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*Presidential Address*

Of cabbages—and kings

*Hiram T. Langston, M.D., Chicago, Ill.*

As I come now to what has seemed the most improbable of all hours, I am unmistakably shaken. On the one hand, I am exhilarated by the honor you pay me on election to this high office. I cannot conceive of an event that might ever eclipse it, and for this I am deeply grateful. On the other hand, I am frightened when I realize the nature of my commitment to you. You expect, and rightly so, a distillate of clinical experience or, more remotely, a thought, a guiding principle perhaps, which might sustain us all in these troubled times.

Would that the gift of prophecy were mine, as it so clearly was Tennyson's<sup>1</sup> when over a century ago he

Dipt into the future, far as human eye could see,  
Saw the Vision of the world, and all the wonder that would be;  
Saw the heavens fill with commerce, argosies of magic sails,  
Pilots of the purple twilight, dropping down with costly bales;  
Heard the heavens fill with shouting, and there rained a ghastly dew  
From the nations' airy navies grappling in the central blue.

There is no possibility that I can come within hailing distance of such prophetic

talent, and I shall not try. Instead, I feel compelled to comment upon the problems that beset our profession from our own especial point of view as thoracic surgeons. This has been a frustrating endeavor, I must admit, because no matter how hard I tried to be clear and concise, the diffuse nature of the topic and the mercurial character of any solution or answer thwarted me.

As I labored to find a common denominator or draw a clear thread of continuity through the problems or the answers, I seemed to deal with the high and the low, the big and the little, the sublime and often, perhaps, the petty to such an extent that I was reminded of the famous lines:<sup>2</sup>

"The time has come," the walrus said,  
"To talk of many things:  
Of shoes—and ships—and sealing wax—  
Of cabbages—and kings—."

Hence the title.

We do indeed live in troubled times, not only politically and socially on a world-wide scale, but in our profession as well. Our general educational systems have reeled under the onslaught of agitation and agitators. Even though our medical schools have been spared the grosser forms of this unrest, they are clearly in line for their share. Medical curricula are under scrutiny, and the length of residency training is causing con-

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cern. Efforts to abridge surgical training are active. We are being called upon to produce more doctors, yet our image before the public is a deteriorating one. The extent of what we have to offer our patients is steadily broadening, yet it seems merely to keep pace with their willingness to sue us for real or alleged improprieties. Always there is the spectre of governmental take-over with progressive loss of our individuality and of the enterprising spirit, which are the very traits that have brought us so far.

Many of these blustery winds that buffet us today are merely expressions of a society trying to find itself, but some, I fear, have a much deeper significance and are signs of illness that can and will destroy us if we do not deal with them correctly. Somehow, we must distinguish between the symptoms of trivial upset and those produced by serious illness within our profession. After all, a cancer is a living, growing thing, but it cannot be allowed life, liberty, and the pursuit of happiness after its own design without spelling the doom of the host. This cancer, if such is the case, must be accorded treatment vastly different from that which would be applied to a transient indisposition that might produce a comparable set of symptoms.

We, as thoracic surgeons and members of this Association, have perhaps lifted ourselves somewhat above the jostling medical crowd by virtue of our attainments. Thus, we may be less aware of some of these struggles and conflicts.

It appears ludicrous indeed to consider that the present Board of Thoracic Surgery might look out some morning and find nailed to its door a list of demands by dissident candidates or that the American Association for Thoracic Surgery might be seriously challenged for partisan action in not according membership to some particular person. Yet, in the future these possibilities may not be so remote.

We are beyond doubt one of the most prestigious thoracic surgical societies in existence today. We are mature. Our membership roster is densely studded with names

of academic and clinical luminaries both domestic and foreign. A position on our membership roster is a highly coveted award. We are circumspect and authoritative. We are unquestionably a venerable society.

I am satisfied that from our position of prestige we are relatively unassailable at present, but at the same time I am possessed by the haunting fear that time is running out. From this position of relative security as paragons of surgical attainment, are we not the ones who should squarely face the issues and move aggressively to correct the defects of our times before the flood waters of change are found lapping at our feet also?

I submit to you the concept that we, probably better than any other segment of the profession, are equipped to lead the way in hanging onto some measure of control over our destiny: (1) We are a "cut" above the general average by virtue of our depth of training and breadth of experience. (2) We are a small group in total numbers and, although fiercely individualistic by nature, could be molded into cohesion by adoption of common aims. (3) We can probably bridge the gap between "town" and "gown" better than other groups. Most of us wear both of these hats in daily life.

In debating the future of thoracic surgery, Allison<sup>3</sup> in 1965 clearly suggests that the Society of Thoracic Surgeons of Great Britain and Ireland had outlived its usefulness. He says directly, "The Society of Thoracic Surgeons should set an example and bring its distinguished and honourable life to a close rather than be allowed to fall into disreputable decay and be kept going by artificial respiration and pacing."

From the mid to the late 1950's, during my stewardship as your secretary, this Association wrestled the problem of its future. The question that required answering was simple—Should the American Association for Thoracic Surgery give in to or resist the strong and mounting pressures for growth and expansion?

I clearly recall the final action. After token acknowledgment of the pressures for

expansion by juggling the membership figure limits, the Council re-affirmed the intent of the Association to remain essentially in status quo as to its aims. It disavowed any evidence of interest in money, even to defray legitimate expenditures such as the Everts A. Graham Memorial Traveling Fellowship. The meeting programs, temporarily expanded by addition of a movie session, were returned to standard fare.

Even though this mantle of self-satisfied disregard of the signs of the times has been eroded by changing faces in key positions as well as by the attrition of evolution and time itself, I shall always consider this attitude and these decisions a mistake. Support for this appraisal of mine was eloquently provided by the birth of the now vigorous Society of Thoracic Surgeons which occurred shortly thereafter.

Despite official assurances to the contrary, and despite a wide overlap in membership rosters, this new Society is in direct competition with us. We are no longer alone in the barnyard, and even if nothing else needs deciding, the "pecking order" must be settled.

This threat to our ascendancy is very real because the young group has committed itself to growth, to ensuring a podium for the younger man, and to educating him. The group is progressive in its methods and practical in its approach. It has a character and an aura that is not entirely borrowed.

Our position as the venerable society is being challenged, however subtly, and I hasten to point out that if this position of venerability is to be maintained it will be by our deeds and not by our decrees.

It is my contention that this realization of how competition looms before us should jolt our complacency and cause us to critically examine our purposes and more clearly define our goals. If we are in truth venerable and prestigious in fact, let us put these traits to work for us before we lose them totally.

This Association has taken a step in the right direction by authorizing a Committee on Medical Ethics. This sets up a mechanism to counter erratic behaviour and possibly

prevent further deterioration in our acceptability to those whom we would serve.

The ethics of our profession have been codified in a complicated manner to fill pages with words that attempt to legislate our professional morals, even though, basically, it is impossible to do so. A practical view of the problem is, however, possible.

In brief, we have responsibilities to the patient and, incidentally, to the family, to ourselves, and to the profession as a whole.

The patient, of course, is the object of first priority. There is no real concern that a patient cared for by a member of this Association would receive anything but the best in diagnostic and therapeutic provisions.

Our contact with the patient's family, however trying to us personally, is a potent force in shaping our professional image. It is easier to impart good news than bad, and it is likewise easier to excuse petulance and irritability on the patient's part than it is when such attitudes are exhibited by the relatives. Yet, through all this, it behooves us to remain in control of ourselves as well as of the situation.

In second place should come our personal interests. A reasonable livelihood should be ours, and we should grow in professional stature as a result of our practice. The limits of these attainments are obviously broad and conditioned by many factors, particularly by the nature of our professional environment. However, excesses at any point are in poor taste.

Finally, this continuous striving by the individual for improvement as a doctor, as a surgeon, and as a person should have no result except a salutary one for the profession as a whole. We cannot allow personal motives to override the good of the patient or the welfare of the total group.

To rise above one's peers is a mark of high achievement and worthy of the greatest accolade. However, when such an individual becomes a law unto himself, he threatens the very order that provided the background against which he has shown so brightly.

It is perhaps some such concept that led Tennyson<sup>4</sup> to reflect "That men may rise

on stepping-stones of their dead selves to higher things."

The weight of numbers and the corporate power of an Association such as this is required to deal with problems of this order of magnitude. May we indeed be given the insight to define our problems, the acumen to differentiate the trivial from the serious, and the strength to deal with each forthrightly.

The changing attitude of society toward health care and the rapidly expanding provisions for financial capability to acquire health care, especially under governmental auspices, have changed much in our profession. In fact, they have rocked the foundations of our security.

Even though we are still living as free agents under a system of free enterprise, the view that health care is a right and not a privilege takes away some of our independence. In the past, we had merely to fulfill the legal requirements for medical practitioners, hang up our "shingle," and build our reputations and our practices from those who sought us out. Now, we are under pressure to assure that the people have made available to them the provisions of health care.

The reaction to this challenge has been to emphasize the need for more physicians. To accomplish this, new medical schools are being formed or planned and increased enrollment in existing schools is ordered. Whereas this may well be necessary, such programs require years for fruition. The need is upon us, however, and the time is now.

Again, I sense that we as thoracic surgeons may be singularly fitted to lead in the matter of improving the existing facilities and in increasing the efficiency of current practices while we await the unfolding of long-range plans.

Everyone looks with jealous admiration upon a smoothly functioning service in any one of our many thoracic surgical centers. Many of them are indeed marvels of proficiency and exhibit the ultimate in technological sophistication.

Many others of us struggle to deliver

correct yet imaginative and sophisticated care through community hospitals, often, but not necessarily, devoid of university connections, and we envy the apparently well-ordered life of our confreres in academic environments.

Providing service to several community hospitals diffuses our talents and reduces control over ancillary personnel, making it tenuous at best. Not only that, but few 350 to 500 bed hospitals of this type can truly be equipped and oriented to provide an environment for all areas of specialized endeavor, including ours. On the other hand, an aggregate of 3 or 4 geographically proximate hospitals so organized as to simulate a 1200 to 1500 bed unit can support a thoracic surgical service in one, a neurosurgical service in another, and so on, above and beyond each hospital's being a highly developed institution basically.

Easy exchange of patients and a well-planned flow by triage will help in proper utilization of available hospital beds.

The establishment of such consortia would provide a sufficient volume of clinical material in one place, so that specific assignment of space as well as personnel would be practical. Certainly, centers of this nature would provide for the patient an environment of maximum security and for the surgeon an environment of maximum efficiency. Furthermore, such complexes would offer much-improved opportunities for residency training by community hospitals, particularly in cooperation with medical schools and other established teaching units.

Medicare has realigned the distribution channels of clinical material. The patients who formerly gravitated to teaching centers because of basic financial limitations or because a complicated illness would likely result in financial depletion are finding that adequate care is often available at home. This is indeed more to their liking. It permits them to avoid the impersonal character of an often prolonged hospitalization while avoiding the risk of a catastrophic financial burden.

It is clear that "gown" must look to the giving of service if it is to successfully com-

pete for clinical material upon which to exercise its “gownly” functions, whereas “town” must look to increasing its sophistication in keeping abreast of technological advances if it is to retain its rightful share of challenging medical and surgical problems. The proper blending of “town” and “gown” is indeed a pressing problem on the current scene.

It is to be emphasized that this concept of consortia must not lead to monopolies. All thoracic surgeons from the respective staffs would work therein with whatever degree of cooperation or independence their natures might require.

This concept has been tested in several regions in this country, yet one of the biggest factors militating against its success is the basic mulishness of many physicians who are otherwise highly intelligent persons. These remind me of the two mules linked together by a short rope, straining to eat two piles of hay separated by a distance greater than the length of the rope that binds them. A bit of cooperation would permit them to jointly consume each pile in turn. There really is enough for everyone.

Concern over the caliber of our successors long has occupied the thought of this Association, and, as a result, the Board of Thoracic Surgery was formed. The mechanism for certification in Canada is different, but the concern of the Royal College has always been the same.

Approved residency training programs must obviously conform to specified standards in providing enough patients for the resident to operate upon. However much we may wish to ensure good training by insisting on adequate numbers of operations done by the resident, there always remain certain intangibles that one would like to know about, and it interests me particularly in the present context, for example. It may be quite apparent from the data on the review forms that the resident has ample opportunity to perform surgery, but do we know how well the conditions of these patients were evaluated before the decision to apply surgical therapy was arrived at or the actual need for surgical exploration was

recognized? Who saw to it that adequate information had been made available so that an intelligent exploration could be undertaken? Who besides the resident is present to guide the reasoning that might lead to correct judgments in the formative years? Or is this a “call me when you get into trouble” type of program?

Endless didactic repetition is trying to one’s patience, but remember that we are grooming our successors! It is not enough that residencies provide an environment suitable for learning into which trainees are injected. It is not enough that material for learning be provided. The residents must be taught, not merely permitted to learn.

Adjustments in training concepts may alter future requirements, but, whatever happens, our standards of adequacy must never be lowered. To use the words of my illustrious predecessor, Julian Johnson,<sup>5</sup> we are surgeons and “something more.” This we must remain.

Our concern, however, seems to stop when we get our understudy to a point of certification as a thoracic surgeon. From that time on, he assumes the unhappy role of a competitor and is eased out of the nest to find his way alone.

Competition is healthy, breeds quality, and sharpens wits, but are we assured that the process of natural selection practiced up to now will distribute our services to the advantage of all? Is it beyond our call to have facilities that offer counsel and guidance on where and how to practice? Is it improper that we prepare our fledgelings to face the facts of practice? How many in this room left the protected environment of a residency armed with an understanding of the duties and privileges of a consultant, or with the evils of fee splitting and, particularly, the many faces of that practice?

If we fear governmental interference in our time-honored systems, it seems to me that it behooves us to offer our help. The government is committed to provide for the people that which it believes the people want. This spells political survival. We as professionals must equip ourselves to offer counsel in terms of what is needed rather than

what may be desired, and particularly in terms of what we can deliver. Unfortunately, we are poorly prepared in this area; but, if we can make this point with effect, it spells professional survival for us rather than subservience as a trade union, albeit highly skilled.

Efforts at preserving our profession, whether by corrective or preventive action, cannot be delegated in their entirety to our societies, committees, or representatives, however competent they may be. This method of dealing with the problem is awkward, uncertain, and slow.

There is another approach that promises quicker results and has been tested over and over. This principle has been phrased in many ways and applied in many settings. I found the present version while browsing many years ago.

In the Transactions of the American Institute of Homoeopathy for the 52nd Session which was held in Detroit in 1896, one paper on anal disease was presented by a Dr. Walton of Cincinnati.<sup>6</sup> In discussion, one of Dr. Walton's detractors, a Dr. Pratt, from Chicago, was accused by a Dr. Fisher, likewise of Chicago, of using the speculum with too much force and possibly rupturing the sphincter. Dr. Pratt countered with the retort that "the only way Fisher can tell how much force I use is by being at the other end of it." Truly, it does make a difference which end of the instrument you are on.

I am certain that if we will discipline ourselves to take up individually the correction of the defects of the profession as a whole, there is no reason for this Association to retire in senescence to the rocking chair. If a sufficient number of us determine to undermine our detractors so that our efforts can spread and be multiplied, Allison's pessimism can have no basis. Token effort and a desultory attack on the problem will doom us, no matter how sanctimoniously we may act or however much such acts may permit us to burnish our own homemade halos.

My friends, I have taxed your tolerance overlong. Yet, in an era when our technological achievements move ahead at an unbelievable pace, we stand to lose the very

respect and stature that has permitted us the freedom to get where we are today. We have, I fear, outstripped our support.

There is much that this Association can do to guide the shape of things to come, and it is likely that we are uniquely equipped for this. For the future, we can look to defining the needs of the people and providing for a suitable number of properly prepared and appropriately distributed successors. For the present, we can look to increasing the output from our existing facilities.

It is not enough to delegate this to an editorial "them," to place the burden on the Council, or to narrow it to a single person—the President. The surest way to gather the strength with which to weather the storms of this day is to assume the responsibility on an individual basis and, each in his own way, contribute to the leavening of the whole loaf. We will be adequate for any contingency, I am sure, if we are willing in truth to "make stepping-stones of our dead selves to higher things,"<sup>4</sup> bearing ever in mind that it does make a difference which end of the instrument you are on.

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