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PRESIDENTIAL ADDRESS

TWENTY-FIVE YEARS OF EXCELLENCE: THE LEGACY AND THE CHALLENGE

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The legacy

The *legacy* for the present Western Thoracic Surgical Association began in the mid-1960s in Oakland, California. A group of thoracic surgeons from the East Bay and San Francisco began conducting monthly meetings in the Alameda Contra Costa County Medical Society offices to train residents in the delivery of scientific papers. The group, originated by Dr Kenneth Hardy, was known as the Bay Area Thoracic Surgical Society. Dr Hardy was subsequently killed in an accident and the meetings were suspended.

In 1973, the records and bank account of the society, totaling \$500, were turned over to Dr David Dugan, and a meeting of the members was organized to determine the future of the society. These members met at Samuel Merritt Hospital in Oakland on November 27, 1973. A

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THE SAMSON THORACIC SURGICAL SOCIETY
WESTERN NORTH AMERICA

Fig 1. The seal and letterhead of The Samson Thoracic Surgical Society.

decision was made to continue the society and to include chest surgeons from all of Northern California. The name of the society was changed to the Northern California Thoracic Surgical Society and officers were elected: Dr David Dugan, president; Dr Arthur Thomas, secretary/treasurer; and Dr Buford Burch of Martinez, California, recorder. Dr Thomas was given the assignment of writing the by-laws and constitution for the society.

On December 11, 1973, the executive committee, consisting of Drs Dugan, Thomas, and Burch, met again at Samuel Merritt Hospital. At this meeting a decision was made to change the name of the society to The Samson Thoracic Surgical Society, this decision being made unilaterally and without the knowledge or permission of Dr Paul Samson. A decision was also made to extend membership to thoracic surgeons throughout all of California, and an inaugural dinner of the society was organized.

Invitations were sent to 98 thoracic surgeons in California on new stationery bearing the red and white



Fig 2. Paul C. Samson, MD (1905-1982).

seal of the society, the same seal anchoring the letterhead of our stationery today (Fig 1). To everyone's surprise, 91 of 98 invitees accepted membership.

Notification of establishment of the society was finally sent to Dr Samson on May 7, 1974, informing him of the organization of this society that bore his name. He received this notification, on stationery also bearing his name and logo, while vacationing in Mexico and accepted this honor, noting he was "deeply touched and completely flabbergasted."

The inaugural dinner was a gala affair held on June 8, 1974, at the Mark Hopkins Hotel in San Francisco and attended by all 91 charter members of the society, as well as invited guests. The guest speaker was Dr Lyman Brewer, a lifelong friend and colleague of Dr Samson, whose address was titled, "Thoracic Surgery Comes to Alta, California."^{1,2}

Shortly thereafter, the executive committee of the society met in San Francisco. The committee decided at that time to extend the scope of membership in the society to thoracic surgeons in the thirteen Western states and the two Western Canadian provinces. Doing so added an additional 124 members, bringing total membership to 215.

In November 1974, arrangements were made for the

first annual meeting. At the November meeting, Dr Brian Blades, then-Editor of *The Journal of Thoracic and Cardiovascular Surgery*, designated the Journal as the official organ of The Samson Thoracic Surgical Society. This designation appeared on the cover and an acceptance editorial and a list of members appeared in the contents of the Journal in January 1975. This material was published before the first meeting of the society. A special prize and honorarium was also offered to the resident submitting the best abstract, that abstract also to be presented at the annual meeting.

Dr Paul Samson was born in Emporia, Kansas, in 1905 (Fig 2). He acquired the nickname of "Buck" from his huge size and physical prowess (standing 6 feet 6 inches) and his widely known competitiveness. He graduated from the University of Michigan, where he was a world-class swimmer and member of the United States water polo team at the 1928 Olympics in Amsterdam.

After graduation from medical school at the University of Michigan, he served a general surgical residency at Northwestern University in Chicago. He returned to Michigan for his thoracic surgical training under the tutelage of Dr John Alexander, a pioneer in the surgical treatment of tuberculosis. He completed his residency in 1935.

During World War II, he was actively engaged in the surgical treatment of casualties in both the North African and European theaters, performing the first pneumonectomy in the foreign field. He coauthored, with Dr Lyman Brewer, the text *Forward Surgery of the Severely Injured*, documenting the treatment of more than 10,000 battle casualties.

After the war, Dr Samson returned to Oakland and began his practice of thoracic surgery, specializing in the surgical treatment of tuberculosis and empyema. He achieved numerous honors during his illustrious career, including president of The American Association for Thoracic Surgery, the first president of The Society of Thoracic Surgeons, and membership on both the American Board of Thoracic Surgery and the Board of Regents of the American College of Surgeons.

The first meeting of The Samson Thoracic Surgical Society was held May 28 to 30, 1975, at the Biltmore Hotel in Santa Barbara, California. The first paper presented at that meeting, "Prosthetic Replacement of the Aortic Arch," was delivered by Dr Randall Griep.³ Dr William Brody, then at the National Institutes of Health and current president of the Johns Hopkins University, was the first resident prize essayist, presenting a paper titled, "Long-Term Morphologic and Hemodynamic Evaluation of the Left Ventricle After Cardiopulmonary

Bypass: A Comparison of Normothermic Anoxic Arrest, Coronary Artery Perfusion, and Profound Topical Cardiac Hypothermia.”⁴ We are pleased to have Dr Brody at this meeting, representing all of the previous resident essayists.

In his book *The Prophet*, Kahlil Gibran⁵ talks about giving, stating, “It is when you give of yourself that you truly give.” The creation of The Samson Thoracic Surgical Society was truly a labor of love of a few giving individuals, specifically, David Dugan and Arthur Thomas, that rapidly spread throughout the society. Dr Dugan, in his presidential address before the society in 1977, stated, “The Samson Thoracic Surgical Society is an infant, delivered spontaneously and with a future of its own making.”⁶

Since its inception, and using this first meeting as a template, the society, later to become The Western Thoracic Surgical Association, has grown from its regional roots to become a society of national and international prowess. We now celebrate its silver anniversary, which provides us an opportunity to cite historic landmarks reached along the way, reflect on the words and achievements of those providing leadership in the past, and to use their accomplishments as teaching tools as we face ever-mounting challenges in cardiac and thoracic surgery entering the new millennium.

As stated earlier, the name of the society was changed shortly after Dr Samson’s death in 1982. Dr David Dugan recalled,

Later, when it became obvious that our STSS, in order to be recognized by the ACS and listed by the American College of Surgeons, had to change the name because they didn’t accept name societies. One day, Paul and I were going over to the San Francisco Surgical, and I was driving. I said to him, “You know, Paul, we are going to have to change the name of our society.” He replied, “Never, not as long as I live you won’t change it.” I said, “Okay, 20 minutes after you die, we’re changing it.” He said, “Okay, that’s fine.” Actually, that is what happened.*

At the annual business meeting in June 1983, a unanimous vote by the membership mandated a change of the name of The Samson Thoracic Surgical Society to The Western Thoracic Surgical Association. This was officially accomplished in October 1984.

Members of the WTSA have served in leadership capacities in our society, as well as in national leadership roles. Five members of the WTSA have served as president of The American Association for Thoracic Surgery, and nine honorary members have served in that capacity. Ten past presidents and one president

elect of The Society of Thoracic Surgeons have come from the WTSA, and another four are honorary members of our society.

The Samson Resident Prize Essay Award was initiated at the first meeting in Santa Barbara and has been a mainstay of each annual meeting since that time. Some of these papers, such as that delivered by Dr David E. Hansen from Stanford in 1986, titled “Relative Contributions of the Anterior and Posterior Mitral Chordae Tendineae to Global Left Ventricular Systolic Function,” have made monumental advances in understanding the pathophysiology of specific cardiac and thoracic disorders and altering the treatment regimen based on this new knowledge.⁷

We have enjoyed the leadership of fine presidents, beginning with Dr David Dugan and extending through my predecessor, Dr Win Wells. Their words of wisdom, inscribed in their presidential addresses, have provided us with historical, clinical, and philosophical treatises pertaining to our specialty, citing where we have been, where we are, and where we should be in the future.

Dr Dugan chronicled the origin of our organization in his initial presidential address, titled, “The Birth of a Society.” He stated, “This has started what we hope will be a fine surgical society... Now the decisions for furtherance of this society will be up to the organization.”⁶

Dr John Connolly addressed the largest gathering of the society in Coronado in 1978, outlining “The History of Coronary Artery Surgery.” In this presentation, he cited my mentor, Dr David C. Sabiston, Jr, for his early pioneering work in coronary artery bypass.⁸

My friend and colleague, Dr Harold Liddle, presented a beautiful address on the “Perspectives in Coronary Artery Surgery,” outlining an extensive and thorough evaluation of patients having undergone coronary artery bypass.⁹

Dr Burt Meyer gave an overview of 30 years of thoracic surgery, predicting revolutionary changes in surgical technology. I especially enjoyed the last paragraph of his manuscript, which states: “I wanted to recognize the contributions of those physicians who were pioneers in this surgical specialty by appending a thorough reference list. However, after poring over the journals, I realize that their place in history has been long established. They have been listed in the bibliographies of many manuscripts more distinguished than this one.”¹⁰

I believe the most profound address was delivered by Dr Robert Jamplis in 1983 at the meeting in Colorado Springs. In his treatise, titled “From Whence and

*From David Dugan Recollects.

Whither To," he stated: "In my opinion, a revolution is occurring in health care in the United States, and the barn is burning. It will profoundly affect the lives of all doctors of medicine and will not exempt thoracic surgeons in particular." He goes on to talk about factors contributing to this problem, citing advances in medical technology, the "graying of America" due to people living longer, and defensive medicine.¹¹

Dr Jamplis goes on to state: "Our greatest failure has been our devotion to the status quo. No matter how nostalgic we feel about it, it is no longer a viable entity. I truly believe we now have only one more chance to lead the revolution or be consumed by it—take charge or be taken over." These are certainly words of wisdom and accurate predictions of subsequent events that have transpired.

We have been taught the experimental basis for cardiac transplantation by the world's leading pioneer in the field. We have been educated on the intricacies of peer review, the pitfalls in medical education and residency training, the renaissance in thoracic surgery, and the anatomy and pathophysiology of the mitral valve by experts in their respective fields. We have been warned of the assault on our specialty from outside forces, and the decade by decade changes that have occurred in cardiothoracic surgery have been chronicled. We have even had a chance to dream: "If I Were King."¹²

By those who created and have led the society for the past quarter of a century, we have been educated, counseled, warned, and taught by example the tools we must master if we are to excel in the practice of cardiothoracic surgery.

The challenge

Our *challenge* in entering the new millennium is to use these teachings and to overcome the many obstacles we now face and will encounter in the future. Sir Winston Churchill said, "The farther backward you can look, the farther forward you are likely to see."¹³

The basic philosophy and foundation of medical care has not changed over these many years. In a valedictory address given before the University of Pennsylvania Medical School graduating class in 1889, Sir William Osler related his deep reverence for his profession and the physician-patient relationship and cited three great lessons of life:

Learn to consume your own smoke with an extra draught of hard work, so that those about you may not be annoyed with the dust and dirt of your complaints... We are not here to get all we can out of life for ourselves, but to try to make the lives of others happier... The practice of medicine is an art, not a trade: a calling not a business:

a calling in which your heart will be used equally with your head... The third lesson you may find the hardest of all—that the law of higher life is only fulfilled by love, i.e. charity.*

I believe we still consider the practice of medicine, including surgery, to be a privilege to all of us. We have a profession to which we are dedicated, which carries with it the responsibility of care of our fellowman. Although this philosophical foundation has remained stable, the delivery of the final product has been ever changing. In his presidential address to this society in 1991, Dr Richard Anderson talked of "Change and Thoracic Surgery," citing the 1960s as a decade of innovation, the 1970s as a decade of clinical expansion, and the 1980s as a decade of increasing restraints.¹⁴

I would append Dr Anderson's treatise, adding the 1990s as a decade of dichotomy. Never before have we been given such elaborate and highly technical diagnostic and therapeutic modalities, while being squeezed ever tighter by those who pay the bills. Compounding this, we are faced with an ever aging population. The graying of America, referred to by Dr Jamplis, has become even more pronounced.

We are being bombarded by new technical advances at an unprecedented explosive rate. We now have the options of MIDCAB, OPCAB, Port-Access, and various other minimally invasive surgical approaches. Aortic and mitral homografts, aortic root homografts, and stentless heterografts are now available. Transmyocardial revascularization and gene therapy as means of stimulating angiogenesis are here or on the horizon. Mechanical cardiac assist devices using right, left, or biventricular support, as well as totally implantable hearts, are now on the shelves of most major medical centers. Surgical treatment of electrophysiologic pathology, such as use of the maze procedure in patients with symptomatic atrial fibrillation, now has clinical applicability.

Our cardiology colleagues are also experiencing tremendous technical advances in interventional techniques—multivessel angioplastic procedures, rotational atherectomy, and the use of stents containing as many additives as ingredients we have proposed for cardioplegic solutions over the years. Percutaneous valvuloplasty, percutaneous myocardial revascularization, gene therapy, ablative procedures, and implantable defibrillators are here or on their way.

The selection of surgical candidates from the total

*From Dugan DJ. Aequanimitas revisited. Am J Surg 1982;144:3-7. Published with the permission of Excerpta Medica.

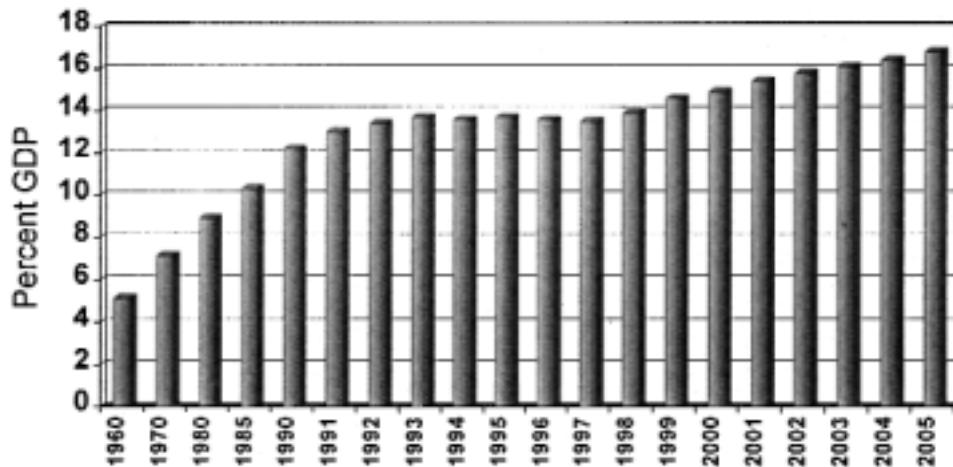


Fig 3. Percent of the gross domestic product (*GDP*) spent on health care in the United States.

patient pool has become ever more challenging. The number of patients potentially eligible for use of this vast new technology is expanding because of the ever aging patient population. Further compounding the dilemma are those patients having had at least one previous cardiothoracic surgical procedure; those with impaired ventricular function; end-organ disease, such as renal, respiratory, and/or hepatic insufficiency; cerebrovascular and peripheral vascular insufficiency; and diabetes mellitus. Our decision making must be tempered by Dr Alfred Blalock's observation years ago: "The fact that a patient could die does not necessarily mean he should be operated upon."¹⁵

We are looked on as the last bastion of hope for treatment of these patients, while, at the same time, we are being scrutinized as never before by survival statistics, published and available to the public in some states, which have questionable risk stratification modifications.

Obviously, this new and advanced technology, as impressive and, in many instances, beneficial as it may be, carries with it an enormous price tag. Many of the new technologies are and will be shown to be cost effective, as well as beneficial to the patient, and should be retained. Others will not be beneficial and should be discarded.

In his same presidential address, Dr Robert Jamplis stated:

When we allowed our profession to become the number one industry in the United States (over \$300 billion annually, dwarfing even the budget for the Department of Defense), when we allowed ourselves to become more than 10% of the gross national product, and when we were complacent in allowing third-party

payers to escalate health care costs to astronomical heights, we inadvertently but most definitely set the stage for the revolution—a revolution that will greatly affect the public, our patients, as well.*

The percent of the gross domestic product spent on health care in the United States in 1960 was 5.1%. This has continuously escalated to 13.9% in 1998 and is projected to rise to 16.8% by the year 2005¹⁶ (Fig 3). An even more astonishing fact is that pharmaceutical costs, as a percent of total medical expense, have risen from 7.3% in 1984 to 18% in 1998.¹⁷ The average cost nationwide of coronary artery bypass in 1991 was \$38,414 and in 1997, only six years later, it had risen to \$50,420.¹⁸

Concomitantly, we are faced by ever compressing payment from third-party managed care providers, who have taken over the decision making in reimbursement for health care delivery. Ten years ago, in areas of high managed care penetration, their reimbursement for hospitals was 15% above total cost of a specific procedure. This surplus was used for education, research, payment of bad debts, and money to shareholders in for-profit companies. Now this reimbursement is 2% below total cost. The tail is wagging the dog because we, as cardiothoracic surgeons, have shown little ability, care, or concern to be selective in adopting and implementing from the vast cupboard of new technology those procedures and techniques that will be cost effective and beneficial to the patient.

We and our cardiology colleagues have shown no

*From Jamplis RW. From whence and whither to. *J Thorac Cardiovasc Surg* 1984;87:1-6.

Cardiovascular Clinical Program

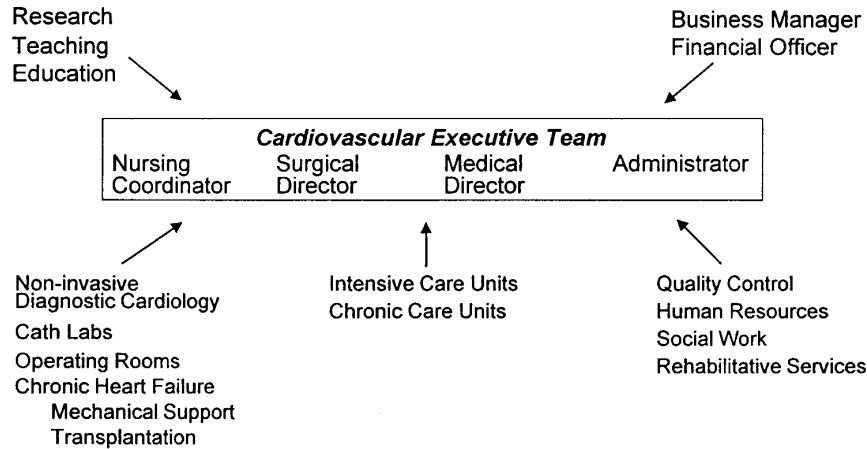


Fig 4. Cardiovascular services health care network.

interest in sitting down together to mutually solve this problem. We should have learned from our experiences in the 1980s that we must take a more active role in the control of our destiny. The cardiologists are presently experiencing their “golden years.” They must be convinced by us that this honeymoon will soon end and that only through cooperative efforts will it be possible to regain control of health care delivery in cardiovascular disease. The ultimate benefactor would be, and should be, our patients. In my opinion, the present situation is doomed to failure. Santayana is quoted as saying, “Those who cannot remember the past are condemned to repeat it.” Bob Jamplis’s barn has now burned. It has been replaced by a smaller barn that is now on fire, the arsonists being the infusion of this new technology compounded by shrinkage in payments from third-party carriers and our inability to scrutinize and be selective.

Our avenue of escape from this dilemma lies in *cooperation* rather than competition. We must again put the *patient* at the apex of our treatment strategy plan. This can only be done through a cooperative effort of cardiothoracic surgeons and cardiologists determining what is right for the patient, assessing such factors as risk, time in the hospital, time away from work, cosmetic result, pain, long-term benefit, and *cost*.

I believe this can best be achieved through a horizontal network of health care delivery for cardiovascular services, consisting of surgeons, cardiologists, nurses, and administrators, networking with other health care providers and all working together to deliver the final product, which would address all of the above factors (Fig 4). At LDS Hospital in Salt Lake City, we have

such an integrated organization, and we have been very impressed with its benefits. Only with such a model can maximum cooperation among all health care providers lead to cost savings, efficiency, and better patient survival. Through this type of model, we as physicians could regain a foothold on health care contract negotiation and the ultimate benefactor would be our patients.

Dr David Dugan, in his presidential address to The American Association for Thoracic Surgery in 1977 titled, “Assured Survival,” stated: “Let us try to put ourselves back on the pedestal of self-respect, not that we are better than our fellowman, but that we are privileged to help him in his time of difficulty. We see him at his worst. May we always give him our best.”¹⁹ In his 1975 address he stated: “We are dependent on the youth in our specialty to carry on the responsible work in maintaining an association of high professional quality, social interchange, and unquestioned academic stature.”⁶

It is my hope and *challenge* that we will use the *legacy* provided us by the namesake, founders, and senior members of this association to confront the challenge before us in the new millennium. I hope that the present and future leaders of this society will use this council and will be the pioneers in implementing new strategies for combating the tremendous problems presently facing us in delivery of health care to patients with cardiovascular disease.

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