A rose by any other name: Lamentations of a thoracic physician.

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In the most recent edition of Info Respiration, a French journal, there is an article on the name used for a thoracic physician in French, a "pneumologue" and traced the origin of the word from the Greek, "*pneuma*" which means the spirit as well as the lung, as the Greeks believed that the lung was the source of man's spirit (Ref.1). Until the time of Hervey, it was thought the job of the lungs was to cool the body and the spirits by conveying blood from the veins. The arteries were this named as they conveyed air. The author elaborated on the art of medicine and our specialty and on the essential importance of a holistic approach to medicine in recognition of the spiritual and metaphysical dimension of the humanity rather than the reductionist approach which makes man more like a cat experiment we did in second year pharmacology.

Herodotus, the Greek historian (484-425 B.C.) in his Inquiries ("historia") a sort of ancient travel log, describes with great warmth, the unique relationship the Egyptians had towards the animal kingdom which they saw as being one with the animals in both a physical and metaphysical sense and which reminds me of the same philosophy of the Australian aboriginal people. They did not see themselves as at the top of the food chain or somehow superior and therefore able to exploit all the other creatures on the planet. This attitude of superiority and therefore having the right to take with impunity from Nature in a way pervades modern thought and also medicine. There is an expectation in modern Western society depicted almost nightly on the television, that medicine and science is so powerful that patients should not die – that we can't always fix it. There is always a solution just around the corner if only enough money can be provided for research. I was struck by the ironic observation by Herodotus, that the Egyptians unlike the Greeks had numerous 'doctors' and that they had one for every disease or ailment; super-specialization which we find now in

many branches of Western medicine and very typically in the field of cardiology (Ref.2).

When I first considered doing this thoracic medicine in the late 1970's in Melbourne, many colleagues at the time regarded it this specialty with disdain, as it was still strongly associated with the treatment of tuberculosis and public health. Even the building in which I worked at the Austin Hospital had been established as a pavilion for the incurable and for tuberculosis. It was a specialty which then did no research in cell biology most research was based on measurements of pulmonary physiology. The instruments used were the chest radiograph, the spirometer and the body box. Some researchers tortured patients with oesophageal balloons. The study of sleep disorders and the use of CPAP were getting underway and the fibroptic bronchoscope had only recently been introduced.

The name "thoracic" comes from the Greek word "thorax" meaning a soldier's breastplate and does not cause even a blip on the radar of the average person in the street. "Jurassic" yes but "thoracic", no. The reason is not stupidity but publicity and advertising and the unfortunate choice of an obscure Greek word rather than an Anglo-Saxon one. To the average Frenchman, the word "pneumologue" while not commonly used in every day speech, conjured up someone who is an expert in the "pneumon" or lung as in "cardiologue". I add that the "p" in the word in French is not silent as in English. The very word "pneumologue" is stated with a plosive; a gush of Gaelic and therefore garlic-laden breath from the lips as almost an onomatopoeia for lung, spirit, exhalation, and the essence of life itself.

The Gettysburg address is one of the shortest but most well known speeches in the English language and like Churchill's famous speech, "we will fight them on the beaches etc ...", is composed almost exclusively in Anglo-Saxon, monosyllables and not polysyllabic Greek, Latin or French words. Indeed the only non Anglo-Saxon word Churchill used was in the last line when he says," We will never surrender" from the French verb "*se rendre* "

The word, "chest" conjures up notions of a box as well as the upper part of the body and is immediately comprehensible to the average man. This even applies to "respiratory" although of Latin origin. "Physician" in modern parlance is also readily digestible but the subtle difference between what the American man in the street understands as an "internist" is a complete mystery to even highly educated people as I have learned over the years at

dinner parties. Most people don't know the difference between a GP and a specialist physician or internist in this country unless it is defined as a subspecialty e.g. cardiologist and even then there is the usual discussion about whether or not they " do operations". I therefore believe that one of the reasons the Thoracic Society of Australia and New Zealand has little impact on the Australasian psyche is the unfortunate name of the "product". We are invisible on the national radar screen both for the general public and politically.

There are other reasons including the number of bodies with an interest in lung diseases such as the Australasian Sleep Association (ASA) the Asthma Foundation, the Cystic Fibrosis Association, Lung Foundation and the Asbestos Associations, all of which are intelligible to the man in the street as all these words are in common parlance -"*thoracic*" is not. With regards the ASA, this group has been cleaved off the TSANZ and appears to me a more cohesive and dynamic body. It is also worth noting that the average man knows the word "sleep" which is neither Greek nor Latin viz. "hypnos" or "somnis". They could have called themselves the Somnological Society or the "Hypnological Society".

Unlike the heart, the lung neither captures the imagination nor bears any emotional overlay for modern man. In the days when people ate offal, they were called the "lights" as they floated, unlike other organs. The Greeks still eat the lights mixed with other offal as a dish for those who have fasted over Easter. They are rather 'stupid" organs as they cannot be trained unlike the heart and skeletal muscles.

My cardiologist colleagues have been able to do so much with this kilogram or so of muscle, not much different in weight and appearance than my regular dog food order at the butchers. They have become specialized into interventional and non-interventional cardiologists, young Turks who have become E.P. (electrophysiology) experts, stent "kings" "echo" echocardiographs queens, transoesophageal echo experts commonly called the TE as the USA rather than the Old World with its American English has subliminally replaced English English etc. Echo's come in all shapes and sizes including like pizzas e.g. the basic "echo's", dobutamine, stress echo's, and family size with extra-pastrami on top. The mind boggles. Thoracic medicine is not in the race.

Cardiologists talk in terms of the latest drug and procedural studies in acronyms such as the FART 1 Study, the FAT 2 study, the CRUD 3 study etc and with such persuasive reassurance for luddites who may be quavering unbelievers. How could anyone argue with such weight of argument? Thoracic medicine has tried to fight back with acronyms, which sound more like advertising jingles such as the recent "SMART study". Somehow they don't have the same ring. We just don't talk the same lingo nor do we flit from conference to conference in the USA to centers like the Cleveland and the Mayo Clinics or to the latest stent meeting in Paris, New York or Chicago. They even use a New York Heart Association classification for dyspnoea and exercise tolerance which sounds far more impressive to a GP than just saying "he was breathless on putting on this slippers in the morning". They even take on American accents. Part of the reason for our lack of such acronyms is that mostly the disease studies such as on chronic obstructive pulmonary (or airways) disease i.e. COPD or COAD don't respond much to anything we throw at them. The lungs are a dumb ox as St Frances called his body which brings me to a review of what advances have been made in the treatment of lung diseases over the past twenty years – in summary, not much.

The keystones of the temple of thoracic medicine are the lower respiratory tract infections, tuberculosis, asthma, COAD, lung cancer. The general practitioner treats most respiratory infections. Tuberculosis has largely been colonized by the infectious diseases specialists and is a relatively uncommon condition in Australia. Asthma treatment, while not revolutionary, has been taken over by the general practitioner with only the worst asthmatics referred for control. COAD is huge iceberg the tip of which is seen by the thoracic physician, the majority going undiagnosed or treated by the G.P. Lung cancer treatment has not changed significantly in the past two decades other than by craftier surgical techniques by surgeons who seem to be able to do more and more through a peephole. Despite neoadjuvant chemotherapy and radiotherapy the overall survival has changes little in the past twenty years.

As a rule we thoracic physicians are good at working out physiological questions such as why is a patient short of breath or the cause of a cough. We are also good at diagnosing pulmonary diseases but over the past twenty years, the treatment of pulmonary fibrosis in all its variety of causes including fibrosing alveolitis now called U.I.P to confuse us and occupational lung diseases such as asbestosis and silicosis has not advanced at all and in most cases there is no effective treatment. There have been only

minor inroads into the treatment of sarcoidosis with drugs such as Infiximab. The drugs used in the treatment of asthma belong to the same menu as when I was a registrar with some minor adjustments with the advent of longer acting agents. Emphysema and chronic obstructive airways disease remains refractory to treatment in most patients and the same cocktail of largely ineffective drugs is still used. Drug trials showing miniscule improvements are vaunted as "breakthroughs". Inhaled steroids and bronchodilators are prescribed for many patients where there is often no proven benefit and new drugs such as the "son of ....." have been adopted with small benefits only in selected patients. We even insist under the aegis of the Health Insurance Commission that spirometry be done before and after bronchodilator even in patients shown to have no bronchodilator response eg many patients with COAD. This ensures that the doctor can legitimately charge a fee reimbursed under Medicare.

We now have a group of "orphan lung diseases" which are more often than not adopted by those physicians seeking new territory to colonise. These experts know a lot about them but can do nothing more for them than the non-expert. However this generates papers, SIG's and research money. In general lung diseases for which we can do little obey the inverse square law i.e. the less that is known about a disease, the more that is written about it and the more expert the expert becomes. Diseases such as angioleiomyomatosis, now affectionately called LAM (sans the "b") as no one can pronounce, have been corralled by lung specialists with special interest and as result, attract patients from across the country as long as they are seen to be gilding the horns of that sacred cow, research and have been on television. The main challenge is to popularize it for Everyman and to the extent that it is fashionable for chitchat at dinner parties. Best of all, it should appear in the differential diagnosis on the television series, House, St Elsewhere's or RPA.

As lung cancers is in general caused by smoking, it would seem sensible for the Thoracic Society to be a potent and vocal force in society against the great faceless tobacco moguls. Sadly, the general public which can now pronounce Jurassic as in Park , would not associate cigarettes with the word "thoracic" let alone know what it means or how to spell the word. However groups such as Bugger Up which defaced tobacco advertising bill boards in my youth, were a household word a bit like Green Peace and the Greens' Senator Bob Brown. The To add insult to injury, a few years ago, one illustrious member of the TSANZ did "research" sponsored by one of the

tobacco houses. As for a loud united voice against the evils of asbestos, our Society has been noticeably "quiet" despite continued mining and export of vast amounts of these substances by Canada, Brasil, China and Russia.

It would appear that the most important inroads on reducing lung pathology in Australia will come not from drugs, surgery or the TSANZ but from public health initiatives emanating from Federal and State Health Departments as has occurred with tuberculosis. As it is improbable that lung damage e.g. from fibrosis and emphysema and chronic bronchitis will ever be reversed (certainly not in my life-time), measures aimed at reducing atmospheric pollution, small particle pollutants such as from diesel, tobacco smoke and industrial causes of lung disease will all lead to fewer patients ever needing to see a thoracic physician. Although the advent of lung transplantation and the treatment of pulmonary hypertension with expensive drugs has led to some improvements in survival for a select few, these are exceedingly small numbers of patients. The education of the young, and an elevation of lung in the national psyche will all help as has already occurred with breast cancer and heart disease. If only we had genetic markers to indicate the best treatment for lung cancer as occurs now in breast and many other non-thoracic tumours. It is also a little ironic that thoracic physicians do not treat breast cancer, as the breast is part of the thorax. As for the word "thoracic", even as one who has studied Greek, I think it should walk the plank in favour of a more simple Anglo-Saxon word for the same thing.

References

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