EDITORIALS

Issues and Challenges for Pulmonary Medicine

The Next Generation's View

On June 24 and 25 a unique meeting, planned and sponsored by the American College of Chest Physicians, was held at the Pheasant Run Resort near Chicago. Thirty-five young pulmonary physicians* were selected from 110 nominees by the program directors of pulmonary medicine training programs in the United States and Canada and brought together to consider, from their vantage point, problems and issues facing our field.

During the initial interactive session, six specific topics of priority interest emerged. These were: (1) current and anticipated problems in financing of pulmonary research and education; (2) the future direction and emphasis of pulmonary training programs; (3) how to deal with the unanswered problems related to cigarette smoking; (4) how to foster a closer relationship between basic and clinical research in pulmonary medicine and its widespread clinical application; (5) the increasing cost of technology; and (6) the increasing influence of government on both academic and private pulmonary medicine.

From these points of departure, smaller groups then focused their respective deliberations on each topic in terms of (1) the challenges which the issue presented to pulmonary medicine in the 1980's; (2) the impact of these problems and issues on the individual beginning a career in pulmonary medicine; (3) the possible ways in which the American College of Chest Physicians could respond; and (4) the role the individual could play in meeting these challenges.

The results of these discussions and group reports were the subject of a presentation to the meeting of the program directors to be held in Houston in conjunction with the annual scientific meeting of the College.

Some observations which emerged from the Pheasant Run meeting deserve emphasis: The young pulmonary physician actively engaged in academic research and teaching is frustrated and perhaps a bit frightened. Well-motivated, well-trained academicians leave their institutions after two to three years under the combined duress of the difficulty in obtaining research support and the inducements of high private-practice income. This, of course, is not unique to pulmonary medicine. Overall, the number of physicians reporting research as a primary activity has dropped from 15,441 in 1968 to 7,944 in 1975, and it has been estimated that there is a $30,000 differential in yearly income between a young physician entering a research-oriented career and one beginning clinical practice. While the decline in number of physician-investigators has been in part compensated for by an increase in PhDs in biomedical research, there remains a major question concerning who will apply their discoveries to patient care and of equal importance, who will be challenged to do clinical research!

Problems in funding of training programs and the directions which such programs may take present another area of concern. Rapid expansion of pulmonary training programs during the last two decades has largely satisfied the need for pulmonary specialists. The question now before us focuses on how many pulmonary physicians do we need to train annually to maintain a high quality profession and deal with expanded needs and replacement of pulmonary physicians in both academic and private practice? Intuitively, it would appear we will need fewer trainees and training programs. While such

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reductions will serve to solve some of the problems of decreasingly available funds to support training programs, it will probably lead to demands that faculty divert time traditionally spent on investigation to the day-to-day patient care activities previously delegated to trainees. To the young academic physician, a decreased number of trainees will mean even more clinical responsibilities and less time for creative investigation. In addition, it is anticipated that academic physicians will be asked to generate more of their personal support through clinical activities. Mechanisms by which the young academician can both carry out investigation and meet such clinical demands need to be established.

As clinical activities increase, academic physicians will become more involved personally with the bureaucratic burdens of practice already familiar to private practitioners. Justification of cost of technology and therapeutic-diagnostic procedures to patients, third party carriers, and government will be common ground to all pulmonary physicians. We will have to be able to deal with irrational and sometimes arbitrary decisions of disallowment of payment for services made by carriers and government.

Other problems are with us and are not anticipated to resolve spontaneously. The rapid advance in knowledge will affect all pulmonary physicians and mechanisms will need to be refined to speed the dissemination of such information as well as promote its acquisition. We will need to continue to confront the problem of cigarette smoking, but we must be careful not to try to reinvent prohibition.

In what possible ways did the group see the College responding to these challenges? One suggested mechanism by which young investigators could be assisted in competing for tightening research funds would be to provide periodic listing by the College in its publications of specific sources of grant support available in chest disease. A particularly intriguing suggestion was that the College coordinate regional and national collaborative clinical research protocols such as has been done in oncology and by the Veterans Administration. Original observations could be made concerning clinical course, effectiveness of treatment, and standards of practice. In this way not only could large numbers of patients be studied, but a mechanism would be established by which young investigators could "earn their spurs" at their individual institutions. It was also the groups' feeling that the College could provide the political leadership force for both academic and private chest physicians. Forums on such aspects of pulmonary medicine such as bronchoesophagoscopy and respiratory care could be potent national lobbies against irrational and short sighted decisions by government or private carriers. Such political force could also offer strong support legislation to control exposure to cigarette smoke—particularly in those settings in which there is a true occupational association with smoking and lung disease.

It was agreed that the College has served a vital role in providing a forum for clinically oriented research. In addition, through its postgraduate programs and annual meeting the College has played a leadership role in meeting the demands of increasing biomedical knowledge. It was suggested that the ACCP pulmonary medicine self-assessment test should be redesigned along the format of the medical knowledge self-assessment program established by the American College of Physicians.

In summary, this unique meeting accomplished two distinct and important purposes. Six issues of particular concern to the young pulmonary physician were identified. Secondly, a group of professionals who, although geographically separate, share common interests and concerns was afforded the opportunity to meet one another and interact. Since the members of this group were representatives of the coming generation of pulmonary physicians, this was a particularly important result. The next step will be the meeting of the present generation of pulmonary training directors in Houston. Here, mindful of concerns raised at Pheasant Run, they will consider the responses of the individual and the College to the challenges which face our exciting profession.

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Reference


How to Inhale a Whiff of Pressurized Bronchodilator

It all seems so simple: the mouthpiece of a plastic vial containing a pressurized bronchodilator is placed in the mouth of the patient, who, by pressing its lower end, activates a valve which delivers a predetermined dose of the drug. The simplicity is deceiving: the design of the vial, the composition of freons, the nature of the solvent, the humidity,