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Editorial

The British Thoracic Society

The members of the Thoracic Society and the British Thoracic Association have decided that the time has come to join forces and form a single new British Thoracic Society. This is not so much a merger as a response to the changing times in medicine, which dictate the need for a unified organisation with a new strength and purpose.

The two parent societies have rather different origins and traditions. The Thoracic Society was formed in 1944 and initially had a membership of around 200, which was restricted to foster free and informal discussion. Its prime purpose was to promote scientific exchange on topics relating to all types of intrathoracic disorders, and it is important to recognise that the original promoters of the Thoracic Society were the thoracic surgeons. With time, those concerned with cardiology and cardiac surgery have tended to move to their own specialist organisations but the Thoracic Society has continued to cherish the ideal of bringing together respiratory physicians and surgeons and has also welcomed those in associated disciplines, including anaesthetists, radiologists, and pathologists.

The British Thoracic Association began in 1928 as the Tuberculosis Association, changing its title to the British Tuberculosis Association in 1948 and subsequently to the British Thoracic and Tuberculosis Association before assuming its final title. Its purpose was to bring together those having special responsibilities for this disease, and because of its public health implications the association has naturally assumed the role not only of promoting scientific discussion but also of fostering professional standards of patient care in several ways. These have included the supervision of training and the examination of nurses for a specialist's diploma and the formation of a Joint Tuberculosis Committee with representatives from each geographical region of the United Kingdom.

As time went on both societies felt the need for change. The Thoracic Society discarded its restricted membership, believing that support from as many specialists as wished to join was more important even if this meant sacrificing the intimacy of the smaller meeting to some extent. In the event, the gain was much greater than the loss. With the decline of tuberculosis in Britain the British Tuberculosis Association looked towards other aspects of chest medicine and began to attract chest specialists with the wider spread of interests that led to the changes of name. In 1947 it developed an organisation to promote and co-ordinate multicentre trials and other studies, and the activities of the Research Committee have been especially successful not only in their achievements but in leading the way as a model organisation for such studies. The work of the Research Committee yielded a number of spin-off benefits. It enabled many individual physicians throughout the country to participate in well-planned studies, which not only brought them together with a single purpose but also introduced them to the discipline of research methods. It also allowed much larger numbers of patients to be collected and studied quickly than was possible in any single-centre trial. In addition, it showed that multicentre research on a national scale was feasible using smaller centres, and did not necessarily depend on teaching hospitals alone with established academic records. A powerful additional influence affected both societies as the scientific basis of thoracic medicine expanded from the stronghold dominated by the physiologists to take in new disciplines, including pharmacology, cell biology, immunology, and biochemistry.

Thus there were many reasons why the roles of the two societies moved more closely together; their programmes for scientific meetings showed progressive overlap and increasingly specialists in respiratory medicine became members of both societies. Natural loyalties ran high, healthy competition developed, and both organisations flourished. An increasing number of very successful joint meetings were held and ideas of a single organisation began to develop. As the societies looked to the future they recognised that medical advances worldwide are now moving on a much larger scale. They appreciated that if we in the United Kingdom are to contribute in the international arena we need to pool our resources, gather up the best from both parent societies, and develop our particular strengths, where our system of medical care and sponsored research gives us special advantage. The logical outcome, overwhelmingly supported by members of both organisations, was the formation of the British

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Thoracic Society. The Memorandum and Articles of the new society have been formulated and accepted by both organisations and the essential structure is defined. Ordinary membership, including overseas membership, will be open to thoracic surgeons and physicians and those in associated disciplines in Britain and abroad in unlimited numbers. Associate membership will be available to registrars and those of equivalent grade, senior membership to those who have retired from active practice, and honorary membership to those who have made a particularly distinguished contribution to thoracic medicine and surgery.

The official journal of the new society will be *Thorax,* and this will publish the proceedings of the society. The two editors will be ex officio members of the council. The *British Journal of Diseases of the Chest* will continue under its present editor and management team and will be sent to all members of the British Thoracic Society. The great contribution it has made in the past, complementing that of *Thorax,* will be recognised by all and it should be able to fulfil a different but important role in the future. The outstanding work of the Research Committee of the British Thoracic Association must continue within the new society, and we can envisage a great expansion in its activities, especially where national data need to be collected.

The essential commitment to create a forum for scientific exchange between surgeons and physicians has already been endorsed, but the society will have to develop its own philosophy and policies on many other issues. While it would be wrong to prejudge its decisions here, a few of the matters needing consideration should be mentioned.

The new society will have to find ways of combining productive forums for the many rapidly expanding subspecialty subjects relevant to thoracic medicine and surgery with a useful central focus for exchange of ideas between them. This dichotomy of purpose is facing most disciplines in medicine at present and there are many possible solutions. Linking some subspecialty meetings with other societies from time to time is one formula; organising symposia designed to highlight various aspects of a special topic, but presented in a manner appropriate to a wider audience, may be another. Overall, there is a strong case for encouraging academic centralisation and my personal hope is that the society will resist the pressures tending to too much exclusive fragmentation into subspecialty groups. Some of the most enjoyable, refreshing, and stimulating aspects of scientific meetings are to listen to other groups of experts debating their own enthusiasms. Whatever the solutions, some members will certainly be dissatisfied some of the time, but we may hope that the society will be able to avoid having everyone dissatisfied all the time.

While there is unanimous agreement that the primary purpose of the new society is for the exchange of scientific ideas there will be much debate on what stand should be taken in other spheres, and differing views have already been expressed. The question of how far the society can contribute to the maintenance of professional standards in Britain will certainly arise. If a single nationally representative society, having membership open to unlimited numbers, fails to discuss and define the principles of what is needed in this country, within the limits of the resources available, for proper respiratory health care no one else is likely to have the knowledge, commitment, or interest to do this for us. Senior posts in thoracic medicine are already disappearing, in part because of lack of proper recognition of the importance and scope of the specialty and in part because of the glut of trainees in general medicine. At a time when the scientific and clinical advances in thoracic medicine are increasing rapidly, its disappearance without trace into a generalists' pool can only diminish standards of patient care, to the detriment of the community. This does not mean that the society should allow itself to develop into a political pressure group as a major objective. The present structure of the central organisation of the National Health Service, however, is so closely interlocked with the Government that to remain completely aloof and let the future of the specialty be determined by others, without the consensus view of those directly responsible for patient care, would be ignoring our professional responsibilities, both as custodians of our patients and as teachers of future respiratory specialists. The society must also decide how it can best relate to the specialist subcommittees of the Royal Colleges. Many exciting and innovative opportunities for creating better standards in both staffing and training lie here.

Having established its role as a national body, the British Thoracic Society must not remain insular and must decide how best it can link its activities with those of other comparable and complementary societies throughout the world. The template for this has been set by the many joint meetings held over the years, both at home and overseas, by the two parent societies—our links with Europe, North America, and Australasia are already strong. Not only do joint meetings allow workers to rearrange their prejudices and dispel misunderstanding but they have also already opened the way for many close personal contacts that would not have been possible without the common bond of medicine.

As president elect of the new society, I would like

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to acknowledge the great contribution that has already been made to respiratory medicine by so many other thoracic societies throughout the world and to express my gratitude to them for opening their doors with immense hospitality to so many of us from Britain, as well as for much personal friendship. I know that the British Thoracic Society will wish to extend and endorse this spirit of international comradeship.

It would be entirely foolhardy to think that the solution to the many local problems facing the new society will be found without debate, controversy, and some dissension. All of these are healthy signs of an active, caring, and enthusiastic membership. The opportunities that lie ahead for the British Thoracic Society are immense and I believe that, with a little good humour, modest confidence, and much enthusiasm from its members, nothing can prevent it from achieving the commanding authority that is within its grasp.

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