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Presidential Address

A heritage and a challenge

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Fifty-six years ago this June, a surgical society was founded that was destined to become a major factor in the development of the specialty of thoracic surgery. For years it was the only thoracic surgery society in the world and was the pattern for those that were formed later. In establishing this specialty, The American Association for Thoracic Surgery has bestowed a unique professional heritage upon all qualified surgeons of this country who have committed themselves to the full-time practice of thoracic surgery as a specialty. However, in the United States, these surgeons now find themselves in a rapidly changing era of continuing social upheaval which is altering the practice of medicine. Thus there are many new problems, particularly in the delivery of surgical care, that challenge the now fully developed specialty of thoracic surgery.

In this fast-moving medical scene, we must see that the remarkable technical advances in thoracic surgery of the past half century are made available to the greatest

number of people in our country. An understanding of how the farsighted pioneer thoracic surgeons surmounted many difficult problems to develop this specialty should give us the impetus for attacking the new problems of the 1970's. This address is concerned with a brief discussion of the heritage that has been handed down to us from the founders and early workers of the Association, the challenges facing the practice of thoracic surgery, and certain initial steps which will permit us to come to grips with solving these problems.

The heritage

The American Association for Thoracic Surgery (AATS) had an unusual beginning. Just before the start of World War I in 1913, Dr. Willy Meyer felt rebuffed because there was no interest in a paper (advanced for its time) on surgery of the esophagus, which he had presented at the surgical section of the American Medical Association (AMA). Frustrated with existing surgical forums, he resolved to found a society whose members would be interested in developing thoracic surgery. After 4 years' effort, Dr. Meyer founded the AATS at the

Waldorf Astoria in New York City on June 7, 1917.

The first scientific meeting on June 10, 1918, was held in the Congress Hotel in Chicago. The early success of the society was due to the vision and determination of the first three Presidents, three giants in thoracic surgery: Drs. Willy Meyer, Samuel J. Meltzer, and Rudolph Matas.

In 1931, THE JOURNAL OF THORACIC SURGERY was founded as an extension of the previously published transactions of the society to disseminate the advances of this developing specialty. For 26 years, under the brilliant leadership of its first Editor, Dr. Evarts A. Graham, this monthly surgical periodical recorded the contributions, mainly from members, which have made the specialty what it is today.

In the 1930's, by making surgical collapse for pulmonary tuberculosis safe and efficacious, Dr. John Alexander provided a chance for surgical cure of patients in whom medical treatment had failed. For the first time, it was possible for surgeons to begin to specialize in thoracic surgery. Dr. Alexander established the first residency for thoracic surgery at the University of Michigan in 1928. Thus the surgery of pulmonary tuberculosis launched thoracic surgery as a specialty.

Time permits the mention of only a small number of surgeons responsible for the kaleidoscopic development of thoracic surgery since the early days of the founders, and other equally important contributors have not been included.^{4, 7, 10} In his Presidential Address, Dr. Richard H. Meade⁸ stated that there are many "forgotten men" in thoracic surgery. Those few that are mentioned here represent my personal bias. In 1933, Dr. Evarts A. Graham performed the first one-stage pneumonectomy for carcinoma by individual ligation. His work stimulated the more complicated development of individual ligation technique for pulmonary lobectomy by Drs. Edward M. Kent and Brian B. Blades 7 years later. Lung resection with low incidences of morbidity and death was now possible. In 1938,

Dr. Robert E. Gross ligated successfully the patent ductus arteriosus, increasing the scope of the thoracic surgeon to include closed heart surgery.

The modern era of thoracic surgery may be said to have started with World War II. Thoracic surgery emerged as a specialty in the Army, where it had previously been a part of "septic surgery." I was privileged to have a part in this development along with my distinguished colleagues, Drs. Thomas H. Burford and Paul C. Samson, in establishing the first Chest Surgery Center in the United States Army Medical Corp and the Armed Forces in Bizerte, Tunisia, in 1943. Later, I helped formulate the standards for initial treatment of thoracic wounds during the Italian Campaign. Accepted in World War II, their value has been proved again in Korea and Vietnam.

The successful palliative operation for tetralogy of Fallot by Dr. Alfred Blalock in 1945 stimulated an upsurge of interest in closed heart surgery. In 1950, Dr. Wilfred Bigelow demonstrated the practicality of total circulatory arrest for brief open-heart operations with hypothermia. Three years later, culminating decades of research, Dr. John H. Gibbons, Jr., began a new epoch in open-heart surgery with the successful use of an artificial heart-lung machine or pump oxygenator. Thoracic surgery had now come to full flower. A new generation of "open-heart" operations and "open-heart" surgeons has evolved from this monumental advance.

The other advances in thoracic surgery to be mentioned are of an organizational type.

The founding of the Board of Thoracic Surgery (now the ABTS) by members of this Association in 1948 demonstrated that the specialty had come of age. A standard of excellence in thoracic surgery was established through the regulation of the training programs and the certification of specialists. The American Board of Thoracic Surgery (ABTS) has set the highest standards of any surgical specialty board in the world, for it is the only board of its kind that de-

mands that the surgeon pass the American Board of (General) Surgery prior to taking the ABTS examinations.

In 1964, members of this Association founded the Society of Thoracic Surgeons (STS) to provide for this rapidly expanding specialty a broader-based organization, a forum for the full-time practicing thoracic surgeon certified by the ABTS, and another needed journal of thoracic surgery, *The Annals of Thoracic Surgery*. The cooperative development of the STS with the AATS, unique in the history of specialty societies, has greatly benefitted the practice of this specialty.

In 1970, the AATS, with the partnership of the STS, inaugurated the National Thoracic Surgery Manpower Study (NTSMS).⁹ This study has just been completed. Its results, which will be discussed later, bring us to the current status of thoracic surgery and certain challenges for the future.

Thus, from this all too brief review, it is readily seen that the influence of the AATS on the development of this specialty has been great, and all thoracic surgeons have a rich heritage in this inspired effort.

The challenge of the 1970's

In this, the second half century of the Association's history, there have been sweeping changes in attitudes regarding the practice of medicine. Medical care can no longer be considered a privilege but a "right" of all people. This right has never been accurately defined. Regardless of the definition, the public must accept its responsibilities regarding its part in health care. The government is becoming more involved with medical practice through Medicare, Medicaid, Health Maintenance Organizations, and the Professional Standards Review Organizations (Public Law HR-92-603). Since the government is not as well informed as it should be, it is the responsibility of the medical profession to provide sound advice and leadership. Yet, up until now, the medical profession has not had sufficient information on which meaningful advice could be given. The NTSMS does

provide information on the practice of this specialty that is helpful in providing a better understanding of some of the problems.

The NTSMS was started under the AATS presidency of Dr. Hiram T. Langston in 1970 and was completed in 1974. It was undertaken because of concern by a number of thoracic surgeons regarding the practice of this specialty with the intent that the information obtained would improve the delivery of thoracic surgical care. I served as Chairman with an Executive Committee consisting of Drs. Hiram T. Langston, Thomas B. Ferguson, and John Weiner.* We agreed to share our results with the Study of Surgical Services United States, which was started after our program, since it had not planned an in-depth study of thoracic surgery. More than 140 volunteer thoracic surgeons worked on this project and rendered a service conservatively valued at \$225,000. Thus the entire project can be considered a quarter of a million dollar effort. Those who have done so much deserve our great appreciation.

National Thoracic Surgery Manpower Study (NTSMS)

This study was divided into two parts. The first, paid for by the two thoracic societies, was the American Hospital Association (AHA) Survey of the 6,031 membership hospitals, which compose 80 per cent of the hospitals in this country. The second part, funded by a contract from the National Heart and Lung Institute (No. 1-HO-3-2951), was the study of 4,744 surgeons who had varying commitments to the practice of thoracic surgery in this country.

Survey of hospitals. Eighty-eight per cent of the AHA member hospitals responded to the AHA survey, so that the figures have great statistical significance (NTSMS,⁹ p. 9). A total of 184,088 thoracotomies was reported for 1970. They fell into roughly equal divisions among pulmonary, cardiovascular, and other types of thoracotomies,

*Dr. John Weiner, Dr.P.H., Assistant Professor of Medicine, University of Southern California School of Medicine, is an outstanding biostatistician.

Table I. Per cent of thoracic operations (major thoracotomies) performed by TS-1, TS-2, TS-3, TS-4 surgeons,* by major census regions

Region	Per cent			
	TS-1	TS-2	TS-3	TS-4
Pacific	55	20	5	20
Mountain	55	20	10	15
Northwest Central	75	10	0	15
Southwest Central	75	10	5	10
Northeast Central	75	10	5	15
Southeast Central	55	10	15	20
South Atlantic	70	20	0	10
Mid Atlantic	65	10	0	20
New England	75	10	5	10

Legend: Data were taken from the National Thoracic Surgery Manpower Study,⁹ Figs. 10, 11, 12 and 13 (pp. 21 and 22).

*For classifications, see text.

Table II. Per cent of TS-1 surgeons who use two or more hospitals, by major census regions

Region	Per cent
Pacific	55
Mountain	70
Northwest Central	55
Southwest Central	65
Northeast Central	65
Southeast Central	55
South Atlantic	55
Mid Atlantic	50
New England	60

Legend: Data were taken from the National Thoracic Surgery Manpower Study,⁹ Fig. 9 (p. 20).

with a remarkable consistency of distribution from region to region. These figures soundly refute a prevalent opinion that thoracic surgery is mainly cardiovascular surgery (NTSMS,⁹ p. 11).

Regional study of thoracic surgeons. The characteristics and professional activities of 4,744 thoracic surgeons, whose names were obtained from the AHA questionnaires, were investigated by a volunteer corps of thoracic surgeons and through personal inquiry and letters. Problems of classification arose because there were "full-time" and "part-time" commitments to thoracic surgery by surgeons with and without certification with the ABTS.

Four groups were identified:

1. *TS-1.* Surgeons in this category engage in the full-time practice of thoracic surgery (greater than 50 per cent) and are Board certified in thoracic surgery. (This definition of the "full-time" thoracic surgeon is more liberal than the one adopted by the STS for membership. The committee believed that a surgeon who made his principle work thoracic surgery was in fact committed to this specialty and should be then considered "full-time." Otherwise, we would have been faced with too many categories and the report would have been bogged down in minutiae.)

2. *TS-2.* Those in this group practice full time (greater than 50 per cent commitment) and are *not* Board certified in thoracic surgery.

3. *TS-3.* These surgeons practice thoracic surgery part time (less than 50 per cent commitment) and are Board certified in thoracic surgery.

4. *TS-4.* Surgeons in this category practice thoracic surgery part time (less than 50 per cent commitment) and are *not* Board certified in thoracic surgery.

The performance of thoracic surgery by the TS-1 group (the full-time thoracic surgeon certified by the ABTS) is shown in Table I (NTSMS,⁹ pp. 21 and 22). It is highest in New England (75 per cent) and lowest in the West (55 per cent). The national average is 65 per cent. The TS-2 group (full-time but not Board-certified surgeon) performed from 10 to 20 per cent of thoracic operations, with a national average of 13 per cent, whereas the TS-3 group (Board certification but part-time commitment) performed from 5 to 15 per cent of the surgery, with a nationwide average of about 5 per cent. Finally, surgeons of the TS-4 group (part-time commitment and no ABTS certification) performed from 10 to 20 per cent of the thoracotomies, with a national average of 15 per cent.

Over 60 per cent of the full-time, ABTS-certified thoracic surgeons (TS-1) are forced to work in two or more hospitals in order to be totally committed to their spe-

cialty (Table II). In sharp contrast, only 16 per cent of the noncertified part-time surgeons (TS-4) use two or more hospitals. This is an inefficient use of the best-qualified surgeons.

Distribution of thoracic surgeons. A study of the distribution of the TS-1, TS-2, and TS-3 surgeons shows that they are primarily practicing in the metropolitan areas (NTSMS,⁹ opposite p. 42). The TS-4 group does tend to work in smaller cities, especially in the East, where the distances between cities are not great and referral to a TS-1 surgeon could be easily arranged. The impression is clear that there is a wide distribution of TS-1 and TS-3 surgeons throughout the country (except in low-population western states), so that the qualified thoracic surgeon is available to the patient in the populous areas of the country.

Adverse factors. One of the most important findings of this study is the fact that noncertified full- and part-time thoracic surgeons (TS-2 and TS-4) are performing from 25 to 45 per cent of the thoracic surgery in the United States, with a national average of 35 per cent. This means that a significant segment of our society is being operated upon by surgeons with less than optimal training. The number of TS-1 surgeons over the age of 60 years, potential retirees (Table III; NTSMS,⁹ p. 31), is approximately equal to the certified young men entering practice (120). This is a satisfactory balance. However, the picture for TS-2 surgeons (not certified by the ABTS), less than half of whom have passed the examination of the American Board of (General) Surgery, is quite different. There are twice as many of these young men entering practice (73) as there are potential retirees (31). These figures present an ominous warning for the future, because they demonstrate an increasing competition for the thoracic surgical patient by less-qualified surgeons. Thus the TS-2 group presents a serious problem. There is no question that a number of them practice satisfactory surgery; however, adequate performance records on this group are not available. Ideally,

Table III. Replacement of TS-1 and TS-2 surgeons, by major census regions

Census region	TS-1		TS-2	
	O	N	O	N
Pacific	17	19	5	10
Mountain	4	4	0	2
Northwest Central	14	10	1	8
Southwest Central	8	19	7	22
Northeast Central	25	18	7	12
Southeast Central	8	5	0	4
South Atlantic	3	12	3	10
Mid Atlantic	25	25	5	6
New England	14	8	3	2
Totals	118	120	31	73

Legend: O, Graduated from medical school prior to 1940. N, Graduated from medical school in 1960 or later. Data were taken from the National Thoracic Surgery Manpower Study,⁹ Fig 24 (p. 31).

all of the TS-2 surgeons should receive training to pass the ABTS examination. However, how can this be done? Most of them will not be able to take the intensive training and study that is necessary. Again, this is an educational problem. This question is discussed further under *Hospital staff appointments*.

Economic and geographical considerations influence the TS-4 group of surgeons to perform thoracic surgery in addition to their main interest, general surgery. The current intense competition in general surgery is due to an oversupply of surgeons, which in a major way is related to surgery performed by general practitioners. Once the providers and receivers of surgical care are educated to the advantages of what may be called a "GS-1," a board-certified, full-time general surgeon, perhaps the majority of the TS-4 group of surgeons will be relieved from the economic pressure of performing thoracic surgery. There appears to be no reason why the current TS-1 and TS-3 surgeons could not readily handle these cases which, excluding trauma, are primarily elective in nature.

According to the pioneer manpower studies of Dr. Frederick A. Coller,² only 41 per cent of the cholecystectomies were performed by qualified specialists for the years 1943 to 1953; this figure rose to 50 per

cent in 1957. Thus, in the middle 1950's, general surgical statistics were comparable to those of thoracic surgery in the 1970's. Twenty-one years ago, Dr. Collier stated, "Fearless emphasis on the rights of the patient to receive our best, rather than an insistence on the rights of the licensed physician to do as he wishes, will correct most of these abuses."

Improvement of the practice of thoracic surgery. If we are to show "fearless emphasis on the rights of the patient to receive our best . . .," we must respond to the challenges for the correction of the shortcomings in the practice of thoracic surgery as revealed by the NTSMS. In fact, the enormous amount of effort involved and the funds expended will have lost their meaning if positive steps are not taken to correct these deficiencies. It is far preferable that the medical profession provide answers to these questions than that it wait for governmental decisions which may be made from a less informed point of view. In attacking these problems, the combined efforts of the two societies would achieve the maximum results.

In order to find a way that the societies could better work together, I communicated with the leaders of other surgical specialties. Four specialty societies have formed coordinating councils and several others are in the process of development. The ear, nose, and throat specialty, for example, has a coordinating council with a permanent office in Washington, D. C. Its Executive Director serves as a liaison officer with Congress and the National Institutes of Health for grants. Thus the formation of coordinating councils has proved to be a successful method for surgeons in specialty societies to work together to achieve common goals. The two societies would, of course, remain completely independent but would have a practical *modus operandi* for more effective joint efforts.

Coordinating Council for Thoracic Surgery. I have placed before the governing bodies of the AATS and STS the recommendation for the formation of a Coordinat-

ing Council for Thoracic Surgery (CCTS). This proposal is now being studied. There are difficult problems inherent in the composition and duties of such a council. Representatives of these societies will have to solve these difficulties, in consultation with the American College of Surgeons, the American Surgical Association, and the Southern Thoracic Society. The CCTS should be a think tank to recommend policies and possible courses of action. It must be admitted that the potential scope of such a council, with its ultimate objective of improving the practice of thoracic surgery and patient care, could be very broad and an impossible task for one council. Certain activities would have to be delegated to committees of the societies. Thus the two societies must decide with what projects the CCTS should be involved. The establishment of this CCTS will demonstrate the statesmanship of both societies.

The remainder of this address deals with proposals for the improvement of the practice and delivery of thoracic surgical care. Some of these may be applicable to the CCTS.

Legislation. A number of health bills have been submitted to Congress and, if enacted, will greatly increase the government's involvement in the practice of medicine. The physicians must try to influence these proposals in order to retain the advantages of current medical practice which are beneficial to the patient. This has been difficult because of the lack of specific information regarding the practice of medicine. The NTSMS has provided facts regarding thoracic surgery which should be helpful in appraising any new programs involving the specialty. The CCTS, working with the other specialty councils and the American College of Surgeons (ACS), should prove to be a potent force to influence positively the legislation in Congress. The ACS and the councils of the specialty societies must develop better internal lines of communication and cooperation if they are to be effective in health legislation.

Communication between representatives.

At this time, there are 17 or 18 representatives of the AATS and STS working on national councils and committees involved with various facets of the practice of surgery. Some of the more important organizations are the Inter-Specialty Council of the AMA, the Council of Medical Specialty Societies, the ABTS, and the ACS. These groups function entirely independently. There is a great need for the representatives of the AATS and the STS on these national councils and committees to be conversant with what the other representatives are doing, in order to work more effectively together. Having the representatives of the societies to the more important national committees serve on the CCTS would establish a practical liaison.

Clearinghouse for thoracic surgeons. There has been a pressing need for a clearinghouse for thoracic surgeons. Each year approximately 175 to 200 thoracic surgeons are certified by the ABTS, and many of them have difficulty finding a suitable place to practice their specialty. (This may account for the significant number of TS-3 surgeons in the NTSMS.) A clearinghouse similar to that of the orthopedic surgeons and neurosurgeons, where suitable openings in thoracic surgery could be registered, would be a great boon to those young, well-trained surgeons, who have more training than graduates in any other branch of surgery. Obviously, there is no way to force a surgeon to go to any given place. However, if a good opening existed, the prudent surgeon might be very influenced by that fact alone.

Recertification. To maintain licensure in certain states, recertification is already in force; the physician must show evidence of a given number of hours of postgraduate study and training. It is conceivable that soon there may be not only state but also national standards for required annual postgraduate study. Periodic recertification by the medical profession is unique among professions, for retesting does not apply to lawyers, engineers, architects, professors, or clergymen.

The subject of recertification is so important to the patient, who should have competent care, and to the surgeon, whose future is at stake, that great caution must be shown to see that fair but sound methods of evaluation of the surgeon's competence are employed. Unfortunately, we have no yardstick to measure the conscientiousness, sympathy, humanity, and integrity with which the surgeon treats his patients. Certainly more humanity is needed in the practice of medicine today.¹

The ultimate evaluation of the surgeon must include a review of his "track record," which may be obtained by a random spot check of a certain number of cases. Such an evaluation should take into consideration his continuing educational studies and an equitable examination which is directly concerned with his type of practice (i.e., general thoracic or cardiovascular). The need for recertification examinations would be lessened if the students in medical school were taught that the practice of medicine included life-long study and learning.

Continuing education. If recertification is to be required of thoracic surgeons, then there will be a pressing need to increase the number of continuing education courses available to members of this specialty. For years the ACS and STS have given postgraduate courses in conjunction with their meetings. With recertification, it is now clear that two courses per year are definitely not enough. They should be increased initially to four per year, with two additional courses, one given in conjunction with the AATS meeting in the spring and another with the AMA meeting in June of each year. This scheduling would space out the courses: fall, winter, spring, and beginning of summer. In addition, regional and local courses could be arranged to supplement the above four national courses as needed. A firm liaison between the ACS, STS, and AATS is desirable so that the subjects to be covered in one course will complement another.

American Board of Thoracic Surgery (ABTS). Since the NTSMS² (p. 31) has

shown that the number of surgeons recently certified by the ABTS equals the number of surgeons on the verge of retirement, it is reasonable for the immediate future to maintain the number of trainees in thoracic surgery at the present level. What oversupply of surgeons performing thoracic surgery that exists today may be found in the TS-2 and TS-4 groups, the noncertified thoracic surgeons. For the patient to receive the best surgical care, we must look to the ideal of increasing the surgery performed by the TS-1 group and gradually reducing that performed by the TS-2 and TS-4 groups (to be discussed later).

The fact that thoracic surgery is two-thirds general thoracic and one-third cardiovascular surgery (NTSMS,⁹ p. 11) is of importance to the ABTS, which must be involved with residency training as well as examination of the candidates for certification. The preponderance of cardiovascular surgery in the larger hospitals (NTSMS,⁹ p. 14) diminishes the opportunity for the teaching of general thoracic surgical techniques. Reportedly, a problem is developing in the teaching of general thoracic surgery in medical school and residency programs. If these training programs become more and more involved with cardiac surgery, undesirable consequences may develop:

1. A large number of residents trained primarily in cardiovascular techniques will be unable to find places to practice this type of surgery.

2. The teaching of general thoracic surgery will suffer.

3. Ultimately, the practice of noncardiac thoracic surgery may gradually transfer to general surgeons, who may be even less well prepared.

Thus the ABTS must be conversant with this problem so that the residency programs give proper training in general thoracic surgery.

The strength of the ABTS lies in the fact that members are chosen from representatives of five surgical societies (AATS, STS, ACS, ASA, and the AMA Surgical Section), so that there is a liaison with these

organizations. There is no question that the ABTS must continue to represent the practicing thoracic surgeons. It would lose this representation if the outside groups, which would like to direct *all* postgraduate education including specialty boards, gained control. This would be a mistake, for it would mean control by persons and groups that would not be as knowledgeable regarding the problems of thoracic surgery. The AATS and STS have donated \$55,000 over a 3 year period to study improvement of the ABTS examinations and training. The current high level of performance of the Board might be lost if the thoracic surgeons were no longer in control of the policies.

Cost of medical care. The cost of medicine has escalated with the introduction of new and expensive methods of treatment. Although the generally prevalent lay opinion is that the increase in medical fees has brought this about, such is not the case. Hospital and ancillary costs have risen three or four times faster than have doctor's fees and have outstripped the general rise in the cost of living. However, there is a limit on the amount of money that can be spent on health. In 1974 we are on the verge of having new national health plans whose added estimated costs vary from the 5.0 billion federal and 1 billion state dollars (Nixon plan) to the 44 billion dollars of the Kennedy plan. How to allocate the health dollar is a difficult problem which needs much more study by the medical profession, for the Congress and government cannot put valid priorities on the various parts of medical care. Are there priorities for various diseases? Can we put priorities on renal dialysis and organ transplants, etc.? Only the physician can determine the timing and the type of treatment that should be used to prolong life. He must always be certain that the quality of life in question justifies its prolongation. It is clear that at some stage every human being must have an opportunity to die with quiet dignity. Since there cannot be an inexhaustible amount of money spent on health, the medical profession must come up with some answers. It

is very clear that the physicians have to take greater interest in costs and priorities in the delivery of medical care.

The other area in medical costs in which the medical profession can perform a service for itself and the public is in the area of medical fees. The California Relative Value Study has proved successful in California. These schedules have also been used by insurance companies and other providers throughout the United States. With modification and consideration of local differences, they might be adopted for use on a national scale. Nevertheless, whatever system is agreed upon, it should be developed by the surgeons, in advance of the government.

Hospital staff appointments. Care of the thoracic surgical patient will be improved if the best-qualified surgeon is performing the surgery in the proper environment. The NTSMS indicates that the distribution of qualified thoracic surgeons (TS-1) throughout the country is quite good, so that these surgeons are widely available. The weakness in the delivery of thoracic surgery care in this country is found in the fact that from 25 to 45 per cent of thoracotomies are not performed by the best-trained surgeons. Twenty-six years have elapsed since the formation of the ABTS, and a new generation of qualified thoracic surgeons is now available. In the East and portions of the Midwest, Board certification and full-time commitment to thoracic surgery (TS-1) are mandatory for the privilege of performing any thoracic surgery in certain hospitals. This requirement should be expanded to include all hospitals.

Thus there is a great need for education of the medical staffs, trustees, and administrators of the hospitals and of the public. The standards for staff eligibility must be improved through an evolutionary process. New appointments to hospital staffs should meet these high standards. Through proper education, the receivers and providers of thoracic surgical care can be made to appreciate the validity of these concepts.

Hospitals for thoracic surgical patients.

The NTSMS⁹ (p. 10) showed that thoracic surgery was practiced in 50 per cent of the hospitals in this country, indicating a beginning hospital concentration of thoracic surgical cases. Currently, there is widespread duplication of equipment and staffs so that a greater concentration of thoracic surgical cases in completely equipped hospitals would result in more efficient and less costly care. Most thoracotomies are elective operations. Thus, with the ease of transportation, moving the patient to a specially equipped and staffed hospital is feasible. Although the proposed operation may appear to be simple, unforeseen complications may develop both during and after surgery to test the most experienced surgeon. Every known modality may have to be employed to save the patient. Like other TS-1 surgeons, I have been called to repair a major thoracic vessel torn inadvertently by a non-certified surgeon who was incapable of handling such an operative emergency. Under these circumstances, the patient is fortunate to have a TS-1 surgeon available. How often this happens in various hospitals is not known. However, no one can disagree that all patients are entitled to have the highest level of surgical care.

Federations or consortia¹⁰ of hospitals working together would ideally improve the practice of thoracic surgery by bringing the patient to the qualified surgeon at the best-equipped hospital for the solution of his particular problem. The establishment of such a triage system to concentrate patients in special hospitals will be very difficult to achieve, because there are deep-rooted prejudices and poor communication between hospitals. This is a very knotty problem with no easy solution, yet local pilot studies initiated by the two societies might show the way to go.

In his 1963 Presidential Address, Dr. Julian Johnson⁵ called the qualified thoracic surgeon "a surgeon and something more," pointing out that these surgeons were certified in both general and thoracic surgery. The NTSMS⁹ (p. 20) has vindicated this statement by showing that the

thoracic surgeon (TS-1) is willing to work harder than many other specialists by driving to multiple hospitals and putting in extra, long hours to carry out a full-time practice of thoracic surgery. His dedication demands our admiration, yet we will be negligent if we do not work to ensure that there is greater concentration of thoracic surgery cases.

Professional Standards Review Organization (PSRO)

Again Dr. Coller² showed prescience when he stated in 1953: "An honest and fearless scientific evaluation of the character of the professional work carried out in every hospital in this country should be done at stated intervals. Whether or not this will be done by organized medical groups or by the state will depend on the character and energy of organized medicine." Since Dr. Coller's prophetic statement, there has been a concerted effort in the better hospitals throughout the country to evaluate the quality of medical care.

The passage of Public Law HR-92-603, which makes peer review mandatory in *all* hospitals, was introduced primarily to reduce the cost of medicine and secondarily to monitor medical care. How much Congress was aware of existing peer review systems is not known, for the bill was hastily put together as a rider on other legislation. The medical profession fears that the program will be completely administered by the central government in Washington, which will not only make the rules but also enforce them. The talk of stiff fines to physicians who do not comply with the letter of the law further alienates the practicing physician. No bill has evoked more controversy in the medical profession.

Out of all the pros and cons, two major approaches emerge:

1. Try to repeal the law. This is now being attempted by several organizations. It is inferred in this effort that a substitute program would be developed by the medical profession.

However, as it appears unlikely that Public Law HR-92-603 will ever be repealed, only one other major alternative remains:

2. Develop a program that is directed by physicians and geared to the best practice of the medical profession within a broad interpretation of this law.

The question we should ask ourselves is this: "What can we do as thoracic surgeons?" There is no easy solution, yet we must be involved.

We should support immediate local testing of the PSRO in various test areas in the country to develop a program on the local level which will be workable on a national scale, which will be physician directed, and which will support and not stifle the practice of medicine. This must be started at once, with the cooperation of the ACS and other larger organizations.

We should be sure that qualified thoracic surgeons are on local boards and that they actively participate.

One thing appears very clear: The medical profession, i.e., the practicing physician, must direct any peer review system, not medical bureaucrats within or without the government.* If the medical profession does not do this, external forces will regiment medical care. Once medicine is totally regimented, other professions and segments of society may subsequently be placed under tight bureaucratic governmental control. Individual decisions as to where, how, and under what circumstances a man will work may be lost. If this comes to pass, it will be a telling erosion of the system of government which our forefathers fought so hard to establish and maintain.

Concluding remarks

In *The Three-Legged Stool: A Doctor's Dilemma*, published in 1890, the physician's role in society was described as a proper

*At the Los Angeles County-University of Southern California Medical Center, all administrative departmental Chiefs, including the Medical Director, are required to actively participate in the care of patients. This unique system has benefited patient care.

balancing of quality of patient care, teaching, and research.³ For over 80 years, these traditional objectives have been considered to encompass the aim of the practicing surgeon and surgical organizations as well. However, as I have endeavored to point out in this address, changes in attitudes regarding the practice of medicine now force the addition of a fourth leg to the stool: an increased social consciousness to make certain that we have adequate *delivery* of thoracic surgical care.

The development of thoracic surgery has been one of the most imaginative and explosive of any specialty. All but the youngest surgeons in this room have had a part of this exciting development. As thoracic surgeons, we must now use the same imagination to improve the delivery of the fruits of this explosive growth to the consumer, the patient. Now that open thoracotomies, closed and open-heart surgery, and organ transplants are a reality, we must not become "fat burghers" and rest on our laurels. Cancer, heart diseases, congenital malformations, and infections remain as clinical challenges. To these we must add the social challenges of the 1970's. The hallmark of the thoracic surgeon is his inventiveness and hard work. Let us use this same drive and resiliency in devising better types of treatment and better ways of delivery. Although this Presidential Address has been written for those attending the Fifty-fourth Annual Meeting of The American Association for Thoracic Surgery, it is my hope to reach a larger audience—not only the members of both societies, but also the TS-1 group of thoracic surgeons as defined by the Manpower report and all concerned providers and recipients of medical care. I also hope that other specialty surgical societies which have similar problems will find these ideas helpful.

The heritage that the pioneers of the AATS have given us is a great stimulus for us to carry on with the fourth leg of our now "four-legged stool" as a new objective. A course of action on pressing problems affecting the practice of thoracic surgery has

been outlined. I must admit that many of these problems seem insoluble now, but we must make a start at finding solutions. We need the cooperation and understanding of those who run our hospitals as well as of the providers of medical care—either governmental or private—and the public. Some of the suggestions have been made before and some are new. Some of the adverse factors facing the practice of thoracic surgery today, as revealed by the NTSMS, have been pointed out. If the best thoracic surgery is to be practiced, we must see that these deficiencies are corrected. The CCTS has been suggested as an instrument to help solve some of those problems. To do this, we must become involved in these newer social objectives. The purpose of this involvement is not to favor any one group of surgeons, for themselves, but to insist that the best-trained thoracic surgeons work in the best environment to improve patient care. It has been said that he who does not help solve a problem that involves him becomes a part of the problem. Perhaps, for too long, we have all been a part of the problem!

In 1974, when the people have had their faith in our government shaken by a series of appalling events, let us show that the medical profession stands firm and worthy of the trust that the people would like to have in those that serve them. To do this, we must not only practice the best quality of medicine possible, but we must also become involved in the social aspects of the delivery of medical care.

In closing, I should like to express my appreciation to The American Association for Thoracic Surgery for the privilege of serving as its representative on various boards, committees, and projects, the most rewarding of which has been the NTSMS. Finally, it has been my high honor to serve as your President. Our wise predecessors named this Association, The American Association for Thoracic Surgery. Let us all be sure in the 1970's that we do our utmost *for* thoracic surgery, and, in doing so, let it be our utmost *for* the patient.

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