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Presidential Address

Let us now praise famous men

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Election to the presidency of The American Association for Thoracic Surgery is the highest honor a thoracic surgeon can receive. It has been a privilege to serve as your President and to follow in the footsteps of the great thoracic surgeons who preceded me. Like many of the Association's Presidents, my scientific achievements occurred some years ago. Preceded in the presidency by the world's finest cardiac surgeon and to be followed by a surgeon equally renowned in the area of general thoracic surgery, it did not seem appropriate for me to attempt to present material of a scientific nature. Casting about among my other interests, neither photography, nor horticulture, nor enology seemed quite right. Some of my "friends" suggested that two more reels of *The Gunfighter* would be more than enough.

There is an organization with which I have been very closely associated during the past 13 years that may be of interest. It is the American Board of Thoracic Surgery. I am going to tell something about it and the people who have been so important in its creation, development, and eventual success.

As I began this task I wrote many Association members asking about their memories of the early days of the Board. The response was so great that I cannot begin to thank all of them personally. I must acknowledge, however, the previous work done on the history of the Board by the late Rollin Daniel, by Ted Beattie, by Hank Bahnson, and especially by Louise Sper. I also am deeply indebted to Herbert Maier, who had such a close personal relationship with Carl Eggers, the first Chairman of the Board of Thoracic Surgery.

The title of my address is "Let Us Now Praise Famous Men," Ecclesiasticus 44:1, from the Apocrypha of the New English Bible. This phrase also appears in "A School Song," a poem by Rudyard Kipling, and I think it appropriate to quote the first stanza:

> "Let us now praise famous men—"
> Men of little showing—
> For their work continueth,
> And their work continueth,
> Greater than their knowing.

Conception

Certification of thoracic surgeons was first discussed by The American Association for Thoracic Surgery in 1925 when a letter was received from J. Stewart Rodman, Secretary of the National Board of Medical Examiners. Two members of the Association were invited to meet with the National Board on May 6, 1925, to consider the value of establishing a method of certifying individuals in the various specialties of medicine. Ethan Flagg Butler represented the Association at the meeting. He indicated he was not authorized to speak for the Association, but he stated it was the consensus

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of the Association that certification was desirable. Dr. Butler later made a report to the Council but no action was taken.

Eleven years later in 1936 the subject arose again, and a special committee of The American Association for Thoracic Surgery was appointed to study the problem of the training of thoracic surgeons and their certification by a national board. The Committee consisted of John Alexander, Edward Archibald, Edward Churchill, Daniel Elkin, Leo Eloesser, Evarts Graham, and Carl Eggers, Chairman.

At the same time a questionnaire was sent to the membership asking about specialization in thoracic surgery, and the findings were reported to the Association in Dr. Eggers'[1] presidential address that year. He stated that opinion was overwhelmingly in favor of special training for thoracic surgeons, but that the decision about thoracic surgery becoming a separate specialty would be resolved as time went on. There were only 18 members of the Association who restricted their practice to thoracic surgery. In addition, the American Board of Surgery was just being formed and would not begin to function until 1937.

Also at the 1936 meeting, Evarts Graham[2] presented a paper on thoracic surgical training from the standpoint of a general surgeon, which was followed by a similar paper, given by John Alexander,[3] from a thoracic surgeon's point of view. It was the first important discussion of certification in thoracic surgery.

The following year the report of the Committee was accepted. The American Association for Thoracic Surgery recognized that the American Board of Surgery should properly control the training and certification of surgical specialists. The Association signified to the American Board of Surgery its willingness to cooperate with it if and when certification of thoracic surgeons seemed advisable. The report went on to emphasize the importance of training in general surgery for any specialty. It did *not* recommend to the Association the establishment of a certifying board for thoracic surgery.[4] Of the members of the Committee, only John Alexander was then in favor of establishing a board.[5]

The problem of certification in thoracic surgery remained dormant until the holocaust of World War II. It was this struggle that finally made thoracic surgery a separate specialty in the United States. The young thoracic surgeons in the European theater of operations wrote frequent letters to their mentors in this country complaining about the lack of recognition of thoracic surgery, particularly when specialties such as orthopedics and neurosurgery were well established.

The first Chest Surgery Center in the armed forces was established at Bizerte, Tunisia, during the North African campaign in 1943. Among the men responsible for this were Tom Burford, Lyman Brewer, and Paul Samson, who were members of the Second Auxiliary Surgical Group. Through their superb results, they and their associates clearly demonstrated that thoracic injuries were best treated by surgeons who understood resuscitation and cardiopulmonary physiology. These concepts were spread around the potbellied stoves needed to dispel the cold of the African nights. The intellectual climate was considerably improved by the use of a mixture of ethyl alcohol and grapefruit juice known then as "yaki docky."

At the close of World War II, Reeve Betts, another member of the Second Auxiliary Surgical Group, wrote J. Stewart Rodman, then Secretary of the American Board of Surgery, asking about the progress which had been made in recognizing thoracic surgery as a specialty. He considered it desirable to have a qualifying board for thoracic surgery. Dr. Rodman replied that it was his personal belief the American Board of Surgery would be sympathetic to the idea. About the same time Dr. Robert Shaw, who had been in the European theater of operations, wrote Dr. Cameron Haight expressing his concern about the lack of recognition of thoracic surgery as a specialty and the need for certification.

In 1945 and in the early part of 1946 there was an interesting exchange of letters among Dr. Graham, Dr. Alexander, and Dr. Eggers. The essence of this correspondence was that steps should be taken to organize a board. In 1945 the President of the Association, Claude Beck, reappointed the original Committee to bring a report to the next meeting. At this 1946 meeting the Committee made its report and the Association adopted a resolution recommending the formation of a Board of Thoracic Surgery.[6]

Another Committee was appointed in 1947 to continue discussions with the American Board of Surgery. Again Dr. Eggers chaired the Committee, which included I. A. Bigger, Brian Blades, Cameron Haight, Richard Meade, and Ethan Flagg Butler. Dr. Eggers requested that Herbert Maier be added to the Committee since he would be able to work closely with Dr. Eggers. The Committee from the Association met with a group from the American Board of Surgery in March, 1947, and recommended the formation of the "American Board of Thoracic Surgery."[7]

A plan or organization was finally agreed upon by the Association and the American Board of Surgery. Unfortunately, formation of the Board was not greeted enthusiastically by all members of the Association. Dr. Churchill wrote to Dr. Womack:

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> Of course, I really wish the boys would give up the idea of having this special Board. Their chief idea seems to be to stop some sanatorium superintendents from doing thoracoplasties, but a Board is not going to accomplish this. There are not enough people to do the thoracoplasties anyway. I do not see how anyone has the temerity to call himself a thoracic surgeon in these days. The chest is a busy place and the neurosurgeons are after the sympathetic trunk, the abdominal surgeons after the stomach and spleen; and fellows like Al Blalock and Bob Gross are playing with the heart. Just how any one fellow thinks he has the proficiency to do all these better than anyone else is more than I can see. A few years ago when we were concerned with collapse for tuberculosis and a few cases of cutting out of the lung, or part of the lung, it was a different matter.

It is interesting that some aspects of this dichotomy have persisted to the present day.

Birth and infancy

Nonetheless, the formation of the Board proceeded and the organizational meeting was held in Detroit, Michigan, on October 2, 1948. It is noteworthy that organization of the Board was stimulated by a competing proposal from the American College of Chest Physicians to establish an American Board of Diseases of the Chest.

Some of the reasons for the decisions that were made are not entirely clear. Why was the Board not named the American Board of Thoracic Surgery when this had been suggested by a number of individuals and appeared in some of the preliminary discussions? The reason was never clearly stated in any of the information available to me but was probably the result of the close relationship between the American Board of Surgery and the Board of Thoracic Surgery. It was originally intended that the Board of Thoracic Surgery be a subsidiary board. Everyone concerned with the formation of the Board accepted this concept until the legal profession was consulted. When it was pointed out that the American Board of Surgery would be responsible for all the action of the Board of Thoracic Surgery, including its debts, the Board was quickly made an affiliate of the American Board of Surgery with an independent existence.

In the final proposal the Board was to consist of eleven members, four from this Association, three from the American Surgical Association, two from the American College of Surgeons, and two from the surgical section of the American Medical Association.

The functions of the Board were (1) to select Founder members, (2) to conduct certifying examinations, (3) to improve opportunities for training, (4) to set up principles of education, and (5) to issue certificates.

Fig. 1. Dr. Carl Eggers.

Founder members would be chosen from active and senior members of the Association who had been certified by the American Board of Surgery. Other surgical members of the Association would be reviewed by the Board for inclusion in the Founders group. Surgeons who were not members of the Association but who were certified by the American Board of Surgery might become Founder members if they met the requirements of the Board.

A rotating term of membership by a stagger system was proposed. The term of membership on the Board was to be five years, although this was changed to six years in 1961. Each appointing group could choose its representatives subject to the approval of the Board of Thoracic Surgery and the American Board of Surgery, although approval by the American Board of Surgery was applied only to the original Board members. It has been suggested that the choice of the first Board members was greatly influenced if not dictated by the pioneering giants of the Association: Churchill, Lambert, O'Brien, Alexander, Graham, Ochsner, and others. The varying philosophies of these masters were reflected in their disciples.

The original requirements for certification included,

Fig. 2. Dr. Cameron Haight.

Fig. 3. Dr. William Tuttle.

first and foremost, certification by the American Board of Surgery and two years of training in thoracic surgery—training approved by the Board of Thoracic Surgery. The requirements for certification also included passing a written, oral, and practical examination.

Let me turn now to the men who made up that original Board. Carl Eggers (Fig. 1) was the natural choice for Chairman. He had been in the forefront of every discussion about certification and had chaired every committee in which the subject had been considered. Herbert Maier, who was so closely associated with Dr. Eggers, has described him as having a profound personal interest in the training of young surgeons. To Dr. Maier he exemplified the true physician. George Humphreys, one of the original Board members, pointed out the benign control he exercised over a group of very strongly opinionated "boys," control characterized by Teutonic discipline but softened by the tolerance of age. The extraordinary correspondence Dr. Eggers carried on at this time, particularly with Dr. Tuttle, is a remarkable demonstration of his organizational ability and his devotion to the Board.

Cameron Haight (Fig. 2), who taught me so much, was elected Vice-Chairman of the Board. He followed Dr. Eggers as Chairman when Dr. Eggers stepped down in 1952. William Tuttle (Fig. 3) was made Secretary-Treasurer and remained in that position until his death in 1962. More than any other Board member, he represented the young thoracic surgeons, particularly those who had served in the armed forces. Dr. Tuttle was a storm petrel but he provided energetic leadership as Secretary during the early years of the Board. Thomas Burford (Fig. 4), the most handsome member of the group, was a strong advocate of thoracic surgery as a separate specialty and insisted that general surgeons had no business doing occasional chest operations. Frank Berry (Fig. 5), on the other hand, was firm in his conviction that thoracic surgery was an extension of general surgery. Emile Holman (Fig. 6) was the only man on the Board who had the distinction of having been trained by Halsted. He was a courtly, erudite scholar for whom all the Board members had enormous respect. Brian Blades (Fig. 7), another believer in thoracic surgery as an extension of general surgery, made important contributions to this Association as Editor of its JOURNAL. George Humphreys (Fig. 8), to whom I am indebted for much of my information about the individual members of the first Board, considered himself a "self-taught" thoracic surgeon and was one of the early entrants into the emerging field of cardiac surgery. Richard Sweet (Fig. 9), that superb surgeon and scholar who contributed so much to sur-

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Fig. 4. Dr. Thomas Burford.

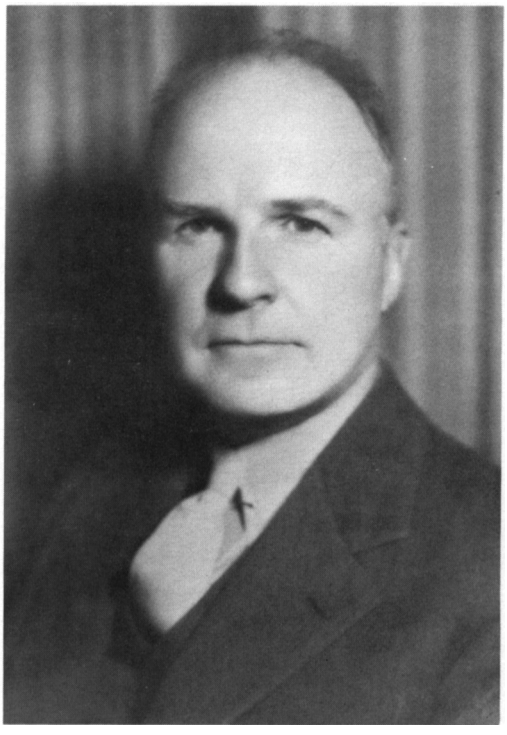

Fig. 5. Dr. Frank Berry.

gery of the esophagus and mediastinum, followed Dr. Haight as Chairman of the Board but remained in that position for just one year. Michael DeBakey (Fig. 10) was a special case. He was the youngest of the Board members, yet he was already very experienced in working with committees. "A legend in his own time," his decisive presence was invaluable. The final member of the original Board was William Adams (Fig. 11), who leaned toward the philosophy of restrictive specialization. He was a quiet, gentle, extremely capable person who made things work. Dr. Adams followed Dr. Sweet as Chairman of the Board and was the last of the original members to retire from the Board in 1957.

To emphasize just what leaders these men were, I would like to point out that nine of the original eleven Board members have been president of this Association. These men had strong personalities and were accustomed to having considerable authority in their own worlds. There were inevitable clashes during the Board meetings, principally about the relationship of thoracic surgery to general surgery. Even so, all of the Board members were imbued with the idea of strengthening the specialty of thoracic surgery and were devoted to the future of the Board.

For the organizational meeting of the Board, Dr. Eggers proposed an agenda that would completely overwhelm most of us today. Yet I am sure that this agenda was completed and in relatively short order.

Among the actions taken at this organizational meeting October 2, 1948, were the following:

1. The requirements for Founder members were defined.
2. An application blank was approved.
3. There was a discussion of the educational and training requirements for certification by examination.
4. A number of Founder members were approved.

In the early days the Board had no permanent home. Dr. Tuttle was able to offer space in the Herman Kiefer Hospital in Detroit, Michigan, but that did not become available until January, 1949. The Board maintained its offices there until 1970, when it moved to its present location. During October, 1948, a young mother began to work for Dr. Tuttle on Board affairs 1½ days a week. Much of the early business of the Board was conducted from a cardboard box file on the kitchen table of her home, while Dr. Tuttle held her two-year-old son on his knee to keep him out of trouble. At this time there was an exchange between Dr. Tuttle and Dr. Eggers emphasizing how important a good staff secretary was. Dr. Eggers hoped she would be intelligent, would take an interest in Board affairs, and

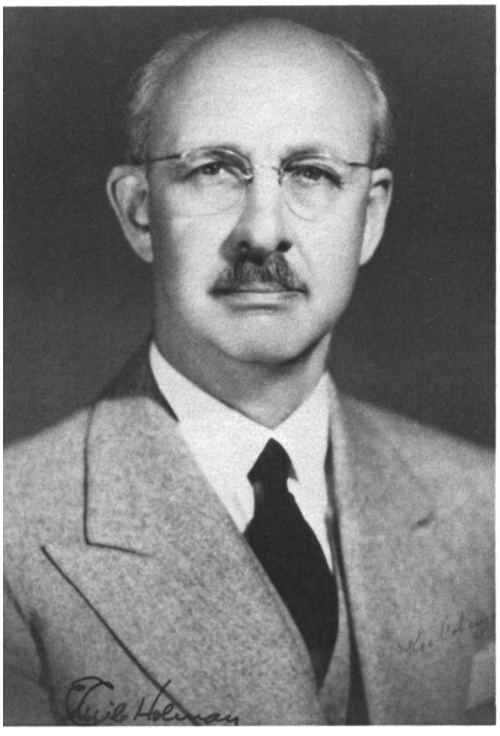

Fig. 6. Dr. Emile Holman.

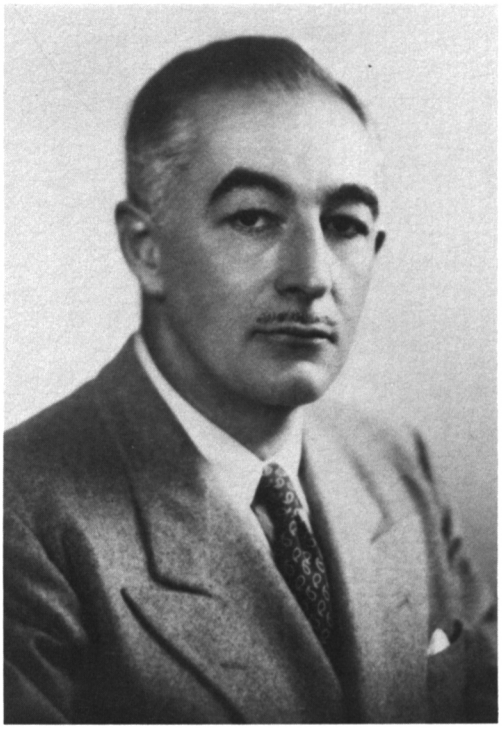

Fig. 7. Dr. Brian Blades.

would stay for a while. Without question, the most important thing Dr. Tuttle did during his entire term as Secretary was to hire this young woman, Mrs. Louise Sper. She has been everything Dr. Eggers wanted her to be and more.

The Board was immediately faced with the problem of money. Although Founder members were to be charged $50, the Board had no money and it needed furniture. This was purchased for $550 at a 30% discount, through one of Dr. Tuttle's patients. To meet its obligations the Board borrowed $1,000 from the Association, a sum it paid back within the year. Early in its experience it was realized that the Board would exist long after the original members had departed, and the custom was established of obtaining a photograph of each new member as he came on the Board.

A booklet of information was published in 1949. This contained all the pertinent information about the Board as well as requirements for certification. There was a section on training requirements. Dr. Herbert Maier has told me that the original version contained a reference to endoscopy, but this was later deleted.

While all of this was going on, a letter was received from a Chicago surgeon stating that "The American Board of Thoracic Surgery" had been incorporated by five Chicago surgeons December 22, 1948, in Washington, D. C. These five men were not certified by the American Board of Surgery and were not members of the Association. It was suggested that the Board of Thoracic Surgery could not legally function so long as the other Board was incorporated. Dr. Tuttle answered this letter in his own inimitable way and the group, whatever its intentions, disappeared into oblivion.

The first written examination given by the Board took place on August 1, 1949. It is fascinating to look at the breadth of the questions asked, questions which included anatomy, pathology, physiology, and surgical technique. Most interesting, in the light of later events, was the inclusion of a question on cardiac surgery.

The first oral examination was administered in Chicago, October 15, 1949. From the beginning prominent and promising thoracic surgeons were selected to aid in the oral examination, which often doubled as a testing ground for future Board membership. Not everything was sweetness and light during these early examinations. Dr. Berry was extremely upset about the handling of examination books. In a letter he wanted to know, "What the hell do you want me to do with the damn books?" The difference in education and training between examiner and examinee was not as great as it is today. During his oral examination Gordon Scannell reports that he had the temerity to point out to one of his examiners, whom he knew well, that he was attempting to smoke the wrong end of his filter-tip cigarette.

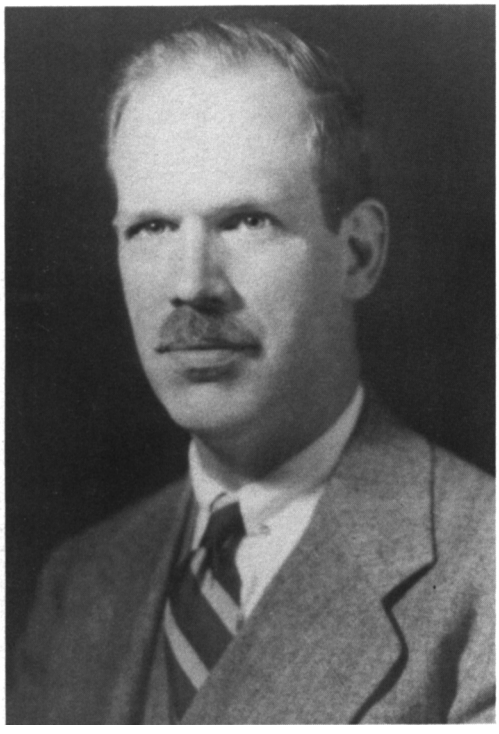

Fig. 8. Dr. George Humphreys.

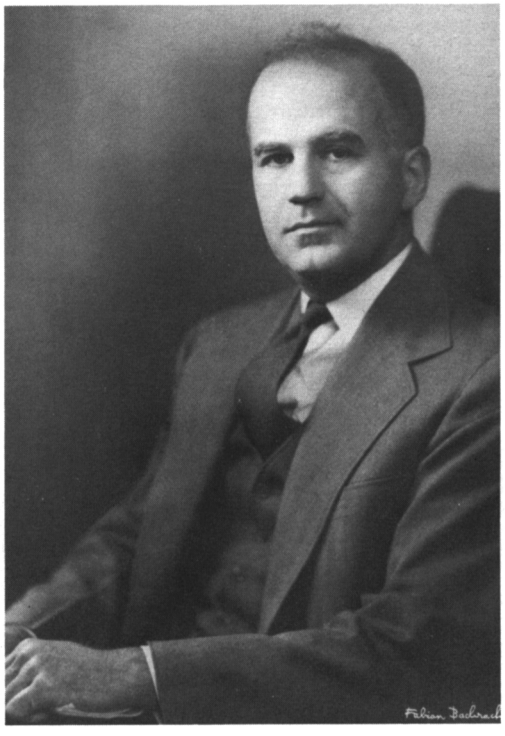

Fig. 9. Dr. Richard Sweet.

According to Dr. Scannell things then went steadily downhill.

Twenty-eight candidates took the first written examination and there were six failures. The first oral examination was given to 20 candidates. Of these, 15 passed and were issued certificates.

During these infant years the Board began to address the question of approving hospitals for the training of thoracic surgeons. The difficulty of serving both as a certifying body for candidates and as the approval mechanism for training was examined. A committee was appointed to investigate this in 1949, and a list of provisionally approved residencies was sent to the Council on Medical Education in October, 1950. Arrangements were made to begin inspection of these hospitals by representatives from the Council. However, the present tripartite Residency Review Committee was not organized until 1966.

The Board operated in these early years with a budget of a few thousand dollars. Expense accounts were minimal by today's inflationary standards. Dr. Tuttle was faced with a problem which has plagued every Secretary the Board has had. He could not get Board members to send in their expense accounts.

The Board was incorporated in the state of Michigan in 1950 to establish itself securely as a separate legal entity. In 1951, the Founders group was closed. Two hundred twenty-eight surgeons were selected as Founders and sent their certificates. Dr. Eggers had been issued the first certificate. The other Founders' certificates were numbered in the order of their election to membership in The American Association for Thoracic Surgery. Dr. Churchill received certificate number 174 instead of number 13, to which he was entitled, because he delayed so long in applying. Another man was officially added to the Founders group recently. Dr. Huang Chia-ssu, President of the Chinese Academy of Medical Sciences, was a guest of the Association in Boston last year. During the course of my research I found his original certificate, which he had never received because he had disappeared behind the Bamboo Curtain. I was finally able to deliver his certificate to him and increase the Founders group to a total of 229.

The infancy of the Board came to an end in 1952, when Dr. Eggers stepped down as Chairman. In one of his last letters to Dr. Tuttle he again emphasized the Board's responsibility to the public. This was typical of the man who had done so much for the Board and thoracic surgery.

The middle years

When Dr. Eggers retired, he felt the Board had been firmly established and that the time had arrived to begin

Fig. 10. Dr. Michael DeBakey.

Fig. 11. Dr. William Adams.

replacing the original members. During this year Julian Johnson and John Jones replaced Dr. Eggers and Dr. Holman. Julian Johnson became the first representative of the Board to the Examination Committee of the American Board of Surgery. This contact was strengthened in 1959, when Herbert Maier was appointed as the first formal representative to the American Board of Surgery.

Perhaps the most interesting part of this era was the Board's continuing dialogue about the position cardiac surgery should occupy in thoracic surgery and the responsibility the Board of Thoracic Surgery should assume for examination in this area.

The Board first formally discussed cardiac surgery in 1954. The following year a questionnaire was circulated requesting information about the amount of cardiac surgery being performed by residents in training programs. Tom Burford noted in a letter to John Jones that the volume was nowhere near as large as one would expect from the barroom chatter of some people. Nonetheless, there was recurrent mention of cardiac surgery as this area began to develop rapidly. Some of the men performing cardiac surgery suggested that this, too, should be a separate specialty. The Board reaffirmed its position in 1956 that there should be no special certification in cardiovascular surgery and that it should be included as a part of thoracic surgery. An ad hoc committee on vascular surgery reported in 1960 that there was no strong feeling for a separate board for vascular surgery. In 1962 the Board considered changing its name to include cardiovascular surgery but decided against this. The following year a statement was filed with the Advisory Board of Medical Specialties, later the American Board of Medical Specialties, establishing the priority of interest of the Board of Thoracic Surgery in cardiovascular surgery.

John Jones, a superb surgeon and fiery Welshman, became in 1957 the first Chairman of the Board who had not been one of the original members. He was followed in 1959 by Jim Clagett and then in two years by Herbert Maier, one of the real scholars in the field of thoracic surgery. During these middle years the Board continued to be deeply involved in the quality of training and the standards for certification. In 1954, it decided that no credit would be given for preceptor training. Certification requirements were strengthened in 1959 when four years of general surgery instead of three years were required. By 1963 the so-called "mixed" residencies had become unacceptable to the Board because the quality of training in these programs could not be satisfactorily monitored.

On only one occasion during the Board's long association with the American Board of Surgery was there ever serious consideration given to severing contact

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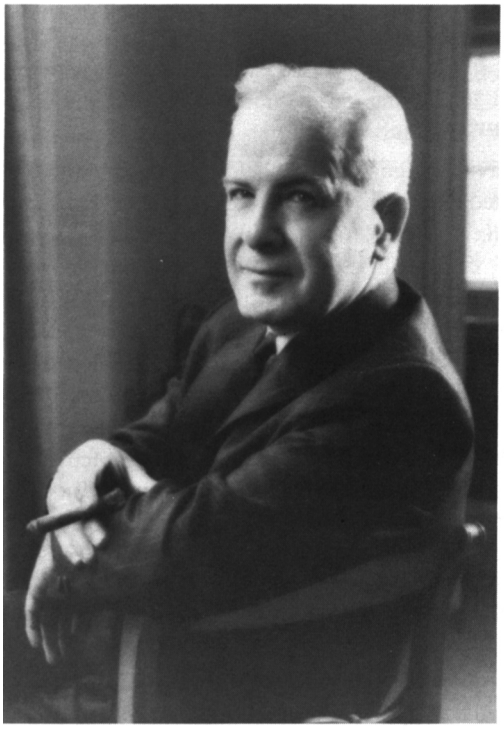

Fig. 12. Dr. O. Theron Clagett.

Fig. 13. Dr. Rollin Daniel.

with it. Despite grumbling from thoracic Board members about being considered second-class citizens, the two Boards remained closely associated. Following this discussion in 1957, the Board of Thoracic Surgery reaffirmed its strong ties to the American Board of Surgery and these ties have continued uninterrupted to the present time.

The Board decided in 1955 that it would no longer administer a written examination and would accept the passage of Part 1 of the American Board of Surgery examination in lieu of the written examination. The oral examination continued to be relatively unstructured, and examiners were allowed a considerable amount of leeway in the questions asked. The Board had moved away from having two examiners with the candidate together and had adopted the policy of using four separate examiners during the oral examination.

Examiners frequently brought difficult roentgenograms to the examination and used them to test the mettle of the candidates during their rite of passage. Julian Johnson writes that he brought a roentgenogram of a little old lady whose waist had been corseted down over a long period of time until it was the size of her neck. He turned this roentgenogram upside down to the complete befuddlement of all candidates he examined, with the exception of Timothy Takaro.

As time went on, the x-ray portion of the examination was standardized and each examiner used the same set of films from a file developed by Dr. Tuttle. This was transported to the examinations by Dr. David Dugan in a box made mobile by an attached skateboard, much to the amusement of airline personnel.

Board examinations were followed by long appraisal sessions in which candidates' grades were discussed by the examiners. The final grade was sometimes influenced by the strength with which an examiner held to his opinion of the candidate.

One of the few special meetings of the Board was called in 1966 to consider the education of thoracic surgeons, the training requirements for their certification, and the examination that was being given them. This set off a series of events which resulted in the present examination system.

Dr. Clagett (Fig. 12) was selected as Secretary in 1963, following Dr. Tuttle's death. He was an inspiring leader who held the affection and esteem of everyone. During these years a number of other important events occurred. In 1966, two representatives from the Society of Thoracic Surgeons, the new and vigorous thoracic group, were appointed to the Board and in 1969 two more representatives were added, increasing the total number of Board members to fifteen. By 1968, the Board had decided that a senior year of residency training would be required for all candidates beginning their

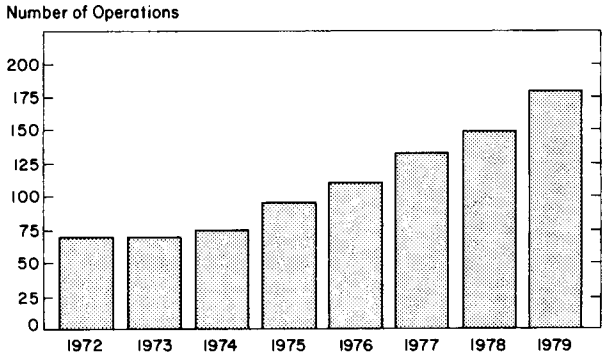

Fig. 14. Change in candidate experience over a six year period.

training in 1969. This was in keeping with the concept of increasing, graded responsibility during the thoracic residency.

At this time the Board made an attempt to investigate alternate methods of training thoracic surgeons. Some Board members believed that two years of training were not enough in the light of the complexity of cardiac operations. In an effort to increase the amount of time spent in thoracic surgery, yet not prolong the entire training period, a trial training program was proposed consisting of three years of general surgery followed by three years of thoracic surgery. The Board adopted this concept in 1969. On completion of such a program, with the approval of the American Board of Surgery, the candidate would be required to pass Part 1 of the general surgery examination followed by the thoracic examination.

There was considerable enthusiasm for these training programs, but few were actually instituted. As a supporter of the programs, I had hoped that they would succeed. I concluded, somewhat sadly, that the programs could produce a well-trained thoracic surgeon, but that he probably was no better than residents who had completed training in general surgery. Internal problems, interest in peripheral vascular surgery, and a desire for certification by the American Board of Surgery limited wide acceptance of the trial training programs, and they finally were abandoned in 1976.

John Strieder, pioneer thoracic surgeon and delightful wit, was made Board Chairman in 1963, to be followed by Rollin Daniel in 1965. The next Chairman, Edward Beattie, introduced the Board to the complicated political superstructure being erected above the specialty boards. David Dugan was elected Chairman two years later. When Dr. Clagett resigned in 1968, Dr. Daniel (Fig. 13) became Secretary of the Board and held the position until 1973. With his gentle Southern manner, absolute fairness, complete lack of animosity, and devotion to the Board, Rollin Daniel was an excellent choice for Secretary.

Maturity

David Dugan was the most charismatic, warmhearted Chairman the Board ever elected; however during his chairmanship there was increased dissatisfaction with candidate experience. Apprehension was expressed about the high failure rate of candidates with limited operative experience. Under the leadership of your Vice-President, Donald Paulson, then Chairman of the Examination Committee, a complete re-evaluation of the examination procedures was undertaken. Within two years the National Board of Medical Examiners had been engaged to help prepare an objective written examination and to aid in the restructuring of the oral examination. Because there was considerable expense involved in this program, The American Association for Thoracic Surgery and the Society of Thoracic Surgeons were asked to provide yearly financial support. This support lasted from 1970 to 1978. Despite the support, it has been necessary to raise candidate fees steadily since the beginnings of the Board, a source of considerable worry to all of us.

At this time, Myron Wheat undertook an extensive evaluation of candidate experience. In 1971, when Dr. Wheat presented his report, it was proposed that each candidate be required to submit at least 100 major operations in which the candidate was surgeon. Because the experience of candidates was in general far below this number, the Board felt it would impose an intolerable burden on them. Instead, James Maloney suggested that records of candidates whose operative experience fell below the thirtieth percentile be examined by the Credentials Committee of the Board and a judgment be made about accepting the candidate for examination.

Thirty percent of the candidates in 1972 submitted an operative experience of 71 major operations or less (Fig. 14). However, there has been improvement in candidate experience in the past six years. Admittedly, the tremendous increase in coronary artery surgery has had a major impact on this figure, but I believe this improved experience is in large part the result of the Board's demand that each candidate have a satisfactory operative experience.

A series of decisions was made during these years, including the thirtieth percentile ruling, each of which resulted in improved training. In 1974 the Board determined that inadequate experience in one area of thoracic surgery would result in the candidate's record

being reviewed by the Credentials Committee. If the Committee concluded that the experience in the particular area was inadequate, the candidate would not be accepted. Finally, it was decided that candidates from unapproved programs who started their training in 1976 and thereafter would no longer be accepted. The resulting uproar, particularly in the Council of the Association, has finally quieted down, but this last decision, more than anything else, has served to improve the quality of thoracic training.

Entrance into the modern era began while David Dugan was Chairman but accelerated under the chairmanship of Donald Paulson. Dr. Paulson had a particularly fractious group of Board members, of whom I was one, and his term of office was symbolized in the minds of most of us by his means of gaining the attention of the group. The sound of the "cricket" is indelibly engraved in my memory.

As this modern era began, the American Board of Medical Specialties recommended that the Board of Thoracic Surgery become a primary board. The Board then applied for designation as a primary board with the consent of the American Board of Surgery, and this was approved in 1971. There was a great deal of discussion about the name of the Board, and some of us believed strongly that the word "cardiovascular" should be included. The committee appointed to consider this problem settled for the name the "American Board of Thoracic Surgery" but also changed the certificate to state that the candidate was qualified in both thoracic and cardiac surgery. This last effort has certainly resolved the question of the Board's responsibility for cardiac surgery.

With the help of the National Board of Medical Examiners, the first multiple choice, objective, written examination was given in 1972. At the examination a booklet was stolen and subsequently returned by mail from San Francisco. The Board members proved to be quick learners and no other thefts have occurred. Formal protocols for the oral examination were developed so that each candidate was examined on the same material. The appraisal meetings, which had generated so much discussion and heat in the past, were discontinued the following year.

The Board was also concerned about candidates' rights. An appeals mechanism was established for the candidate who was not accepted for examination and for the candidate who failed the oral portion of the examination.

Fred Kittle succeeded Dr. Paulson as Chairman. With his scholar's knowledge and gentle humor he made Board meetings a delight. He was followed by Paul Adkins and Tom Ferguson, two of the finest people with whom it has ever been my privilege and pleasure to work. Their contributions to thoracic surgery are immeasurable. In the struggle to improve the quality of thoracic training, increased efforts were made to communicate with the directors of thoracic surgery training programs. The directors had organized a breakfast meeting group. This quickly became a much more important force under the leadership of such men as Hassan Najafi. To recognize the importance of the group, in 1975 the President of the Thoracic Surgery Director's Association was invited to attend Board meetings. Later it was decided that all guest examiners would be chosen from the directors of thoracic programs on a rotating basis.

The Board obviously did not exist in a vacuum; it was influenced by changes in the world around it. Recertification had begun to be an important subject at meetings of the American Board of Medical Specialties. The first Board committee on recertification was appointed in 1974, and the Board, after careful and prolonged deliberation, decided that recertification would be required of all diplomates who received their certificates in 1976 and thereafter.

Recertification was to include continuing medical education, a practice review, and an examination by the Board. This decision led to the establishment of a combined committee, including representatives from the Association, the Society of Thoracic Surgeons, and the College, as well as the Board, to consider the problem of continuing medical education and practice review. The Board would prepare and administer any examination given for recertification and would be responsible for the certificate issued. The diplomate could choose either general thoracic surgery or cardiac surgery or both areas in which to achieve recertification.

By 1980 the Board had returned to an earlier format in which it was necessary to pass the written examination before being allowed to take the oral examination. At this time 3,768 diplomates have been certified either as Founders or by examination, and Dr. Huang makes one more.

The future

There are problems still facing the American Board of Thoracic Surgery and its present superb Chairman, Robert Ellison. One of these problems is the method of determining continuing competence. Another is deciding how many thoracic surgeons are necessary. There is an ongoing controversy about peripheral vascular surgery and its place in thoracic training programs. What

training should be required of the thoracic surgeon interested in the surgery of congenital heart disease? The federal government will obviously have an increasing impact on the future of thoracic surgery as it will on all other areas of medicine. The Board must improve the ability of the examinations it gives to measure whether the individual who passes the examination is competent and the one who fails is necessarily incompetent.

The Board has two invaluable assets as it deals with these problems. First and foremost is the skill and devotion of Louise Sper. The second major asset is the dedication of every Board member to the goals and ideals so clearly enunciated by that first Board.

I have attempted to trace the history of the American Board of Thoracic Surgery and to point out its great debt to The American Association for Thoracic Surgery by emphasizing the strengths of the men who have made up the Board. They are the best and brightest thoracic surgery has to offer. Nothing underlines this more clearly than the fact that 23 of the Board members have been President of this Association. In his marvelously amusing presidential address in 1972, John Strieder[8] has Aesculapius say in an awed voice, "They all do this. They must be gods." A position paper prepared by the Board summarizes this very clearly: "The process of training, examination, and certification of a thoracic surgeon has evolved . . . over the past three decades and has repeatedly proved to provide a satisfactory measure of competency in thoracic surgery. It is an achievement of which all thoracic surgeons can feel justly proud."[9]

Let me conclude by paraphrasing the last stanza of "A School Song" by Kipling:

> Bless and praise we famous men [and women] —
> Men of little showing!
> For their work continueth,
> And their work continueth,
> Broad and deep continueth,
> Great beyond their knowing!

The material for my address was culled primarily from the extensive correspondence files of the American Board of Thoracic Surgery. Material from the American Board of Medical Specialties, the American Board of Surgery, the National Board of Medical Examiners, and The American Association for Thoracic Surgery was also reviewed.

Most important, however, was the personal correspondence from members of the Association who had information about the beginnings of the Board. In addition to those individuals mentioned in the address, I wish to thank the following Association members personally: Reeve Betts, Lyman A. Brewer III, O. Theron Clagett, David Dugan, Julian Johnson, Hiram Langston, William Lees, Herbert Maier, and Paul Samson.

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