CANADIAN THORACIC SOCIETY
SOCIÉTÉ CANADIENNE DE THORACOLOGIE

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HISTORICAL NOTES

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The Canadian Thoracic Society (CTS) decided to record its history in part because the Royal College of Physicians and Surgeons of Canada (RCPSC) requested the specialty societies to do so in 1989, but also because an understanding of our origins and development might give us some guidance in our future evolution.

These notes are derived from files of the executive meetings kept at the Canadian Lung Association, from personal records, and from conversations with some of the people who are or have been active in the Canadian Thoracic Society.

The Canadian Tuberculosis Association was founded in 1900, with goals to provide facilities for the care of TB patients and to ultimately eliminate tuberculosis. Physicians played an active role in this association, comprising 30 of the first 40 presidents up to 1960.

A medical section of the Association was formed to discuss medical and surgical aspects of TB. Perhaps with the realization that TB was not going to be a permanent raison d'être, the concept of the Thoracic Society (CTS) started to gel in 1955. The aims and objectives of this separate society were written in 1955 but there is no copy of these in the archives of the Canadian Lung Association. In 1956, Dr. C.W.L. Jeanes was recruited from Britain to be the Medical Director. The Canadian Thoracic Society was officially formed in 1957. The constitution of the Canadian Thoracic Society was proposed, accepted and published in both official languages in 1958.

The CTS considered its advisory role to the CTA to be an important function. Initially the Society actively promoted the formation of provincial societies, offered them leadership, and developed liaisons with the Canadian Medical Association, the College of General Practice and the Association de Médicins de la Langue Française.

Membership was initially free.

In 1960 the annual meeting included the president of the newly formed American Thoracic Society. Those minutes proudly announced that the Canadian Thoracic Society was two years its senior.

At the same time a research program was established by the CTA with President Dr. Shaver as the CTS representative on the research committee. A Continuing Medical Education program was also promoted. Dr. Colin Wolfe gave the first CTA lectureship to the annual meeting of the College of General Practice for Canada.

A newsletter was also started, initially three times per year. Contents included membership activities across Canada and communications from the CTA. It was agreed that clinical material would only be included if of general interest.

The CTA granted an annual budget of $2,000.00 to cover the expenses of the CTS.

In 1961 the International Union Against Tuberculosis (IUAT) met in Toronto. Dr. George Wherret was President and Dr. W. Jeanes was general secretary of the IUAT that year.

At the 1961 annual meeting the importance of the Provincial Thoracic Societies in continuing medical education on respiratory topics for general physicians was stressed. It was agreed that non-TB topics were also important. Some of the presentations to different Societies included "influenza," "Cancer Registration Schemes", and "Emphysema". The minutes recorded the perception that the success of the CTS required recognition of the importance of non-TB respiratory topics.

The Annual meeting of that year cost $849.00. Indirect expenses covered by the CTA included cost of speakers, publications of abstracts and interpretation. The management committee of the CTA suggested the CTS take more responsibility for their expenses in the future.

In the early 1960's, the need to expand the interest of the CLA to non- TB respiratory disease was apparent to some of the CTS members. There was still concern among the "TB doctors" that the closure of sanatoria could be a financial handicap, or at least a change in a very satisfying lifestyle. Not all welcomed the change in focus of the CTS. Emphysema, chronic bronchitis, lung cancer and smoking were considered the causes to which the fund-raisers of the CLA could rally. For some reason, asthma was not considered an important issue. It soon was apparent that funds could be raised from Christmas Seals for a long time despite the decline in morbidity and mortality of TB.

In 1962 the CTS presented a brief to the Royal Commission on Health Services, focusing on tuberculosis and other respiratory disease.

In 1968 both the CTS and the CTA were asked to submit briefs concerning the impact of medicare. The CTS recommended that within any fee schedule arrangements for tuberculosis should be included. They stressed the importance of continuing free medications for patients being treated for tuberculosis and the need for government supported public health measures.

The CTA changed its name to the Canadian Tuberculosis and Respiratory Disease Association.

In 1972 some of the provinces wished to curtail the activities of the CTS administration. Possibly the combined executive directorships of the CTS and the CLA in the hands of a physician was threatening to the provincial branches of the CLA, which was a grass-roots and lay organization. Dr. Jeanes resigned because of this but for the next decade physicians held these combined positions (Dr. J.J. Laurier and Dr. E. Hershfield).

It was decided to revise the constitution to clarify the duties of the medical director and his relationship to the CTRDA and the CTS.

In 1973 the CTS urged the CTRDA to contract its name to Canadian Lung Association. The Americans had not yet done this and the CTRDA was reluctant also. The CTS also urged the parent organization to increase the research tithe from the provinces to 5% from 3%. There is no record that this recommendation was accepted. Membership was 150. Peter Macklem began exploring a joint ATS-CTS meeting in Montreal for 1975.

In 1974 the CTS decided to participate with the RCPS/Canadian Society of Clinical Investigation (CSCI) meetings by producing a symposium and giving research presentations at the annual CTS meeting.

The first Canadian conference on air pollution was held at Gravenhurst, organized by Dr. David Bates and sponsored by the CTS and the CTRDA. The standards committee was working on position papers for tuberculin skin testing, immigration control and a re-issuing of the book, Canadian Tuberculosis Standards. They produced a statement affirming the acceptability of blood donations by people with inactive tuberculosis.

1975
Once again the CTS was torn between more active participation with the RCPSC/CSCI meetings. It decided not to combine their annual meeting with the 50th anniversary of the RCPS.

The Standards Committee was requested to explore standards of home care in respiratory disease, minimum standards for pulmonary function testing equipment in small hospitals, the need for chest physicians in urban and rural areas and in medical schools and income tax benefits to patients with respiratory disability.

The CTS budget was $19,000.00. $10,000.00 was for support of scholars and speakers at the annual meeting. The membership was 392. The membership fee was $5.00.

In 1976 the Standards Committee, with Health and Welfare representation formed task forces on pneumoconiosis and grain handlers' respiratory problems. A registry of respiratory residents was established. Membership increased to 425.

By 1977 the membership was 527. Discussions regarding the relationships with the Societies of respiratory technologists and of cardiac and pulmonary technologists lead to the affirmation that the CTS would be prepared to offer advice on standards, training, etc. but would not extend its involvement into political or economic problem areas. That year the CTS co-supported a symposium on the diaphragm with the ATS. Membership fees were increased to $10.00. The concept of a National Research Committee reviewing all National or Provincial applications for research grants was discussed but not resolved. The IUAT announced increased interest in non-tuberculosis respiratory disease and formed a Respiratory Disease Committee. Peter Macklem represented Canada on the committee.

In 1978 the CTS produced a position paper on grain dust and respiratory health. Other standard committee projects included Home Care Program, Pneumoconiosis Task Force. Proposed topics included aerosol delivery technique, fitness to drive an automobile, fitness to fly, life insurance risk for patients with healed TB.

The CLA decided to raise $2,000,000 for a foundation to support research. Means of developing this fund were unclear.

Membership fell from 400 to 350.

The CLA introduced a Christmas Seal visiting professor program. A visiting professor would stay for 2 months overlapping with the annual meeting. The professor would visit several centres, including non-academic ones. Drs. P. Pare and Jacques Cretien were selected. Dr. P.T. Macklem reported the IUAT non-TB respiratory disease committee was highlighting the role of smoking in respiratory disease .

In 1979 new projects for the standards committee included- respiratory disease statistics report-to develop a new RD questionnaire, Canadian Tuberculosis Standards, and cough suppressants. A report on standards for use of pulmonary function testing techniques and equipment was recommended, but a subcommittee was not established.

The Asthma Society requested the CTS assess their research projects. A fellowship was to be funded by the Asthma Society.

There is no record that this materialized.

The lack of representation of neonatology, pediatric respiratory disease, radiology, surgery, and acute care at the annual meeting was discussed. The poor attendance of many of the board of directors was noted. It was decided to revise the constitution to streamline the board of directors and to reassess the role of the CTS.

The CTS presented the concept of Career Development Awards to the CLA. They accepted this but the source of funding could not be identified. The CTS and the Canadian Anesthesia Society were considered to be advisors to the Society for Respiratory Technology. The nature of this relationship was controversial. It was finally "clarified" by declaring the relationship to be an informal one, not representing the position of the CTS and not requiring regular reporting to the CTS. The following year, after resounding repercussions, the CTS agreed to nominate representatives for a 3-year term, renewable. This person should be a member of the Standards Committee. The terms of reference of this person were not clear.

In 1980 the Standards Committee was dissolved, to await its redefinition under the new constitution. It first however produced a number of important statements. A statement on cough suppressants was sent to Health and Welfare and "circulated widely". Other statements included safety of patients while flying in commercial aircraft, fitness to drive a motor vehicle, and oxygen in nursing homes.

The annual meeting was held in conjunction with the ATS in Washington. The consensus was that while the joint meeting in Montreal five years earlier had met the needs of the CTS, this American site did not, and it was recommended not to hold joint meetings with the ATS in the USA. There was no objection to joint meetings in Canada, but it was recognized there were no facilities for this.

There was some controversy over the annual Jonathan Meakins lecture at the annual meeting and the Christmas Seal Visiting Professorship. It was suggested that the latter be dropped or the two be amalgamated. It was also suggested to rotate the name of this lectureship every five years. It was agreed to name the lectureship for the next five years after Charles Clifford Macklin. The minutes of the next meeting indicated the annual Meakins-Christie lectureship would be dropped for 1981, but a special lectureship would be re-established in 1982.

A New constitution was presented in the interests of improving the effectiveness of the CTS.

The OLA, through Dr. Cam Grey, recommended provincial thoracic societies offer joint memberships. This suggestion was to be "looked into". In 1981 the CTS co-sponsored a Sleep Symposium (with the Canadian Congress on Neurological Sciences and the Cdn Psychiatric Assoc.), and a Symposium on Respiratory Health Risks in Agriculture and Mining (with the CSCI).

In 1982 concern was expressed that the reports of the Standards Committee were not being widely disseminated. The Research chairman expressed dismay that the OLA had cut back $70,000 in research funds (50%). It was decided to concentrate funding on Research Fellows or Scholars. The national meeting with the CLA continued to be a problem. The quality of the scientific papers was thought to be poor because of competition with the more prestigious ATS meetings the previous month. The membership was surveyed and found generally receptive to holding scientific meetings with the Royal College and the CSCI. The CTS would then have an educational role at the annual CLA meetings with a CME program for local physicians.
In 1983 the Standards Committee produced reports on tobacco smoking and health, and on urea formaldehyde foam. In 1984 the Standards Committee presented a position paper on the respiratory effects of marijuana. It aborted production of a position paper on "health effects of acid rain" because not enough scientific information was available.

The merits of changing the research presentations to the CSCI/RCP&S meetings were again considered. One suggestion was to move the CLA as well as the CTS meetings to avoid the perception that the CTS wished to "separate" from the CLA. Formal discussions were initiated with the RCP&S regarding the possibility of conjoint meetings. The CLA agreed to consider holding its annual meeting with the RCP&S/CSCI, but indicated this could not occur in the immediate future.

The OTS suggested that the CTS take on a part-time medical director and that each provincial thoracic society president become an ex-officio member of the CTS Executive. The CTS Executive felt that the Executive would become too cumbersome. They resolved that these provincial presidents become "corresponding members". The CTS did decide a permanent recording secretary would provide continuity on the CTS Executive and Dr. Peter MacLeod accepted the position of temporary recording secretary pending appointment of a permanent one. The real need of a part-time medical director was again restated and by now there were no objections.

The Research Committee chairman, Dr. Michel Bureau indicated the CTS could assist the CLA fund raising committee by recommending projects suitable for funding by national corporations.

The budget for the CTS was $18,000.

In 1985 the Standards Committee produced a position paper on occupational asthma.

The first meeting of the CTS with the RCP&S/CSCI was held in Vancouver. There was concern expressed by some of the provincial societies that the CTS would be weakened. The B.C. and Ontario Thoracic Societies supported the concept of provincial presidents having a voice on the CTS Executive. They also recommended the CTS sponsor a CME program at the CLA meeting to maintain a CTS presence.

It was also agreed that the president of the CTS would give a lay summary to the CLA on research activity.

The Macklin Lecturer was Dr. Ludwig Engel of Australia

The CLA was formally encouraged by the CTS to pursue the goal of banning all smoking on aircraft.

In 1986 the following scientific meetings were arranged: the National Tuberculosis Conference (to review national policy for TB prevention and Control), the Victoria course on occupational disease, and the Montreal Conference on Environmental Lung Disease (with the American College of Chest Physicians).

Membership was 425.

After a meeting with Blair McKenzie (CLA Executive Director), Dr. Jim Dosman (CTS President) and Peter MacLeod, Dr. C.W.L. Jeanes was offered and accepted the position of part-time Medical Director of the CTS.

In 1987 the CTS participated in a CMA-RCP&S committee on medical manpower. For the first time a reasonably accurate listing of all the respirologists in Canada was compiled.

Some CLA members were concerned that research funds should not be spent outside Canada or given to non-Canadians. After some discussion, the CTS felt strongly that this was a healthy situation for respiratory medicine in Canada.

After 18 months of exemplary service to the CTS, Dr. Jeanes was notified by the CLA that he was dismissed "for cause". The CTS Executive was greatly distressed. The explanations offered by the CLA President and a few others on the CLA Executive were unsatisfactory. Some suspected Dr. Jeanes was a victim of "cross-fire" in the complicated dismissal of the CLA Executive Director. The CTS Executive passed a motion supporting Dr. Jeanes' activities as being in the best interests of the CTS and CLA. It deplored the lack of explanation offered to Dr. Jeanes and the lack of opportunity for him to defend his activities. It requested the CLA board review Dr. Jeanes' side of the case. The CLA never officially reacted to these motions. The out-of-court settlement of a lawsuit initiated by Dr. Jeanes suggested the CLA's actions were not supportable. The effect of this affair on Dr. Jeanes who was one of the founding fathers of the CTS can only be imagined. He returned his life membership in the CTS.

The CTS initially considered disassociating itself from the CLA. It finally decided that both societies were mutually interdependent. The Executive affirmed its belief that it could play an important role within the CLA but that it needed an appropriate budget, the right to hire and fire its medical director, and a voice on the CLA Executive of the Governing Council as well as a voice on the Governing Council. It also requested an audit of the research endowment fund which they believed had been used for non-research purposes by the CLA. In the long run the CTS may have been strengthened and made more cohesive by this unfortunate domestic squabble that nearly led to divorce from the CLA.

The CLA became more active in advocacy against tobacco advertising. The CTS Executive helped make several presentations to various levels of government.

In 1988 it was realized the CTS constitution did not clearly define the relationship between the CTS and the CLA. Recommendations were made for a redefinition of the role and mission of the CTS.

Dr. Ian Warrack was appointed to be the Medical director.

The Standards Committee submitted reports on AIDS and on occupational asthma.

In 1989 the Standards Committee position papers on transplantation, home ventilation, sleep apnea syndrome, alpha-1 antitrypsin deficiency and aerosol therapy were in progress. A chairperson for a paper on radon gas could not be identified.

Drug company sponsorship was obtained for most of the program of the annual meeting.

Membership was 240.

The concept of a newsletter was accepted as an important means of unifying the society and enlarging the membership.

A committee was established to rewrite the constitution. This new constitution was to clarify the relationship between the CTS and the CLA, to redefine the roles of various members of the Executive and to satisfy the CLA's desire to have the constitutional similarity among the other scientific members of the group - the Canadian Respiratory Nurses and the Physiotherapists.

An international review committee was established to monitor and assess the CTS and CLA involvement in respiratory health in developing countries, particularly in IUATLD activity. As late as 1987 the CLA and CTS enjoyed enormous international prestige for its work in the fight against TB in developing countries. Our contribution, in terms of funding and volunteer assistance between 1975 and 1989 no longer justified this respect.

The Royal College requested representation of the CTS to a committee to consider the maintenance of competence in the various specialties.

RESEARCH AND THE CANADIAN THORACIC SOCIETY:

The Canadian Tuberculosis Association had supported research, principally for tuberculosis, for many years prior to the formation of the Canadian Thoracic Society. In 1959 the Canadian Tuberculosis Association nucleus committee on research was formed, under the chairmanship of Dr. Wicks. The terms of reference for this committee were to receive suggestions for research projects, to serve as a central registry for projects and to recommend projects to the management committee of the CTA for financial support. Dr. Wherret conducted a survey on research and respiratory disease with a questionnaire which was sent to the provincial directors of tuberculosis control, the superintendents of the sanatoria, directors of chest clinics and the secretaries of provincial tuberculosis associations. Apparently questionnaires were not sent to the universities.

That year there were 57 requests for projects related to tuberculosis and six requests for non TB projects. $40,000.00 of research funds were dispensed, to 9 T.B. projects and 3 non T.B. projects.

In 1963 the Canadian Tuberculosis Association Research Committee restated the objectives and in addition recommended to the Executive that a fellowship in tuberculosis and respiratory disease be established. The fellowship would be offered to a physician in a university program who would be eligible for a university position. The fellowship would be renewable two times. The hope was expressed that the candidate would be trained to work in some field of tuberculosis.

At that same meeting, Dr. Rueben Cherniac presented the application of Dr. Earl Hershfield for this fellowship. He would serve as a teacher of respiratory disease to the medical students and house staff, and he would do a clinical and research project.

The CTA Executive recommended to the provinces that research funds be doubled from 1% to 2% of the gross returns for Christmas Seal sales. 8 Tuberculosis projects and 5 non T.B. projects were funded. In 1964 the research committee, under the Chairmanship of Dr.R.F. Farquharson, gave CTS fellowships to Drs .Paul Landrigan of Halifax, Brian Kirk of Winnipeg and J.C. Griffiths of U.B.C. They debated the need to decentralize research. Dr. Armand Frapier thought it would be more economical to fund research through a central organization. $78,700.00 were made available for respiratory research.

In 1966, $89,200.00 was available for respiratory research. All of the provinces except British Columbia agreed to increase the Christmas Seal tithes for research to 3%. British Columbia felt this could not be done because of the needs of their own respiratory program. Malcolm Brown, Chairman of the Medical Research Council of Canada, was a guest at this meeting and was distressed that there were fewer applications than funds available. He cautioned against funding research that could not be funded by other sources (presumably the MRC).

Many of CTS scholars continue to be active in academic medicine in Canada.

By 1970 the annual funds available for grants and scholarships was approximately $118,000.00. The committee debated the need for recipients of grants in aid or scholarships to do their studies in Canada. Presumably they decided that work should be done in Canada as the first scholarships for outside studies were seen in 1975. Only a few grants were awarded for research outside Canada at reputable institutions such as Johns Hopkins, Albert Einstein (New York), Hammersmith Hospital, U.K., London School of Tropical Medicine, and Harvard University. The average research grant in 1977 was $14,000.00. That year only one TB-related grant was given compared with the 15 non-TB grants. It was recommended that researchers present resumes of their projects to the annual meeting.

In 1990 $455,000.00 was available for CTS fellowships. This permitted funding 17 of 38 applicants who were considered "good to excellent". There were 47 applicants. The average salary of the fellowship was $26,000.00, approximately 75% of current MRC funding. There were no grants for studies in tuberculosis. 50% of the granted projects were for asthma, 15% for sleep apnea syndrome, and 15% for lung transplantation. 10% of the requests were for studies in respiratory physiology and 5 % for lung cancer and for lung cancer and for respiratory failure studies. There was still no national peer-reviewing for provincial research requests, mostly because of the magnitude of the task. Requests by nurses and physiotherapists were still assessed by their own research committees, but they were becoming more competitive for CLA research monies.

CONCLUSION:

The CTS began as a forum for specialists in tuberculosis, and later in respiratory disorders in general. Its mission originally was to facilitate the development of provincial thoracic societies, to encourage education at the post-graduate level in respiratory diseases, to offer scientific guidance to the CLA, and to interact with the various national medical bodies. The scientific meetings have become attached to the annual meeting of the RCP&S and the CSCI, because of a more receptive audience. It has become the forum to produce national statements on specific issues in respiratory disease. It also had a variable international involvement through the

IUATLD. Research funded by the CTS/CLA has shifted from tuberculosis to asthma and a broad spectrum of other respiratory problems. The maintenance of competence has become an important issue with which the CTS, at the request of the Royal College, will become more involved.

Jurisdictional problems with the CLA have plagued the CTS because of weaknesses in its often-rewritten constitution. It is ironical these problems resulted in the resignation, rehiring and subsequent dismissal of one of the founding fathers of the CTS in a manner more usually associated with a professional sporting organization rather than with a professional scientific body.

The CTS has had an interesting history and an understanding of its evolution may help avoid problems in a future where health care is rapidly changing.

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