

American Thoracic Society Documents

An Official American Thoracic Society Statement: Position Statement on ATS Activities for the Promotion of Respiratory and Sleep/Wake Health and the Care of the Critically Ill in the United States

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THIS OFFICIAL POLICY STATEMENT OF THE AMERICAN THORACIC SOCIETY WAS APPROVED BY THE ATS BOARD OF DIRECTORS ON JULY 9, 2009.

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Background: The 1997 American Thoracic Society (ATS) statement "A Framework for Health Care Policy in the United States" outlined core principles for the Society's activities in the public health arena. In the succeeding 10 years, profound changes have taken place in the United States health care environment. In addition, the 2005 publication of the Society's Vision highlighted some differences between the original Statement and our current priorities. Therefore, the Health Policy Committee embarked on a re-analysis and re-statement of the Society's attitudes and strategies with respect to health and public policy. This Statement reflects the findings of the Committee.

Purpose: To outline the key aspects of an internal ATS strategy for the promotion of respiratory and sleep/wake health and the care of the critically ill in the United States.

Methods: Committee discussion and consensus-building occurred both before and after individual members performed literature searches and drafted sections of the document. Comments were solicited on the draft document from ATS committee and assembly chairs and the Executive Committee, resulting in substantive revisions of the final document.

Results: Specific strategies are suggested for the ATS in the arenas of research, training and education, patient care, and advocacy so as to enhance the delivery of health care in the fields of respiratory medicine, sleep medicine, and critical care.

Conclusions: The American Thoracic Society's Mission, Core Principles, and Vision provide clear guidance for the formulation of specific strategies that will serve to promote improved respiratory health and care of the critically ill in the United States.

Keywords: health policy; public policy; delivery of health care; outcomes assessment; practice guidelines

OVERVIEW

This Statement updates the 1997 American Thoracic Society (ATS) document "A Framework for Health Care Policy in the United States" (1). The content of the original position paper has been revised to account for the changing realities of health care over the intervening years and modified in conformance with the ATS Vision as promulgated in 2005 (2). Most significantly, rather than the general statement of principles that was a hallmark of the original, this Statement is intended to provide perspectives on the direction for future initiatives of the ATS. Consequently, it focuses on internal ATS policies and strategies rather than actions by external agencies. The Statement calls for new activity in the following arenas:

Research

1. Encourage membership for investigators doing "translational research," which is most broadly defined as a bidirectional investigative strategy that identifies intractable clinical problems through collaboration with active practitioners, then develops a basic science research agenda to address these needs, and finally translates subsequent basic science advances back into improved clinical care.
2. Fund research in basic, translational, clinical, health services, and health policy research with a focus on currently underrepresented areas including translational and health services and health policy research.
3. Encourage the submission and publication of papers related to basic science, translational science, clinical research, health services research, and health policy research in the journals of the ATS: the *American Journal of Respiratory and Critical Care Medicine*, the *American Journal of Respiratory Cell and Molecular Biology*, and the *Proceedings of the American Thoracic Society*.
4. Incorporate presentation of diverse scientific material, including translational science, into ATS-sponsored educational events on respiratory, sleep, or critical care subjects.

Training and Education

1. Influence the development of training curricula in medical education so that graduates in our field are familiar with techniques for translating basic science advances into improved health care, for expanding access to care, and for lifelong learning.
2. Expand educational programs for the public in respiratory, sleep, and critical care health issues.
3. Expand offerings for in-training and in-transition ATS members so as to attract these individuals to our field, and develop mechanisms that will encourage leaders in diverse and related fields of science, education, and clinical care to become ATS members.
4. Augment training of clinicians and clinical educators, while investigating approaches for funding clinical training and debt relief on behalf of clinicians in our field; develop and support mechanisms for financial assistance that would encourage trainees to attend ATS-sponsored meetings; use these strategies in ways that will foster the acquisition of skills for promoting and assessing the quality of health care delivery.
5. Expand the ATS web site so as to offer more services and learning opportunities for clinicians from varied disciplines that care for patients with respiratory, critical care, and sleep-related illnesses, and for patients, their families, members of patient-advocacy groups, and the general public.

Patient Care

1. Widen ATS efforts and partner with other professional organizations, health care regulatory agencies, and advocacy groups, so as to create new information technology tools, quality benchmarking techniques, and continuous quality improvement methods that will foster better health care delivery.
2. Formulate improved techniques for implementing clinical practice guidelines and other products of evidence-based medicine, and for evaluating the influence of these products on medical outcomes. Ensure that every official ATS statement and clinical practice guideline includes plans for its dissemination, implementation, and outcomes assessment.

Advocacy

1. Actively campaign for the best possible patient care while taking into account the limitations imposed by scarce resources.
2. Create and identify funding for training opportunities in advocacy, such as a fellowship programs, to prepare individuals for this critical activity.
3. Collaborate with the ATS Public Advisory Roundtable and other public and patient advocacy groups on important public health issues.

INTRODUCTION

The mission of the ATS is to prevent and treat respiratory disease, critical illness, and sleep/wake disorders through research, education, patient care, and advocacy. The Society's long-range goals include decreased morbidity and mortality

from respiratory and sleep/wake disorders and from life-threatening critical illnesses. In 1997, the ATS (in collaboration with the American Lung Association) published a position statement entitled "A Framework for Health Care Policy in the United States," which provided a structure for health care policy initiatives of the Society (1). Almost a decade later, as part of a comprehensive strategic planning process, the ATS engaged a broad base of its constituencies in developing a vision statement. This statement, "The American Thoracic Society Vision," (2) was released in early 2005 and called for the ATS to be an international organization defined by dedication to a spirit of inquiry, and existing to serve patients with respiratory diseases, sleep disorders, and critical illnesses, as well as their families and the larger community. In view of the fundamental principles now stated explicitly in the ATS *Vision*, and because the 1997 *Framework* document was published when pressures and constraints on health care systems differed substantially from those of today, the ATS now wishes to re-address its health care policy initiatives in the United States. The 1997 *Framework* document primarily dealt with the manner in which federal, state, and local governments should act to improve the delivery of health care. In considering a revision, the ATS Health Policy Committee elected to draft a statement that explicitly addresses how the ATS itself should act to improve health care delivery and outcomes for patients with respiratory, sleep, and critical illnesses. In drafting this more internally focused document, the Committee seeks to assert the ATS' collective responsibility for improving health care in the United States, and to also foster dialogue on the opportunities and challenges that its *Vision Statement* poses for the ATS both as an organization and for its members as individuals.

METHODOLOGY

This document was initiated in April 2006 by Dr. Derek C. Angus, then chair of the ATS Health Policy Committee. The concept was discussed at an in-person meeting of the Committee in Washington, D.C., at which time the following steps were taken: (1) review of the original Health Care Policy Task Force Statement (1); (2) review of the ATS *Vision* (2); (3) discussion of proposed content of a revised Statement; and (4) appointment of a writing committee with assignment of individual topics.

During the following months, each member of the writing committee researched an assigned topic (including literature search, as applicable) and drafted their section of the document. Drafts of each section were circulated to all Committee members for comments, and an initial draft of the combined document was constructed from these contributions by Dr. Angus. Initial and subsequent drafts were then discussed at a series of committee conference calls, with intermediate drafts circulated by e-mail for additional comments. Intermediate drafts were synthesized by Dr. Angus, his successor as Committee chair Dr. Matthew G. Marin, and Dr. Marin's successor, Dr. Lee K. Brown. The document then underwent peer review through the usual process for ATS documents and subsequently, due to the focus on ATS policies, was circulated to the ATS Executive Committee of the Board of Directors and to the chairs of all ATS standing and *ad hoc* committees and assemblies for comments. Written responses were received from 6/24 (25%) of the chairs of standing and *ad hoc* committees (Communications and Marketing, Environmental Health Policy, Scientific Advisory, Publications Policy, Drug/Device Discovery and Development, and Clinicians Advisory), 2/13 (15%) of assembly chairs (Pulmonary Rehabilitation, and Pediatrics), and from the Executive Committee. Dr. Brown, as current Health Policy

Committee chair, then synthesized the comments from ATS leadership into a final document.

Core Principles of the ATS

In the 1997 statement “A Framework for Health Care Policy in the United States,” the ATS outlined the core principles that served to guide the Society (1). Three interrelated principles articulated in that statement continue to motivate the ATS as it considers issues of health care that presently affect people in the United States. These core principles remain as a strong underpinning for ATS action. The principles included:

1. Access to health care
 - a. *Guarantee of access to health care.* Health care is a right, and health care systems must guarantee access to medically necessary health care for all individuals in the United States.
 - b. *Scope of health care services.* Individuals in the United States should have guaranteed access to medically necessary preventive, acute, chronic, rehabilitative, and palliative care.
 - c. *Eliminating barriers to access.* The ATS will engage in activities to eliminate disparities in health and to remove barriers to health care including, but not limited to, racial, ethnic, geographic or educational barriers, cultural and language barriers, barriers for the physically and mentally impaired, sexual orientation and gender identity, and the ability to pay.
 - d. *Administration for health care.* The delivery and administration of medical services should enhance the health benefits of individuals in the United States. Although health care delivery requires administrative tasks, these tasks should not be so burdensome as to interfere with delivery of care. Administrative tasks that do become a burden to patients and providers should be eliminated.
 - e. *Medical information systems.* Medical information systems should support continuity of care and coordinated delivery of health care. These systems should facilitate the development of effective strategies to prevent errors in care and the creation of population-based investigations for the improvement of clinical outcomes.
2. Quality health care
 - a. *Effective, appropriate, and timely health care.* Health care services should be consistent with the Institute of Medicine quality domains, which include effectiveness, efficiency, equity, patient centeredness, safety, and timeliness (3). In addition, the principles of evidence-based medicine should be applied in the evaluation of potential health care methodologies.
 - b. *Access to appropriate health care professionals.* Individuals should be able to access clinicians who have the appropriate level of knowledge, experience, and skill.
 - c. *Provider-patient relationships.* The integrity of the health care provider-patient relationship must be protected so that health and medical conditions are not adversely influenced by inappropriate economic considerations.
 - d. *Patient protection and full disclosure.* Patients or their surrogates should be given the tools they need to become informed and responsible health care consumers. They should know and exercise their rights to

medically necessary care, but should also assume an appropriate level of responsibility for monitoring the quality and cost of health care services.

- e. *Biomedical research.* The health care system should place increased emphasis on biomedical research that extends across the full spectrum from basic science to health services research, as a tool to improve the health of all individuals.
 - f. *Education of health care professionals.* Training new health care professionals and continuing the education of current practitioners in innovative and novel biomedical and health sciences to engage in lifelong learning are essential to maintaining health care access and quality.
 - g. *Public education.* To attain and preserve optimal health care and to participate capably and fully in the patient/clinician relationship, the public should be educated regarding all aspects of health care, prevention, and rehabilitation.
3. Prudent stewardship of health care dollars
 - a. *Preventive health care and public health.* The U.S. public should recognize the value of preventing illness and promoting health, and support mechanisms that incorporate prevention in all aspects of health care.
 - b. *Organization of health care delivery and financing of health care.* The delivery and financing of health care should be rational, efficient, coordinated, and adhere to the strongest ethical principles.

HEALTH CARE POLICY IMPLICATIONS OF THE ATS' MISSION AND CORE PRINCIPLES

The ATS' Mission and Core Principles provide a strong foundation and considerable guidance in the development of a coherent health care policy. The remainder of this document sets forth the key policies that derive from these basic doctrines and provides examples of how the ATS can enhance its research, advocacy, educational, and clinical care missions.

Research

The ATS vigorously supports research initiatives through advocacy, grant programs, scientific and clinical meetings, and high-quality medical journals. The membership of the Society includes many of the world's leading researchers in lung, sleep, and critical care medicine. Most research questions addressed by the membership have been of a clinical or basic science nature, although socio-behavioral, epidemiologic, and environmental sciences have also been featured. Members of the Society have contributed substantially to the body of knowledge regarding environmental causes of disease, particularly with respect to occupational lung disease, tobacco control, and the health effects of air pollution on respiratory disorders such as asthma. Members have also actively explored issues related to quality of care and end-of-life care. The ATS also recognizes the need to emphasize research that will further facilitate translation of basic and clinical discoveries into improved health care delivery and outcomes. For example, patients with acute respiratory distress syndrome will fail to benefit from new pathophysiologic insights unless these findings are transformed into new clinical advances and improved delivery of care. Although overcoming these translational blocks has been recognized as a priority for the entire medical research community, to be truly effective in this arena the ATS should enhance its structure and function in the following spheres:

ATS membership. The ATS should be a home not only for researchers who address biological and clinical questions, but also for translational researchers who propel novel basic and clinical scientific findings into improved, higher quality care and outcomes. The ATS *Vision* requires a diverse, multidisciplinary membership that welcomes and includes those with expertise in many disciplines including (but not necessarily limited to) biomedical sciences, economics, epidemiology, informatics, nanotechnology, mathematics, statistics, and the social sciences.

ATS grant programs. In addition to awarding grants for basic biomedical research, the ATS should provide funding for research in translational work, clinical epidemiology, health services, and health policy.

ATS journals. The ATS journals, consisting of the *American Journal of Respiratory and Critical Care Medicine*, the *American Journal of Respiratory Cell and Molecular Biology*, and the *Proceedings of the American Thoracic Society*, have published high-quality manuscripts in diverse areas of research and clinical care. The ATS journals should strongly encourage the submission and publication of research from diverse fields including basic science, translational, epidemiologic, and health services research.

Annual International Conference and other meetings. Currently the ATS International Conference includes tracks and sections of both the didactic program and research presentations that deal with basic science, translational, epidemiologic, and health services research. However, program committees should actively work to expand activities that cut across these diverse areas. Diversity of science and interactions among scientists from different fields is an area of great strength and opportunity for the ATS. In the future, some sessions or tracks relating to a particular respiratory, sleep, or critical care disorder should start with insights from relevant basic science, proceed through new clinical research findings, and conclude by presenting potential mechanisms for translating new knowledge into improved health care delivery and outcomes.

Training and Education

The ATS continues to support the development of incentives within the established system of medical and allied health education that will ensure the availability of a full range of health care providers in all geographic areas, especially locales that are currently underserved. The Society has a longstanding tradition of promoting lifelong learning for physicians and other providers involved in the care of the patient with pulmonary diseases, sleep/wake disorders, and critical illness. The ATS has worked closely with the Accreditation Council for Graduate Medical Education and other organizations in establishing educational curricula for physicians and other health care professionals. At present, these curricula emphasize the key clinical faculty, the facilities and resources, and the specific clinical program content needed to deliver certifiable training. In turn, these oversight agencies have enforced the standards so as to ensure a supply of well-trained clinicians and clinical scientists. However, these curricula all too frequently do not impart the skills necessary for translating basic and clinical science knowledge into practical health care delivery; nor do they provide the tools necessary for judging the success of new health care delivery paradigms.

To advance its *Vision* for the future and to further its core principles, the ATS should increase its efforts in shaping future training curricula. In so doing, the ATS should seek to attract and train health care providers and scientists with traditional interests in basic and clinical science as well as particular expertise in translational research. ATS educational activities should address the development of techniques to formulate,

implement, and evaluate the effectiveness of clinical guidelines for the treatment of pulmonary diseases, sleep disorders, and critical illness. Educational programs should include the study of successful approaches for improving access to health care and increasing the quality of health care. The ATS should facilitate a training environment that enables the acquisition of lifelong self-education in these areas. In addition, the ATS acknowledges its obligation in public education. The ATS will continue to educate the public in making healthy life choices by providing readily available, accurate information through a variety of venues.

The Society can achieve its educational goals by advocating change in the following areas:

ATS membership. The Society should continue to emphasize its In-Training and In-Transition membership categories to attract newly trained medical practitioners. To capture the interest of translational researchers in the activities of the ATS, the Society should develop mechanisms for enhancing participation of the leaders in these fields, such as awarding memberships to these leaders.

ATS Grant Program. The ATS Grant Program was started in 2002 and has grown considerably since that time. The Grant Program currently targets junior investigators to build research capacity. Some of this investigative portfolio is offered in collaboration with research partners that focus on specific lung diseases while other grants are unrestricted in content area. In addition, the ATS offers some grant support that is inclusive of clinical educators. The Society should continue these and other efforts that foster the education and training of researchers and clinical educators through the provision of grant support. In addition, the ATS should work to instill in trainees the importance of learning the necessary skills for promoting and assessing the quality of health care delivery.

ATS web site. The ATS web site (<http://www.thoracic.org>) provides clinicians, researchers, and the general public with information about the activities of the Society and access to relevant clinical, educational, and research resources. The web site includes a large number of statements, guidelines, and reports pertaining to respiratory diseases, sleep disorders, and critical care; members also have online access to the various ATS journals. More recently, the ATS has initiated efforts to include information for patients and their families as an integral part of the site. The Society should continue to expand web site content that addresses the needs of both clinicians and researchers as well as the interested public, and capitalize on innovative, newly emergent technologies for the dissemination of information including podcasts, streaming video, and interactive materials.

Patient Care

The ATS believes in the promotion of improved patient-centered outcomes by facilitating the delivery of the most effective, timely, and safe health care. As such, the ATS supports the implementation of best practices of care.

Assessing quality of care. To assure fairness and accuracy and to improve the coordination and dissemination of health care, the ATS should enhance its partnerships with other professional organizations, health care regulatory agencies, and advocacy groups. The Society should facilitate the development and implementation of information technology tools (e.g., Pareto chart or run chart software) and benchmarking performance tools for continuous quality improvement. The ATS should be actively involved in performance measurement and pay-for-performance initiatives, when they also serve to achieve quality improvement. In the final analysis, an important measure of the Society's success is the benefit it provides to patients and their families and by the health of the public.

Developing practice guidelines. Clinical practice guidelines serve as an example of how the science of health services augments the potential impact of ATS activities in providing health benefits for patients. During the last decade, the field of evidence-based medicine has resulted in standardized methods for developing (4), ensuring quality (5), reporting (6), implementing (7), and evaluating outcome (8, 9) of these instruments. The ATS has been cognizant of this trend and is active on a number of fronts.

More than 20 years ago, the ATS Board of Directors approved a document that set forth guidelines for developing formal statements and position papers. Since then, the process has incorporated a state-of-the-art system for document development, including anonymous peer review of the finished product prior to endorsement by the Society. The ATS Board of Directors approved an extensively revised "Guidelines on Guidelines," and recruited a Documents' Editor who works with the Documents Development and Implementation Committee, which is charged with directing the entire document creation process. Most recently, the ATS Board of Directors approved a comprehensive Statement defining the procedures for grading quality of evidence and strength of recommendations in its official documents (10). As of this writing, the ATS web site formally endorses 84 active statements, position papers, and conference or workshop proceedings. Most of these serve as practical, evidence-based guides to important aspects of clinical practice (11).

The ATS, however, recognizes that synthesis and dissemination of best practice guidelines are limited in actually influencing practice change or providing a measurable benefit to patients. For instance, despite the proliferation of guidelines for the detection and management of chronic obstructive pulmonary disease (including those originating from the ATS as well as those endorsed by the ATS), relatively few peer-reviewed reports have appeared evaluating the efficacy of these guidelines in actual practice. Most reports have been incidental to, rather than a result of, a guideline (12), and only two directly and explicitly applied to the contents of a guideline (13, 14).

The ATS should remain in the forefront of the evidence-based medicine movement. In pursuing this goal the Society should continue to formulate novel, scientifically sound actions to incorporate and support quality improvement. However, the subsequent implementation and evaluation of all such guidelines should not be neglected. Achieving improved care requires that the ATS supplement traditional activities of guidelines development with provider change approaches, performance measurement, quality enhancement, and health system and information technology innovation. The establishment of the position of Documents Editor and the Documents Development and Implementation Committee provides an opportunity to ensure that any clinical practice guideline commissioned by the ATS include plans for its dissemination and outcomes assessment. Mechanisms and resources for achieving this goal should be developed in collaboration with the Education Committee and Research Advocacy Committee. A recent article describes the ATS vision for the development of multidisciplinary, multiorganization, globally relevant guidelines in respiratory disease, using chronic obstructive pulmonary disease as an example (15). Finally, the ATS should encourage development of guidelines that incorporate the flexibility to adapt clinical care to the unique needs of the individual patient and his/her family.

Advocacy

The ATS *Vision* statement clearly indicates that improving patient care and preventing disease are primary goals of the Society. Consequently, advocacy that furthers these ends will

always represent the greater part of ATS effort in the public arena. However, the ATS also advocates for its members, provided that such advocacy is in the best interests of our patients and the health of the public. The potential for tension between these goals suggests the need to answer five fundamental questions:

How does the ATS respond when the needs of patients are in potential conflict with the needs of ATS members? The ATS acknowledges the potential for conflict of interest that arises when a professional society has as its primary mission the health and well being of patients, their families, and the public, but also seeks to advocate for its individual members and their constituencies. Actions that may require significant change on the part of practicing physicians could potentially alienate various segments of the ATS membership, but altruistic concern for patients should ultimately dictate ATS actions and activities. The ATS should advocate for the best possible care for patients and their families while taking into account the quality of the evidence, emerging areas of evidence, and the limitations of scarce resources.

How does the ATS develop a member-driven advocacy program? A second challenge relates to helping ATS members become advocates for change. ATS advocacy activities are spearheaded by an outstanding professional lobbying staff (the ATS Washington Office) that monitors federal legislation and regulatory policy, alerts the membership when input is needed, and facilitates member involvement in advocacy efforts on the federal, state, and local levels. The success of the ATS Washington Office depends on the commitment and enthusiasm of ATS members as well as the participation of patients and family members who have been affected by respiratory disease, sleep disorders, and critical illness. Consequently, the Society should find ways to enhance member involvement in these endeavors, promote cooperative advocacy activities with patients and their family members, and collaborate with patient advocacy groups to leverage our influence in the public arena.

The development of a funded advocacy fellowship program might represent one approach through which the ATS could increase membership participation in ATS advocacy. This competitive policy fellowship would be open to ATS members, with the successful applicant receiving financial support for working in the ATS Washington office, a congressional office, or a federal agency. The Society would thereby develop a cadre of members with policy expertise and familiarity with the federal bureaucracy who could then assist the ATS in developing important legislative and regulatory policy as an integral part of their subsequent careers.

How does the ATS Advocacy program benefit from partnerships with patient groups and other organizations? Effective collaboration with patient organizations to improve health related to respiratory diseases, critical illness, and sleep disorders represents major opportunity as well as significant challenge. The ATS has developed a remarkable partnership with patients, their families, and the public by forming the ATS Public Advisory Roundtable (PAR). The ATS PAR is a group of patient interest organizations who come together under the ATS banner and with ATS support to advocate for public health and individual patients and their families. The ATS PAR is a remarkable resource for ATS and for the public, and ATS should continue to support and enhance the ability of the ATS PAR to do its work.

The ATS has always partnered with other professional societies and public health organizations that are active in the respiratory disease, critical illness, and sleep disorders arena. Cooperative action leverages the resources of all involved, as long as there exists substantial alignment of mission and goals

between the different entities. The ATS should enhance its collaboration with these professional societies and health organizations, particularly on broad public health issues such as air pollution, tobacco control, and health care reform.

What types of activities has ATS advocacy focused on recently? In August of 2008, the U.S. House of Representatives passed a bill giving the Food and Drug Administration the authority to regulate tobacco. For two years, this was a major priority for the Society, working in conjunction with the American Lung Association and other organizations. This victory in tobacco control came only a few weeks after another major "win" for the ATS, when Congress passed legislation mandating that a uniform national Medicare policy for pulmonary rehabilitation be established by 2010. The ATS fight for this coverage lasted several years and success was ultimately achieved by leading a coalition of patients, including the ATS PAR along with other professional organizations, in advocating for this change. ATS also participated in advocating for the passage of major bills regarding national and global tuberculosis control and treatment. These victories highlight the importance of ATS advocacy activities and of the Washington office.

What are the activities that ATS advocacy should focus on in the next few years? The immediate future will be a critical period in advocating for health care and health-related research. Two of the major priorities for ATS advocacy include health care reform with universal access to health care and increased funding for health-related research through the NIH and other institutions. Additional priorities of the ATS include legislation mandating Food and Drug Administration regulation of tobacco products, and regulatory and legislative initiatives to mitigate the potential health effects of climate change. Finally, continued excellence in the prevention and treatment of respiratory disease and sleep disorders, and in the care of critical illness, will require adequate numbers of skilled and dedicated specialist physicians engaged in the day-to-day care of patients. A recent Health Resources and Services Administration report has predicted a profound shortage of critical care physicians by the year 2020 (16), and other published forecasts portend shortages of pulmonary medicine practitioners (17). The ATS, in cooperation with other stakeholders, has aggressively pursued legislative and other initiatives aimed at ensuring an adequate workforce of pulmonary, sleep, and critical care specialists in the United States. These vexing issues present both challenges and opportunities for ATS advocacy efforts; the ATS should continue to work diligently with our partners and with government to bring satisfactory resolution to each.

SUMMARY

The American Thoracic Society's mission, vision, and core principles have profound implications when applied to issues of health policy that in turn suggest the need for a degree of change within the organization and its membership. The ATS seeks to improve the well being of adult and pediatric patients with respiratory disease, sleep disorders, and critical illness by increasing preventive efforts, augmenting access to health care, improving the quality of care, and managing health care costs efficiently. The organization acts in this regard using the tools of research, education, patient care, and advocacy. ATS policies and activities related to public health should be consistent with its mission, vision, and core principles; this tenet dictates that the organization will continue to support basic and clinical research, but also requires expansion of research activities in translational fields of inquiry. The ATS will continue to be a leader in education for health care providers and patients, families, and the community. The organization will continue to develop pa-

tient care guidelines, but will stress the importance of implementation and evaluation of best health care practices. While mindful of the practical implications of limited health care resources, the ATS will continue to advocate for the best care of all patients with respiratory, sleep, and critical illness.

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