dilemma of selecting a topic is upon one. The fact that no title appears in the program should suggest to you, correctly of course, that I reserved an escape route to be employed should I stampede myself into a change at the last moment. There is still no title, for the only one I could accept is quite out of character, namely, "Tell it like it is, Man!" There are many members of this association who are far better qualified to discuss the matters I wish to bring before you. Unfortunately, I have the opportunity and now is the time. I only hope that I can make sense, that I will be able to present the picture clearly, that I will succeed in saying what is on my mind.

Since my remarks will be related in some degree to those of Samson[2] which he expressed in his presidential address before this organization a year ago, I wish to recall briefly for you some of his more pertinent points. Dr. Samson referred to the details of the founding of our association in 1917. He pointed out the date of establishment of the first formal training program in thoracic surgery by Alexander in 1928. It was recalled that a symposium on Thoracic Surgical Training was conducted during the annual meeting of the Association in 1936. One year later the first Eggers' Committee reported to the membership of the Association that there was no need at that time for specialty certification in thoracic surgery.[3] In less than 10 more years a second Eggers' Committee submitted a completely contrary opinion and the formation of the Board of Thoracic Surgery was the direct result.

Samson also outlined the activities of the American College of Surgeons in support of the specialty of thoracic surgery. Important among these are the Advisory Council for Thoracic Surgery, the Residency Review Committee for Thoracic Surgery, which is comprised of representatives from the Board of Thoracic Surgery, the American College of Surgeons, and the Council on Medical Education and Hospitals of the American Medical Association, and finally the comparatively new Cardio-Vascular Committee of the College.

Samson revealed the results of a questionnaire which he sent to 650 surgeons who limit their practice to thoracic/cardiac surgery. The yield was a reply from 557 (85 per cent). Of these, 92 per cent voted that thoracic/cardiac surgery should remain a major specialty. It can be said that the very nature of the selectivity of sampling resulted in a pre-judged result, yet some 2 per cent expressed the opinion that non-cardiovascular thoracic surgery should be absorbed into general surgery. Indeed the case for such a philosophy has been supported strongly by Allison[4] who urged that the Society of Thoracic Surgeons of Great Britain and Ireland bring its "distinguished and honourable life to a close!" However, Temple was at least equally effective (in my opinion) in his support of a contrary viewpoint. Are there those present today who feel as Allison does? Undoubtedly there are, but the evidence offered by Samson's questionnaire indicates that an overwhelming majority sides with Temple. Yet, it required courage on the part of Allison to face our sister society of the British Isles and advise the members to go out of business.

Samson's survey also revealed a fact with which we are all somewhat familiar. There is some disagreement concerning the period of residency as a whole and the division of this span of years into general surgical and thoracic/cardiovascular training. While almost two thirds approved the present usual distribution of 4 years in general surgery and 2 in chest, another one third felt otherwise.

John M. Russell has been President of the John and Mary Markle Foundation for some years. He must be considered a thoroughly informed authority in the area of postgraduate medical education. Probably no other man has enjoyed quite the same opportunity for intimate observation of virtually all of the contemporary scene in academic medicine during the explosive years of the past two decades. I quote Russell[5] for you,

"There is no denying what we hear so often, that is, surgical education in the United States is the best in the world today. But it does not mean that it will always be so. This does not mean it cannot be made much better. As a matter of fact, that sort of braggadocio may be a sign of weakness in itself."

You are all aware that much has been going on in the field of medical education. Undoubtedly, the greatest changes have been achieved at the undergraduate level and the curriculum at most medical schools has undergone drastic revision. Indeed, the present concept of medical education in almost every American institution differs so radically from the practice of a few years ago that it is safe to say that a great majority of those here today would find little similarity to the education of physicians as offered to each of us.

These changes continue and are affecting graduate and post-graduate education of the doctor. Three very important events have taken place within the past 4 years. First was the Coggeshall report in 1965.[6] On February 10 of this year, during the 65th Annual Congress on Medical Education, Anlyan[7] described the extent of implementation of this report to that date. Drastic changes have been made in the structure of the Association of American Medical Colleges and greatly expanded fields of interest on the part of that organization have been assured. In brief, the Coggeshall report is truly being implemented. The details are numerous and varied and will not be discussed today.

The second event to which I refer is the passage of the federal law creating what we know as Medicare and Medicaid. The first of these, Title 18 or Medicare, has been in operation since July 1, 1966. The impact of this legislation on surgical programs for graduate education has been very real and many groups have met in many places in an effort to arrive at solutions for some of the problems which have been experienced. At present, there is no method of operation which has been suitable for all educational institutions. Despite this, the majority have been able to arrive at a functional policy which holds things together for the present.

Title 19, or Medicaid, is likely to make much greater difficulties for training centers. Full implementation has not been achieved in all states as yet. In many of these, the complete scope of the benefits to be offered is not clear at this time. However, one can be reasonably certain that the final form of Medicaid legislation in every state will release drastic forces on all hospitals offering residencies in surgery.

The third important event is the Millis Report[8] which was submitted to the Board of Trustees of the American Medical Association in August, 1966. This report of the Citizens Commission on Graduate Medical Education was specifically prepared in response to a direct commission on the part of the American Medical Association. I believe it is agreed by most observers that the Millis Report will have even greater impact upon medical education in the United States than the Flexner Report[9] of nearly 60 years ago.

What has happened with respect to implementation of the recommendations of the Millis Report? Briefly, the Council on Medical Education was requested in 1967 to bring to the Board of Trustees and subsequently to the House of Delegates "recommendations for implementations of parts or the whole of the Report." This has been accomplished and the Board of Trustees acted upon the recommendations late in 1968.[10] These proceedings will be presented to the House of Delegates for action by this body, presumably during 1969. Further, Haviland[11] reported on the current state of implementation of the Millis Report earlier this year at a meeting previously referred to.

The recommendations of the Citizens Commission on Graduate Medical Education are twenty-three in number. These are listed here in the order of appearance in the report.

No. 1. "Because educational programs properly differ from one institution to another, we recommend that each medical

school faculty and each teaching hospital staff, acting as a corporate body, explicitly formulate and periodically revise, their own educational goals and curricula. To do this would be a healthy exercise for medical educators and a fundamental step toward the solution of many of their educational problems."

(Board of Trustees recommends approval with the suggestion word "corporate" be changed to "unified.")

No. 2. "Medical schools and teaching hospitals should prepare many more physicians than now exist who will have the desire and the qualifications to render comprehensive, continuing health services, including preventive measures, early diagnosis, rehabilitation, and supportive therapy, as well as the diagnosis and treatment of acute or episodic disease states."

(Board concurs.)

No. 3. "No physician, by himself, has all of the knowledge and skills necessary to provide all of his patients with optimal health care. Specialization implies division of responsibility. But the patient is undivided. Programs of graduate medical education should therefore give greater emphasis to the training of physicians for cooperative effort—among medical specialists and with members of other health professions—in order that each patient may be provided with the combination of skills and knowledge best adapted to his particular needs."

(Board concurs.)

No. 4. "Stronger, more centralized, and better coordinated procedures and agencies than now exist are needed for systematic, continuing review and improvement of graduate medical education."

(Board concurs.)

No. 5. "In the determination of educational policies and the establishment of programs and standards, the amount of attention given to the needs of medicine as an integrated scientific and professional whole should be greatly increased."

(Board concurs.)

No. 6. "First, simple rotation among several services, in the manner of the classical rotating internship—even though extending over a longer period of time, will not be sufficient. Knowledge and skill in the several areas are essential, but the teaching should stress continuing and comprehensive patient responsibility rather than the episodic handling of acute conditions in the several areas."

(Board concurs.)

No. 7. "Second, some experience in the handling of emergency cases and knowledge of the specialized care required before and following surgery should be included."

(Board concurs.)

No. 8. "Third, there should be taught a new body of knowledge in addition to the medical specialties that constitute the bulk of the program."

(Board concurs.)

No. 9. "Fourth, there should be opportunities for individual variations in the graduate program."

(Board concurs.)

No. 10. "Fifth, the level of training should be on a par with that of other specialties. A two-year graduate program is insufficient."

(Board concurs.)

No. 11. "We recommend that each teaching hospital organize its staff through an educational council, a committee on graduate education, or some similar means, so as to make its programs of graduate medical education a corporate responsibility rather than the individual responsibilities of particular medical or surgical services or heads of services."

(Board concurs with addition of phrase "or medical school faculty" and substitution of word "overall" for "corporate.")

No. 12. "We recommend that the internship, as a separate and distinct portion of medical education, be abandoned, and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole."

(Board concurs with certain qualifications.)

No. 13. "We recommend that state licensure acts and statements of certification requirements be amended to eliminate the requirement of a separate internship and to substitute therefore an appropriately de-

scribed period of graduate medical education."

(Board concurs.)

No. 14. "We therefore recommend that graduation from medical school be recognized as the end of general medical education, and that specialized training begin with the start of graduate medical education."

(Board concurs with certain qualifications.)

No. 15. "We recommend that hospitals experiment with several forms of basic residency training, and that the specialty boards and residency review committees encourage experimentation by interpreting liberally those statements in the residency requirements that now inhibit this form of educational organization."

(Board concurs.)

No. 16. "We recommend that the specialty boards, in amending their regulations concerning eligibility for examination for certification, not increase the required length of residency training to compensate for dropping the requirement of a separate internship. This can be done by retaining present wording concerning length of residency training and deleting statements concerning internship training."

(Board concurs with certain qualifications.)

No. 17. "We recommend that programs of graduate medical education be approved by the residency review committees only if they cover the entire span from the first year of graduate medical education through completion of the residency. (This does not mean that each teaching hospital should be required to offer programs in all specialties.)"

(Board recommends further study by Council on Medical Education.)

No. 18. "We recommend that programs of graduate medical education not be approved unless the teaching staff, the related services, and the other facilities are judged adequate in size and quality, and that, if these tests are met, approval be formally given to the institution rather than to the particular medical or surgical service most directly involved."

(Board recommends further study by Council on Medical Education.)

No. 19. "We recommend that staff members of university medical centers and other teaching hospitals explore the possibility of organizing an intensive effort to study the problems of graduate medical education and, where such development appears feasible, they seek to arrange for the development of improved materials and techniques that can be widely used in graduate medical education."

(Board concurs.)

No. 20. "University medical centers should be among the pioneers in establishing the facilities for teaching comprehensive and continuous medical care, and in developing corporate responsibility for residency training and in initiating new programs of basic residency training."

(Board concurs with substitution of the word "unified" for "corporate.")

No. 21. "We therefore recommend that a newly created Commission on Graduate Medical Education be established specifically for the purpose of planning, coordinating, and periodically reviewing standards for graduate medical education and procedures for reviewing and approving the institutions in which that education is offered."

(Board recommends further study. See Committee of Five in text.)

No. 22. "In summary, we recommend that the Commission consist of ten members, all of whom are appointed by the Council on Medical Education; that three of the members be appointed from a list of six or more names submitted by the Association of American Medical Colleges; that two be appointed from a list of four or more names submitted by the National Academy of Sciences; that the other five be appointed by the Council on Medical Education without restriction as to the source of suggestion; that other organizations involved in graduate medical education be consulted in preparing the lists of names from which appointees are selected; that in later years, successors to the original members be selected from lists of suggestions developed and submitted in the same manner as the

lists from which the original members were selected. We recommend that not less than two of the members serving at any one time come from outside the field of medicine; that all of the members serve as individual statesmen of medical education rather than as representatives of particular organizations; and that members be appointed solely on the basis of established records of distinguished service in medical education, the related sciences, higher education, or public affairs."

(Board recommends further study. See Committee of Five in text.)

No. 23. "We therefore recommend that each residency review committee include a few members from outside of the particular specialty."

(Board recommends further study by Council on Medical Education.)

The Board of Trustees has grouped these under six broad headings which are:

I. Commission on Graduate Medical Education.

II. Corporate Responsibility.

III. Comprehensive Health Care.

IV. Reorganization of Specialty Training.

V. Licensure Acts and Certification Requirements.

VI. Role of the University.

I will attempt to summarize the actions taken by the Board of Trustees of the American Medical Association with respect to the recommendations contained in the report of the Millis Commission. In the effort to achieve brevity there will be risk that clarity will be sacrificed.

I. Commission on Graduate Medical Education

(Includes recommendations Nos. 4, 5, 21, 22)

The Trustees recommend approval of Nos. 4 and 5 and pointed out that the Advisory Committee on Graduate Medical Education is currently considering the feasibility of an over-all Commission of Graduate Medical Education. I will have more to report to you in this area in a few moments.

II. Corporate Responsibility

(Includes recommendations Nos. 1 and 11)

The Board of Trustees concurred with these recommendations with some changes in the wording.

III. Comprehensive Health Care

(Includes recommendations Nos. 2, 6, 7, 8, 9, 10)

The Board concurs with these statements and points out that the House of Delegates had already approved similar recommendations in November 1966.

IV. Reorganization of Specialty Training

(Includes recommendations Nos. 14, 12, 16, 3, 15)

In essence, the Board of Trustees concurs with each of these.

V. Licensure Acts and Certification Requirements

(Includes only recommendation No. 13)

The Board believes that efforts should be made to work toward this goal.

VI. Role of the University

(Includes recommendations Nos. 19, 20, 17, 18, 23)

The Board concurs with Nos. 19 and 20 with a change in a single key word. With respect to recommendation Nos. 17, 18, and 23, the Board of Trustees expressed the opinion that these matters require further consideration and study, recommending that the Council on Medical Education be authorized to continue its deliberations in the areas concerned.

Earlier I stated that I would have more to say about the recommendations of the Millis Report dealing with the creation of a Commission on Graduate Medical Education. I refer to initial steps which have been taken in this direction. A so-called Sub-Committee of Five has been created for the specific purpose of working out the details involved in the creation of such a Commission. This committee will have as members representatives of the American Medical Association, the Association of American Medical Colleges, The American Hospital Association, the Council of Medical Specialty Societies,*

*The Council of Medical Specialty Societies is presently composed of representatives from the American College of Surgeons, the American College of Physicians, the American College of Radiologists, the Academy of Pediatrics, and the Association of American Pathologists.

and the Association of Medical Specialty Boards.

I can also report to you that the Advisory Board of Medical Specialties, Inc., met in February of this year. Among the actions taken at this time was a change of name to the Association of Medical Specialty Boards, which you will recognize as one of the groups having representation on the Sub-Committee of Five. Further, the formation of a Board of Family Medicine was approved. In addition, this meeting resulted in a vote favoring the creation of a Commission for Graduate Medical Education and in the appointment of a surgical ad hoc committee to study the matter of establishing a mechanism for an examination in basic surgery to be taken by all trainees in surgery and its specialties. Possibly of even greater interest to us is the fact that this body recommended that the Board of Thoracic Surgery become a primary board.

You may be wondering what I am trying to say and why. It is simply this, the American Association for Thoracic Surgery is not without highly respectable competition, specifically the Society of Thoracic Surgeons to name only one. We cannot assume that our position will not be seriously challenged. I believe we must increase our efforts to be activists in behalf of the causes we elect to champion. If you as an individual have suggestions to make to your officers, by all means, communicate!

Though there are many areas which demand our attention, one posture we have assumed continuously since 1917 has been in the academic world with particular emphasis on the training of surgeons. This is obviously a characteristic which attracts individuals to apply for membership. Would you believe that of the twenty-nine candidates for consideration for the first time in this year of 1969, twenty-six have medical school faculty appointments and the remaining three are associated either with one of our major clinics (two) or a unit of the National Institute of Health (one)?

I do not claim that this is necessarily desirable but it must convey a message to all of us. Therefore, one of the paths we are to follow with ever-increasing speed is well lighted. Dramatic and rapid changes in undergraduate and graduate education are already upon us. More, much more, is sure to come. The members of this association, both collectively and as individuals, are facing a challenge which must be met. It is apparent that our best efforts of yesterday will not suffice for tomorrow! Let us not live in the past but explore the future! The key word today is "involvement!" I urge that this association become increasingly "involved" with the many problems that face us. The responsibility for the fate of your association in the coming years rests in your hands. As proud as we are of our first half century, I am certain that we have the people and the motivation to achieve an even more illustrious record in the coming years.

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