Delivered by Benson B. Roe, MD on Jan. 23, 1973, Whither in Maturity? [Ann Thorac Surg 1973;15:553-64] was the first STS presidential address to focus on topics within the broad arena of societal challenges facing cardiothoracic surgeons.

Early on in his address, Dr. Roe says, “Although the Society was founded with the objective of being a scientific, professional forum, the time has now come to consider and to implement its potential as a vehicle for promoting the interests of our specialty and the safety of our patients.” Speaking of cardiothoracic surgery as a profession, he notes that, “With maturity comes responsibility.” He goes on to say, “Cardiothoracic surgery stands in the forefront of public attention because of its high cost, its team aspect, its dramatic impact, and its highly publicized activities. The future of medical practice is now a political issue.” He is optimistic that cardiothoracic surgeons could lead the way in dealing with governmental and other bodies that had become much more involved with our professional activities: “Our specialty is young and we are still adaptable…We are therefore a group capable of dealing effectively with bureaucratic intrusion.”

He then lays out five specific challenges for the Society and the specialty, and he proposes some suggestions for meeting those challenges.

1. Define the minimum standards for the specialty and find the means to enforce them: He proposes voluntary regional peer review panels to examine hospitals’ cardiothoracic programs and so help improve the quality of care.
2. Determine present and projected manpower needs: He states that we must not train too many surgeons, or develop more cardiothoracic units than needed, or let proficiency decline due to inadequate case loads.
3. Define the education and experience needed to train capable thoracic surgeons: He suggests that the American Board of Thoracic Surgery, the Residency Review Committee for Thoracic Surgery, and the Council on Medical Education together arrive at appropriate decisions concerning these matters.
4. Establish and enforce an ethical code consonant with present day reality: He suggests that an ethical code related to modern cardiothoracic surgery practice be clearly defined and that voluntary regional committees, with whom the press would consult for objective opinions and perspective regarding medical matters, be established.
5. Develop a realistic policy concerning fees to assist planning by public and private insurers: He advocates establishment and endorsement of a nationwide relative value scale for the specialty, with the possibility of variations that would be consistent within a region, and with the possibility of subsequent additions and adjustments.
He closes with a belief that is still widely held today. “We are better qualified to regulate ourselves than anyone else, but unless we prove it, the door is open for some agency to do it for us … Let it be us!”

Dr. Roe’s address was followed by another that focused on broad societal issues pertinent to the specialty, including government involvement. In 1974, Earle B. Kay, MD delivered a two-part presidential address: I. Professional Standards Review Organizations and Their Implications for Physicians and II. Thromboembolism on Mitral Valve Prosthesis. [Ann Thorac Surg 1974;18:105-21]

In the first part of his address, Dr. Kay makes reference to Public Law 92-603, which was enacted to monitor the quality and cost of medical services performed under Medicare and Medicaid. He notes that numerous individuals at the time questioned whether or not the stipulations contained in that legislation could possibly accomplish its intended goals, and serious concerns were raised about “an expensive, growing bureaucracy adding further to the cost of medical care and not solving the real problems in health care delivery.” He adds, “The attempt by the federal government and others to make physicians the scapegoats for the complex problems related to the overall health of the nation only confuses the real issues and solves nothing.”

Dr. Kay predicts that efforts to determine norms for appropriateness of care and to reduce the costs of care through regional Professional Standards Review Organizations would likely fail. He further states that any cost reductions would likely be offset by increased administrative expenses and the ordering of more tests to comply with treatment guidelines. Furthermore, he argues, the rules, regulations, and guidelines established for physicians do not guarantee improved quality of care. It is his contention that “a better working relationship between organized medicine and the government on controversial aspects of this law would more likely provide a satisfactory solution.”

Dr. Kay points out, as did Dr. Roe, that public insurers and the government both were exerting pressure on the profession to provide realistic fee schedules so they could better plan budgets and address inconsistencies in fee systems. He also makes note of the active discussions going on at that time concerning recertification and relicensure, which he described as “further steps toward regimentation in an attempt to improve quality care and maintain competence.” In the second part of his address, Kay leaves societal issues to discuss a clinical topic, Thromboembolism on Mitral Valve Prosthesis.


He Dr. Sloan moves on to the topic of manpower, citing the National Thoracic Surgery Manpower Study of Dr. Lyman Brewer. Dr. Sloan notes the concern that, at the rate of certifying 150-200 new cardiothoracic surgeons each year, there would be too many surgeons to care for the needs of the country, especially in view of a projected zero percent population growth. He notes as well that Dr. Brewer’s study indicated that 30 percent of all thoracic operations were being done by surgeons not certified in the specialty.

Dr. Sloan also discusses Continuing Education and Evaluation of Clinical Competence, saying that “if you don’t continue to educate yourself, you face partial obsolescence in 5 to 10 years…” He goes on to reflect that continuing education “has become a fact of life.” At the same time, he despairs the reality that there was usually modest attendance at meetings offering continuing education, and he concludes that “there is relatively widespread indifference to combating obsolescence.” He then reviews the problem of determining clinical competence. At that time, it seemed highly likely that clinical competence would be determined through demonstrated participation in continuing education, a survey of clinical practice, and an objective examination.
Dr. Sloan ends his presentation by commenting on the fact that “the entire medical profession is in turmoil about the future of medicine in the United States.” He notes that the future of thoracic surgery is as bright and exciting as it was in the past, and he stresses three points crucial to the specialty’s continued vigor.

1. He stresses the need for better cooperation among the American Board of Thoracic Surgery, the Residency Review Committee, and the thoracic surgery program directors in order to improve thoracic surgery training.
2. He reminds us of the necessity to address the manpower needs and hints that restriction of the number of training positions was needed.
3. He advises us to accept the inevitability of continuing evaluation of clinical competency and to view it as valuable assistance in the effort to provide better patient care.

The mid-1970s was a time when the specialty was growing and forced to focus on a bigger practice picture, one that went beyond clinical issues to deal with the implications of government regulation, reimbursement, manpower, self-regulation, and credentialing – issues we still contend with today.