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CARDIOVASCULAR SURGERY

Presidential Address

From whence to whither

Some reflections on surgical specialty training

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H Having somehow attained the awesome height of the fifty-first rung of the presidential ladder of this disinguished Association, an honor which I had never hoped for nor sought, I am afflicted with the same sense of unworthiness that has been professed by my modern predecessors. A study of past Presidents and their addresses to this Association is interesting. Our founding fathers, as has often been said, were a remarkable group. They were not unaware of their talents and contributions. They were certain of their objectives and were confident that they would succeed in their ventures. Those who became president wasted none of their time, nor that of their listeners, with apologies. Theirs was an enviable sense of noblesse oblige.

I was taught by my Christian mother that, according to the Good Book, "the meek . . . shall inherit the earth." I have mustered much meekness and, unhappily, have been rewarded only by insomnia, dyspepsia, and a fine tremor. In my agnostic agony, I am hoping that the poet's promise that "humbleness is always grace, always dignity"

proves more dependable than the Scriptures.

I am not certain when euphonious titles for presidential addresses came into vogue. Frank Berry's¹ address in 1952 was to me and many others the apogee. "The waste of slaughter and rage of fight" from Homer's *Iliad* was a classic that will stand as required reading for all who aspire to real knowledge of what war and wounding have contributed to all of surgery and to this specialty in particular. Could it have been that Berry, by including in his paper the couplet from which he took his title in Jove's dialogue to Mars, "Inhuman discord is thy dire delight/The waste of slaughter and the rage of fight," was rebuking statesmen as well as instructing surgeons? He was, at that time, Assistant Secretary of Defense in Charge of Medical Affairs, and we were involved in another dirty war—Korea. Johnson,² in 1963, titled his address, "A surgeon and something more." He delivered an excellent paper but may have been trapped by his title, as I may by mine. He stated, "I would hate to find the thoracic or even the cardiovascular surgeons of this country set aside as an entirely separate and autonomous group in a fashion similar to that of certain other surgical specialties in which

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the individuals who operate are not conceded by most of us to be surgeons in the broad sense of the term." Today I think my friend Dr. Johnson might alter that pronouncement.

Kergin had the good fortune to be President in 1967 and to preside at the half century mark of our founding. His³ title was "Retrospect and prospect." So accurately did he present "Retrospect" that I suspect he somehow had managed a beforehand look at the volume *The Founding of The American Association for Thoracic Surgery* which appeared that year—a project envisaged and started by Ethan Flagg Butler and eventually completed by Dr. Miscall and his committee. At any rate, he admirably summarized the events of our origin and stated, ". . . I wish to sketch in a little of the background from which we have come, . . . some of the things our founders were doing, some of the surprising things they knew, and some of the equally surprising things which they had failed to recognize." He added that the founders "really spoke their minds." This has apparently become a lost art. Later in this address, with your indulgence, I shall speak at least part of my mind.

Apropos of Kergin's "Retrospect," I quote from one of our most articulate surgeons—one of my mentors, and a man with whom this Association today has enriched itself by electing to honorary membership—Dr. Edward D. Churchill. In his foreword to Hochberg's book *Thoracic Surgery Before the 20th Century*, he⁵ wrote, "Surgeons have travelled a long rugged road to bring their craft to its present position. This road can be measured by milestones of triumph and progress: Also by tombstones of tragedy and prejudice. The journey cannot be described as a particularly sentimental one, but rather as a struggle in which stern realism has usually obscured any elements of romance. Only the words of those who have lighted the way remain to show the romance of surgery. They are the words of earnest men, the strengths of whose convictions exceeded the techniques available for its

expression. These men stand poles apart from today's 'bright boys' who are so facile in wielding the techniques they have inherited."

Samson's⁶ 1968 address, "The compleat thoracic surgeon," was an admirable addendum to Kergin's "Retrospect and prospect." It modernized and strengthened our specialty stance. Seeking a subject for my address to fit the times, I sought advice from trusted advisers. I had not, it was obvious, ever been first in the dramatic things. I have never transplanted a heart. I have not even attempted a triple valve replacement or a vein graft to the coronary arteries. All of those feats, however, have been accomplished by my trainees.

I might have built a reasonably respectable address on various surgical subjects. I could have recalled that I,⁷ along with Calodney, Carson, and Goldring, was among the first, if not the first, to prove that surgical correction in the sick infant with a short-segment postductal coarctation of the aorta, with or without an associated patent ductus arteriosus, yielded a far better prognosis than the conservative approach of tiding the infant over, under conservative management, until enough time had passed to determine whether the infant was to live or die. I might have discussed with some authority the problems of the esophagus, particularly with reference to the tragic caustic strictures caused by the ingestion of various burning agents. Bosher and I produced such strictures experimentally and, with Ackerman's perceptive pathologic eye, demonstrated some sensible objections to the nonsensical persistence with dilatation. The gastrostomy with a string and retrograde dilatation was ineffectual sadism, often resulting in rupture and death. We⁸ reported on a significant number of successful supra-aortic and even supraclavicular esophago-gastric anastomoses to this Association in the 1950's. Our thesis, I am proud to state, was strongly supported by Sweet, the modern master of the esophagus. I could have gone further and recounted the final conquest of the esophagus by the alleviation of

caustic strictures involving the hypopharynx, the pyriform sinus, and even the vocal cords. This significant report, which Ogura, Roper, and I⁹ presented in 1961, was mainly a result of the contributions of Ogura. We were able to bring the colon to the scarred pyriform sinus and reconstitute normal swallowing without sacrificing vocalization by the use of skin grafts. This is a feat that, to my knowledge, has not been duplicated.

"From whence to whither" was a query voiced by Lincoln during the long agony of the Civil War. His backward glances were concerned with issues, events, and directions—large things and small things that proved right or wrong. His retrospection was purposely practical. He was seeking guidance down the long road ahead. He knew all too well that repeated mistakes are costly, and often fatal. In a far less dramatic and less important context, this phrase has considerable relevance to the affairs of this Association today. I have already recounted briefly the excellent addresses of some of my noted predecessors and their accounts of our past. Would I be ungracious if I suggest that we have all been too complacent and self-satisfied with our heritage and our progress? Would it be unseemly to ask why it took 30 years after the founding of this Association by men of the stature and vision of Willy Meyer for this specialty to achieve the status of a Board and to be satisfied with affiliate status? Meyer,⁴ in summing up after Meltzer's first presidential address, said, "The outlook for thoracic surgery is wonderful. What particularly is to be emphasized is that the thorax today is not only open to surgery, but that it is 'safely' open to it." Why were we less confident than those who founded The American Board of Ophthalmology in 1913? Why didn't we manifest the self-assurance of the neurosurgeons? Sealy,¹⁰ in a well-researched and excellent presidential address before The Society of Thoracic Surgeons, has covered much ground that I had intended to discuss. Parenthetically, all future Presidents of this Association should check with their counterpart in the Society. They meet in January.

The American College of Surgeons, which began so auspiciously among the academic surgeons as the guardian of standards, somehow fell into disrepute in the first quarter of this century. It neglected training supervision and became an inspector of hospitals. The American Board of Surgery originated with the provocative discussion of these matters by Archibald of Canada before The American Surgical Association in 1935. Evarts Graham, Allen Whipple, and Samuel Harvey were quick to pick up the challenge, and, in 1937, the members of The American Association for Thoracic Surgery believed that there was no need for certification in thoracic surgery. The long shadows of what Sealy has termed the Germanic-Halsted image obviously still obsessed us like paternal fear.

In certain medical schools, including my own, the famed Flexner Report,¹¹ published in 1910, became a veritable vade mecum for restructuring medical curricula and medical schools in the Germanic image. American medicine, like the American populace, was perhaps still too provincial to trust the indigenous. Rush Medical College affiliated with Lake Forest University in 1875 and with the University of Chicago in 1898! Before 1904, when he graduated from Princeton, Evarts Graham had resolved "To do major surgery, to engage in research work, and to have a clinic of younger men who would be interested in studying and developing ideas."¹² He, of course, went to Rush Medical College where his father was a Professor of Surgery. Long before 1910, American medicine and surgery were moving forward with idealism, effectiveness, and a realization of the need for an academic type of milieu. Any real student of our beginnings will not forget Meltzer, Auer, Lillienthal, and Matas. Without intended discredit to Flexner, I am persuaded by historic evidence that his report probably strictured our efforts for an imaginative pattern of medical education of our own for too long.

I raise these questions not to imply that we might have come farther or faster, but

only to suggest that we should perhaps look to our future with more careful scrutiny than we have sometimes directed toward our past. It is ironic that, by the time The American Board of Surgery was created, its periphery was already being threatened by erosion.

It was John Alexander who established the first formal training program for thoracic surgery at The University of Michigan in 1928. Few men have had a greater impact on this specialty. I came to Washington University and Barnes Hospital in 1937. I came on the advice of Harvey Cushing, because I aspired to be a neurosurgeon. It was some time before I realized that I might have applied for a service with Walter Dandy and a longer time before I realized why I was not so advised. It was not long until I switched my interest. There was Graham with his overwhelming prestige and, particularly, there was Blades with his charisma. I have already recorded my admiration and respect for Graham. It was Blades, however, who was valiantly and patiently trying to start a prototype of the Alexander program. He finally succeeded. In 1938, Dr. Edward Kent was appointed the first resident or Fellow in Thoracic Surgery. In 1940, Dr. Lawrence Shefts and I were appointed for 2 year fellowships in thoracic surgery. This appointment for both of us meant 1 year at Barnes and 1 year at the Robert Koch Hospital for tuberculosis. Kent's appointment probably instituted the second formal training program in thoracic surgery in this county. Then came the war.

In 1946, I joined Graham as a member of The Department of Surgery at Washington University. I came as a thoracic surgeon and persuaded Graham from the beginning to follow Blades' plan of appointing two qualified, interested men as Fellows in Thoracic Surgery.

Thus began the most interesting phase of my career. The immediate postwar years provided an endless list of qualified applicants eager to get on seriously with the business of adequate training. They were clean-shaven, well-groomed, and hard-

working, and they expected to work harder and longer than the Chief. Blalock's "blue baby" operation, Craaford and Gross's successes with the surgical correction of coarctation of the aorta, closed mitral valvotomy, the successful surgery for tracheoesophageal fistulas, and the vastly improved results from individual ligation techniques in pulmonary resections presented an exciting and challenging future for young surgeons.

In a short time, our volume had grown and our trainees had doubled. In 1948, when the first Board of Thoracic Surgery was activated in Quebec, I was elected a member and was privileged to serve under the austere but effective chairmanship of Dr. Carl Eggers. Things were considerably enlivened by the first secretary, Dr. William Tuttle. It is sad to relate that not everyone realized that behind the witty facade of this attractive, sometimes intemperate, man there was the larger presence of one of the sharper minds, and one of the finest technical surgeons, that this specialty has produced. My associates were Berry, Sweet, Haight, Blades, De Bakey, Clagett, Jones, and others of equal distinction. Although outclassed, I had the capacity to learn, and I did.

This was a good Board, but again, in retrospect, we made mistakes. We persisted too long in requiring training in tuberculosis. We seemed to ignore the impact of the anti-tuberculous drugs and the changes in the surgery of that disease. Thoracoplasty was being rendered obsolete, and resection, no different from that for bronchiectasis, had become the established method of treatment.

In my opinion, we were too docile in our relations with The American Board of Surgery. Emancipation should have been sought years earlier.

Serving with men of this caliber was not only a privilege but also an experience which encouraged rapid maturing. I might add that there is nothing so effective in enhancing a man's prestige and respect with his residents as being elected to membership on the Examining and Certification Board of his specialty.

This advantage, however, is short lived.

Inevitably, you encounter a distinguished surgeon, often 10 to 15 years your senior, who button-holes you just before the ungodly breakfast hour in some fashionable hotel and threatens to destroy "your damned board" because it failed his wonder boy. After 2 or 3 years of dedicated service on the Board, it is even more harassing to be continually challenged by the "little fellows." They seek you out in all sorts of places and blandly inform you that you examined them on "the Board." It is like meeting some unknown person who says, "Doctor, you operated on my son 4 years ago." Did he pass or fail? Did he live or die? With desperate nonrecognition and total nonrecall, but with an instinctive sense of self-preservation, you look for evidence of a shoulder holster or the quickest exit. Or so it was in the beginning.

The training or teaching program which Graham and I instituted was purely thoracic and cardiac, although Dr. Graham, even to the end, could not resist the challenge of a cholecystectomy, particularly if it was on a patient who might enrich the coffers of the university. Our formula was simple—pick the best man and give him the broadest experience that our service afforded. Graham was patient and, for him, particularly tolerant of my many demands and perhaps, in retrospect, my arrogance. We established a program of 2 years' intensive training in thoracic and cardiovascular surgery. Men from general surgery rotated through the intern and assistant residency level and either went on to other areas of interest or returned, if good enough, to become 2 year trainees in the specialty. Many completed the general surgery program and then came on to devote 2 years' training to thoracic surgery. We were fortunate enough to attract many bright and talented men from other institutions. I might add that we were intelligent enough to take them. In my opinion, no system is more certainly destined to ultimate extermination than that which accepts only its own products for perpetuation. Some of our most renowned trainees were products of other schools and other systems!

Selection of candidates for training is an art not easily acquired. Breeding lines and past track records in young colts can be deceptive. Recommendations from former chiefs of surgery can be even more untrustworthy. Medical school records are particularly poor indices—so much so that I learned early not to be beguiled by the flashy academic credentials of the number one or two men in any given class. Too often these men, after years of training, somehow never master the simple technique of venipuncture or knot tying. Tragically, a few ultimately resort to self-annihilation, and some wander into psychiatry or administrative positions. This is not a rule and is not meant to be. The art is in recognizing the latent surgical potential in the very bright graduate. A few times I have succeeded, and the rewards are great. Often I have failed, and the disappointment is bitter. Do not be too impressed by the excessively verbose in an interview; too often, a glib tongue represents a compensatory adaptation for clumsy hands and a nonsurgical temperament. Discard those who are overly sensitive and indecisive. Probe carefully for evidence of latent sadism.

Resident training or teaching, particularly in this specialty, is an awesome responsibility. I have been convinced from the beginning that this is best accomplished by the straight service method. The ideal program, in my opinion, is one in which the trainee is appointed after a sufficient period of time and with sufficient surgical training, when he is deemed able to enter the program as a full-time thoracic and cardiovascular trainee. He is supported below by the intern and assistant resident staffs that are rotating for the purpose of acquiring general knowledge of the specialty in their general surgical education. The thoracic and cardiovascular trainee is shortchanged in the mixed program in which, after 6 months, he is shunted off to be the resident in general surgery at the veterans hospital or local city hospital and then, after this period, comes back to pick up the pieces; unfortunately, he is often expected to assume responsi-

bilities which he is not capable of fulfilling. Professional dog trainers and horse trainers, although most are unadorned by college degrees, would be appalled by this method. Imagine the reaction of these people if they were told to have a horse ready for the Preakness on one Saturday and to compete the same horse 3 months later in the Olympic Jumping events. In the straight service program, the educational process is a continuum designed to deliver at the end a product who is intellectually prepared and technically proficient for the challenge of properly and safely correcting the ailments of people and, what is more difficult, of adding to our already formidable heritage of knowledge and skills. The wise director of such a program will see that his proteges are thoroughly grounded in the fundamentals and will provide ample clinical material for their instruction.

First assisting is unhappily becoming a lost art. I firmly believe that daily contact with the Chief at the operating table is the best teaching exercise ever devised in surgery. I have little respect for talking operating surgeons, particularly if they tend to over salivate. A modern resident needs little or no instruction in the anatomy of the parts involved. He is usually well versed in methods. What he needs is the subtle, indefinable "how" of the master. Once his mentor is certain that he is ready, the trainee should be given individual operating responsibility without a mother-hen Chief either on the team or in the room. With this privilege there goes, of course, the mandate that with any doubt or any trouble the Chief or a qualified associate is immediately summoned.

As Cicero wrote centuries ago, "Not only is there an art in knowing a thing, but also a certain art in teaching it." A Chief must possess or acquire this art. He must above all earn respect. It cannot be commanded or demanded.

One of the most delicate and demanding challenges for the director of young surgical talent is to accurately assess the temperament and potential of his stable. Some,

fortunately a small minority, rather quickly can be crossed off as nonwinners. This is disappointing, but inevitable. This group either falls by the wayside or achieves, at most, the humble status of a nonharmful surgeon. This represents poor selection, and the blame rests entirely on the director who chose him. A good Chief learns rapidly, and as his experience accumulates these mistakes in choice level off to a minimum. The remainder of the trainees must be handled by different methods. Some will require a short leash, whereas others can be allowed more range. Some require prodding, while others need only encouragement and an occasional compliment. Be parsimonious with praise, and reserve it only for a particularly outstanding performance. Be restrained and totally private with rebuke and criticism. It is a weak man who attempts to glorify his own image by publicly stripping another of his dignity.

Each man who occupies a command post must have an efficient intelligence staff. No matter how he recruits them, they must be loyal and efficient. In academic circles, perhaps even more so than in the military, his effectiveness and even his survival may depend upon their devotion. Their sensitive antennae pick up all sorts of things. A number of years ago, I had a trainee who was not particularly impressive in the beginning. He was truculent and, although bright, was performing in a desultory fashion. My G-2 finally gave me the clue. This fellow had said of me, "like some wit said of Disraeli, a self-made man who worships his creator." Initially incensed, I was certain that I had him pinned. I was positive that this had been said about Voltaire. However, experience has taught me caution, particularly in stalking young game. I investigated and found that my critic was right in his quote—it had been said of Disraeli. This led to discreet blandishments from me which, in the end, led to mutual respect and the development of a productive and significant surgeon.

Finally, in this vein, I would advise all directors of training not to linger too long.

The time comes when a man, although rich in wisdom and judgement and still a master surgeon, finds that his zest is lessened and that he would like nothing so much as to cancel an occasional day's schedule and go fishing or riding. Don't stay on to become a flapping old crow in an eagle's nest. As they say in sports, "Go out a winner." To my critics and competitors, this is not contemplation of early retirement. Quite the contrary. I feel very deeply that qualified younger men should be entrusted with the major responsibilities of training and teaching. They have the zest and the energy to inspire. They yawn less obviously at inanity, and they have far more patience with immaturity.

And now to "whither." This is an era of unrest, yes, even of revolution in all areas of society. Human beings everywhere are rapidly bursting the shackles of repression, discrimination, poverty, and lack of equal opportunity. Nowhere will the impact of this angry tidal wave of social consciousness be more manifest than in the area of preventing and healing disease. I'm sure that my Honored Guest will fill us in on some of the implications of this, as well as of our upcoming obligations and threats.

Medicine and surgery, through their various organizations, have always been mindful of these challenges. Although sometimes thwarted by selfish minority interests, they have managed, even though at times their efforts have been inept and bungling, to keep the curve of compassionate and competent service to the sick and maimed on the upswing.

We have sponsored and endured many committees. Some have been helpful, but most often the results have followed Parkinson's law, engendering the creation of more committees.

This specialty was granted a somewhat illusionary and provisional mandate to begin the creation of a new and eventually independent "Primary Board." After several letters of query, to which I was a concerned respondent, as were you, we were recently given an answer. I trust that my long-time

friend and esteemed colleague who so eloquently, and in the most proper diplomatic phraseology, authored this report will bear me no ill will if I assume the presidential prerogative of attempted wit and the light touch. We were informed by editorials in both *THE JOURNAL OF THORACIC AND CARDIOVASCULAR SURGERY* and *The Annals of Thoracic Surgery* that, "The Ad Hoc Primary Board Committee, after due consideration, concluded its deliberations and unanimously recommended the change in name of the Board of Thoracic Surgery to *The American Board of Thoracic Surgery*. The Committee was in agreement that this name has the advantages of logic, continuity, simplicity, and flexibility and has none of the restrictive or divisive disadvantages of the alternatives."

This had to be a soul-searching decision. Think of the awesome international consequences if, at the all-important christening ceremony, it had been decreed that the Board be renamed "The United Board of Free Democracies for Thoracic Surgery." It is noteworthy that these prolonged and profound deliberations resulted in the addition of only one word—American. However, in this era, this is a familiar phenomenon. With all our know-how I am told that it is impossible to abort a mountain, and I am further advised that even after prolonged labor it is most frequent for the mountain to deliver a mouse. At this moment, I have no statistics on neonatal mortality in this area of reproduction. I would suspect that it is quite low. It is also apparent, as you have heard, that to quote Sealy,¹⁰ "The task of fabricating examinations has reached the point where the Board, now American Board of Thoracic Surgery, has to be supported financially by both major thoracic surgical societies." I am further informed that we now have nonmedical consultants advising the Board on how to examine.

We are and have always been aware of our health care responsibilities. I am confident that we will meet them. We have already instituted a manpower study, for good or for bad. Since our beginning, we have

been in the forefront of surgical progress. Few would deny that the surgery of thoracic and, in particular, the surgery of cardiovascular diseases is the ultimate in this time. Technologic skill has again out-distanced physiologic and immunologic knowledge. Again, surgeons are forced to mark time while these and related sciences catch up. With these advances we recognize the need to reappraise teaching and training methods. We are seeking intelligent advice from all qualified sources and are receiving it from both professional and political sources—some sought and some not sought. The distinguished publication *Pharos*,¹³ the journal of the Alpha Omega Alpha, has been filled with erudite and provocative papers on all aspects of medical education and postgraduate training for months. As surgical specialists, we are, I fear, becoming too enamored with the sophisticated patois and behavior of the very liberal academician and medical educator. The latter are rapidly beginning to sound more and more like the bureaucratic supersalesmen for the National Institutes of Health and The Department of Health, Education, and Welfare. We have been down that trail before. As Dr. Walter Palmer¹³ has written, “. . . the extent to which in the last 25 years the national granting agencies have succeeded in selling their seductive wares in academic halls is both gratifying and frightening, for now these agencies also are proving to be fickle mistresses. The escape contemplated is to make bigger, better and more innovative programs. The schools should beware of the blandishments of NIH, HEW, and other governmental sources and make every effort to gain independence.” This distinguished physician, scientist, and educator has wisely and lucidly put modern problems into proper perspective. I suggest that those who have not read his contribution do so.

I am particularly concerned by the current popular phrase, “delivery of medical care.” For over a half century the civilized portions of the world have “given” medical care that has been unexcelled in all history. Who among you has not in the past, many

times over, gotten out of bed at 3 A.M. to go to a city hospital for free, or to a private hospital for a fee, and tended the sick and injured with knowledge, skill, and devotion?

If I read the connotations of the new era correctly, we are now supposed to travel to the patient, wherever he is, and minister to him with facilities that are in no sense adequate. We have watched the nursing hierarchy destroy the noble art of bedside nursing, and we have seen the ultimate verification of Bernard Shaw's statement “that those who can't, teach.”

Again I quote Palmer¹³ who said so well, “I am sceptical of the phrase, ‘delivery of medical care to.’ Our major problem still is to make available for those who seek them, physicians and facilities of high quality.”

One now hears much about the need for “paramedical personnel.” Those who, like me, have witnessed the inept performance of these poorly educated, inadequately trained, although well-intentioned people must share my forebodings about the future of patient care.

We are a fortunate and select group. We are privileged to practice the most exacting skills, and we require the ultimate in facilities for the utilization of those skills. Let us be mindful of the statement of Sir Theodore Fox,¹⁴ former editor of *Lancet*, who said, “. . . knowledge, skill, empathy, equanimity, perspective—each can be futile without the other. Often technical excellence is what matters most; for, unless a patient survives, he will himself gain nothing from the other qualities of his doctor.”

The Society of Thoracic Surgeons, in 1969, created an ad hoc committee to investigate the past, present, and future attitudes and aims of this specialty.

Their investigation covered professional relations with the community, need of changes in training programs, and to some extent the restructuring of the Board of Thoracic Surgery. The final report was significant and important. Its conclusions are similar to my own. I feel that some revision in medical education is imperative. I am

convinced that the training period in the specialty of thoracic and cardiovascular surgery must be intensified, better oriented toward the basic sciences, and lengthened. Conversely, I feel that the training period in so-called general surgery could be profitably shortened. As one consultant to the committee wrote, "I agree that a thoracic and cardiovascular surgeon should have sound basic training in general surgery. However, 3 years of such training is thoroughly adequate to ground the prospective thoracic and cardiovascular surgeon, and there is no need in this day and age for a man to practice both general as well as thoracic and cardiovascular surgery." I feel that the idea of establishing well-conceived and properly supervised experimental training programs is sound and should be supported. A review of their results in 3 or 4 years might well be very exciting.

For the present, I would favor the so-called 3 and 3 program—3 years in general surgery and 3 years in thoracic and cardiovascular surgery. I would have the trainee devote 1 year to training in cardiology, cardiac catheterization, angiocardiology, and pulmonary disease, including pulmonary function. Despite what many people feel, the lung is rapidly re-entering this specialty, and it is becoming increasingly apparent that knowledge of these structures is important, particularly in the preoperative and postoperative management of cardiac and general thoracic surgical patients.

Above all, let's remain flexible in our thinking and in the decisions about surgical education and specialty training, particularly the latter. I favor, in those schools which teach well and which allow the senior class to pursue electives, the idea of crediting with intern status those students who know what they want.

Our task is simple. Let's continue our efforts to select, educate, and train the best thoracic and cardiovascular surgeons that our many resources and collective talents can produce. Let's not get overly involved

with the other affairs which I have mentioned. If we are successful in modernizing educational and training methods, many of these problems will disappear. We can then be assured of producing the best specialty talent that we have yet seen. Their accomplishments will far transcend our own.

We will then again reaffirm the 1918 promise of Willy Meyer—"The outlook for thoracic surgery is wonderful."

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