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President's Message

Upgrading Training In Thoracic And Cardiovascular Surgery

JOSE C. GONZALES, M.D.*

THE RAPID development of cardiac surgery since the early 1950s relegated to a secondary role the field of general thoracic surgery, remarked Dr. Paulson in his 1981 presidential address before the American Association for Thoracic Surgery[1]. He was concerned that the abundance of myocardial revascularization procedures in most training programs was producing surgeons with minimal training or interest in general thoracic surgery. The result would be the deterioration of the overall quality of general thoracic surgical care as pulmonary and esophageal surgery would be performed by surgeons with superficial thoracic training.

The American Medical Association defined thoracic surgery residency as a " graduate education program designed to give the resident a broad clinical experience in pulmonary, esophageal, mediastinal, chest wall, diaphragmatic and cardiovascular disorders"[2]. Yet the American experience shows a widening divergence between thoracic and cardiac surgery. Should a cardiovascular surgical resident be exposed to general thoracic surgery? Must general thoracic surgical training include rotations in areas of cardiac surgery ? Pursuing that line of thinking, why are general surgery residents required to rotate in some subspecialties like urology, plastic and reconstructive surgery, or even orthopedic surgery? Mention has been made about shortening general surgical training to 3 years and lengthening minimal cardiothoracic training to 3 general years plus 1 specialty year in a center specifically identified for specialized areas in thoracic surgery, surgery for congenital heart disease or even in valvular surgery or surgery for ischemic heart disease[3]. As early as 1970, modernizing training essentials partly by extending training programs was proposed; the extended program was seen as a natural step in the evolution of the growth of the specialty[4].

In 1983, an agreement was forged among three specialty training centers regarding residency in thoracic and cardiovascular surgery. The Philippine Heart Center for Asia, now the Philippine Heart Center (PHC) under Dr. Avenilo Aventura, the Lung Center of the Philippines (LCP) through Dr. Alfredo Balderrama and the Section of Thoracic and Cardiovascular Surgery of the Philippine General Hospital (PGH) under Dr. Enrique Ona proposed rotation of residents among the three hospitals to complement the strengths and remedy the weaknesses of each program. The PHC was strong in adult and pediatric cardiac surgery including cardiovascular diagnostics and perioperative critical care; the LCP had a good bronchoscopic program and had sufficient clinical material in pulmonary surgical diseases; while the PGH provided a broad range of adult and pediatric thoracic cases including closed cardiac and vascular surgery and thoracic and vascular trauma. There is no doubt that a well-rounded training in our specialty will result in better care for our patients.

That is why the PATACSI board of officers has met with the Philippine Board of Thoracic and Cardiovascular Surgery to assess the present state of training of the specialty in the Philippines. Specialty boards exist, as thoracic surgeon Mark Orringer wrote, "to protect the public by providing assurance that a certified medical specialist has successfully completed an approved educational program and an evaluation process, including an examination designed to assess the knowledge, experience, and skills requisite to the

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provision of high-quality patient care in the specialty"[5]. The PATACSI should likewise improve the quality of prospective fellows and one of the first steps which we have taken in professionalizing the PATACSI is the requirement for associate members to take the certifying examinations within 3 years after completing the residency program. Of course, there was the earlier step of requiring all candidates for residency in thoracic or cardiovascular surgery to be board certified in general surgery.

Other concerns of the specialty include the introduction of video-assisted thoracic surgery or VATS which has resulted in a resurgence of enthusiasm in thoracic surgery, as laparoscopic surgery has revolutionized the approach to abdominal surgery. Our association should encourage members to gather more experience in this field. The encroachment of general surgeons in the field of esophageal surgery is also a concern among thoracic surgeons. Likewise, interventional cardiologists are increasingly invading the cardiovascular surgeon's scope.

Thoracic and cardiovascular surgeons should anticipate the changes in the highly specialized and competitive medical world last they get left behind. After all, it is not only a question of better patient care but of survival as well.

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Editorial

The Medical Journal And Milestones In Chest Surgery

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IN VOLUME 101 of the Journal of the American Medical Association (JAMA) in 1933 appears a report "Successful Removal of the Entire Lung for Carcinoma of the Bronchus" written by Drs. Evarts A. Graham and J. J. Singer. This successful one-stage pneumonectomy performed on April 5, 1933 profoundly affected the surgical treatment of lung cancer and heralded the emergence of thoracic surgery as a specialty[1].

On May 6, 1953, Dr. John Gibbon, Jr. successfully closed an atrial septal defect in an eighteen-year-old girl using the heart-lung machine which took him 22 years to develop from inception to reality[2]. This milestone forever changed and revolutionized the practice of cardiac surgery; open-heart surgery is now a routine procedure performed hundreds of times daily worldwide. A mute testimony to this surgical feat simply reads: Gibbon JH Jr. Application of a mechanical heart and lung apparatus to cardiac surgery. Minn Med 37:171-180, 1954[3].

The first human cardiac transplantation in the world was performed in an obscure hospital in Cape Town in South Africa on December 3, 1967. This dramatic surgical feat was described by Dr. Christiaan Barnard in the December 30, 1967 issue of the South African Medical Journal. "The achievement did not come as a surprise to the medical world," Dr. Barnard wrote. "Steady progress towards this goal has been made by immunologists, biochemists, surgeons and specialists in other branches of medical science all over the world during the past decades to ensure that this, the ultimate in cardiac surgery, would be a success[4]."

Medical journals have chronicled several milestones in the history and development of thoracic and cardiovascular surgery. Pioneering surgical operations, bold innovative techniques, surgical rarities, personal experiences, commentaries and criticisms — all have found their way into the pages of medical and surgical journals. The publication of significant contributions would insure posterity, provoke controversy or spur debate, or perhaps aid in the performance of an academic exercise. In this age of information, however, reports in medical journals are overtaken by the instantaneous replay in the world press and maybe by the computer network's information superhighway. Nevertheless, the medical journal remains indispensable to physicians and surgeons who have something important to say and want to share it with others.

Take for example Professor Dr. Ludwig Rehn, an essentially self-taught German surgeon, who sutured a 2-day-old 1.5 cm stab wound of the right ventricle in a dying 22-year-old gardener on September 9, 1896. The patient lived and Rehn's first successful cardiorrhaphy, which he published in a German medical journal, marked the beginning of modern cardiac surgery[5]. Several years later, Dr. Robert Gross of the Boston Children's Hospital successfully ligated a patent ductus arteriosus for the first time in 1938 and reported this in the Journal of the American Medical Association the following year[6]. Six years later, the palliative Blalock-Taussig operation, first performed at the Johns Hopkins Hospital in 1944, dramatically transformed the cyanotic baby into a pink and active child[7]. Many patients with congenital heart defects who were given the death sentence could now be helped by the surgeon's knife and a new era in congenital heart surgery began. Interestingly, all these milestones were case reports published in medical journals.

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The birth of the Philippine Journal of Thoracic and Cardiovascular Surgery hopes to provide a forum for the exposition of unique case reports and interesting research papers provided primarily by members of the Philippine Association of Thoracic and Cardiovascular Surgeons, Incorporated. It has been thirty-five years since this association was founded and no historical record of its scientific meetings is available. Interesting surgical case after surgical case have been presented during the associations bimonthly case management conference and nothing of permanence either in the form of written records or published manuscripts have ever come out of it. Oral tradition has not much to offer considering the erosive quality of time. Much has been lost, perhaps forever, never again to teach and inform future generations of surgeons.

The Philippine Journal of Thoracic and Cardiovascular Surgery attempts to preserve these experiences in thoracic, cardiac and vascular surgery. If we succeed even in this attempt, the waiting has been worth it.

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