

THE SURGICAL ONCOLOGIST

Presidential Address, The Society of Surgical Oncology, New York City, 1976

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IT IS A REAL HONOR TO BE IN THIS POSITION OF delivering a presidential address to a society with a new name, The Society of Surgical Oncology, whose various committees and Executive Council have been planning, discussing, and working on the reorganization of the Society to accomplish its objectives. I want to take this opportunity to thank the many committee chairmen and members who have met repeatedly during the past year, have attended the many meetings of the Executive Council, and who have accomplished almost everything that could be possible within one year.

Before I go into details of "The Surgical Oncologist," I would like your permission to say a few words about Dr. James Ewing in whose honor the original society was developed. While I had had the privilege of visiting him several times in the old hospital on 107th Street in New York City, when I returned to Memorial Hospital in 1941 for my second session of training there I was working with Dr. Fred Stewart and Dr. Frank Foote in tumor pathology. Inasmuch as the office they shared was small, I was put in the library across the hall next to Dr. Ewing's office. Because of my adjacency to him, I spent a substantial amount of time with him; some of it was academic, some was social. I have heard a good many stories about him. Some have said he did not like surgeons, but I do not believe this. I am fully aware of the fact that he was aggressive and dynamic when he was in an administrative position; yet at this time in his life he was spending most of his time doing medical-legal work, and writing a book on the epidemiology of cancer which for some reason has disappeared. As far as my experience with him at that time was concerned, he was a perfect gentleman, pleasant to everyone who came to see him for consultative reasons. Many such visitors he did not even know or had never heard of, but he was always

available to spend unlimited time with them, answering their questions and reviewing their slides. I never heard him raise his voice or say an unpleasant word during the year and a half I spent with him in tumor pathology. He had a pleasant home at the beach on Long Island and Fred Stewart and I were often his guests over the weekends. In early 1942 he was under pressure to become an honored professor in a chair of oncology in another institution. We discussed this on many occasions and he finally agreed that he would go as the occupant of the chair if I would go with him and do the work. I felt rather apprehensive about the arrangement since I was single at that time, World War II was on, and I really felt that as a single, relatively young surgeon, I should go into service. There was, however, an institutional arrangement that I would be immune from induction if I would go with him. About this time I was offered a position as Captain in an affiliated hospital unit. When Dr. Ewing heard this, he said go into the affiliated unit since he really would prefer to stay at Memorial Hospital, and in New York City. He was sincere and was relieved at being able to avoid the transfer from Memorial Hospital, so I went ahead and joined the hospital unit and went to Burma. Naturally, I was disturbed when I heard he had developed cancer of the bladder and died before I returned to Memorial Hospital in 1946 after the war was over.

Time is tight this afternoon and I had better get on with oncologic surgery. Dr. Robert Schweitzer gave an excellent talk on the role of the oncologic surgeon and cancer control two years ago and last year Dr. Edward Scanlon spoke in a very sophisticated way about the evolution of surgical oncology. Dr. Scanlon reviewed the development of the more recent oncologic specialists in chemotherapy, immunotherapy, and radiation therapy. While he certainly agreed that the oncologic surgeon was an integral part of the overall care of the cancer patient, he believed that several years ago the oncologic surgeon was scarcely identifiable as such. In his presentation last year he felt that the process of the revival of the oncologic surgeon had gone through a full circle and that surgical oncologists were again largely doing what they

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were doing 35 years ago. I would like to speak briefly about this.

I began my training as an oncologic surgeon 38 years ago. At that time the oncologic surgeon was full time within his field and handled the total aspects of cancer therapy. When I helped open the front doors of the new Memorial Hospital on 68th Street in 1939, each of the oncologic surgical specialists was in charge of all radiation to his patients as well as the surgical management and follow-up. Memorial Hospital was the outstanding cancer center at that time but there was no radiation therapist in the Department of Radiation. There were two excellent radiologic physicists, Dr. Failla and Dr. Edith Quimby, who operated the department and acted as very sophisticated consultants. Although these physicians and PhD's were full-time oncologists, neither cared for the term oncology and insisted on being called surgeons or physicists. This was possibly due to the fact that most physicians never informed their patients that they had cancer, although they usually did let some member of the family know. The word "cancer" was absolutely forbidden in any conversations with patients and their families and the word "oncology" was essentially unknown. What are the origins of the word "oncology"? The Greek words are *onkos*, meaning mass, and *logy*, meaning study, i.e., the study of tumors. What better descriptive term could have been used for any 100% specialist in any aspect of cancer study or treatment, and yet it was forbidden and rejected at that time.

When I returned from Burma around Christmas 1945, I received a telephone call from Memorial Hospital that I was to return January 1 as a Fellow in Surgery. I was a little surprised but interested in the appearance of mustard and some other investigational chemotherapeutic agents. I was also a little shaken when I found that a good many of the surgeons had lost their interest in radiation and were doing much more radical surgery. Only the head and neckers were persisting in radiation therapy.

There is no question that there is a marked difference between the philosophy of the general surgeon and the cancer surgeon. The general surgeon is indeed well trained, primarily is handling non-malignant conditions, is responsible for his surgery and the immediate postoperative phase but usually relinquishes his patients to some other type of specialist for continuing care. In contrast, the oncologic surgeon is well trained in general surgery, then has overlying training in special oncologic surgery. He must be

knowledgeable about radiation therapy, chemotherapy, and immunotherapy so that he is immediately aware of the advisability of multidisciplinary management of his patient. In addition to his surgical management of most cancer patients, he continues to follow them indefinitely, through recurrences and other complications to death. This may be over a period of several decades. After the decades when the oncologic surgeon accepted full control of the cancer patient, the specialities of radiation therapy, chemotherapy, and immunotherapy have been developed in well-organized training programs in appropriate institutions. In addition to their proper training, they indeed have been certified within their specialties and almost invariably restrain their clinical activities to cancer patients.

When I returned to Memorial Hospital as a Squibb-Olin Fellow in 1965, I found that the surgeons had totally separated themselves, or almost so, from radiation therapy; there was an impressive proliferation of radiotherapists totally dominating the radiation therapy department and the chemotherapists were doing the same thing for chemotherapeutic problems, including adjuvant therapy for surgical patients.

My personal feeling about the proper training for the oncologic surgeon is that he should either be boarded in general surgery or be eligible at the time he transplants to oncology. Most of us feel that he should then have 2 years of specialized training in oncology. One year should essentially be restricted to oncologic surgery; the residual time should include experience in medical and immuno-oncology, radiation therapy, and, it is hoped, pathology as well as continued activity in cancer surgery. Obviously, such training should be available in universities or institutions specifically organized for this purpose. These surgical oncologists should be active as authors for oncologic publications and unquestionably should restrain their activity to clinical cancer surgery. While I say 2 years of special training is appropriate, I confess that I spent 3½ years in cancer surgery mixed in with radiation (no chemotherapy in those days) and an additional 2 years in tumor pathology for a total of 5½ years in oncologic training. I may have been a little slow in learning but I have never regretted the time and experience I had during those 5½ years.

Well, to get back to what has been going on during the past year. In spring of 1975, the Board of Regents of the American College of Surgeons passed a resolution indicating that the

control of cancer was rapidly becoming a complex, multi-disciplinary activity; they recognized the emergence of a group of highly skilled specialists, including medical oncologists, radiation oncologists, pediatric, gynecologic, and pathological oncologists. They indicated surgeons have contributed and must continue to contribute a large portion of the teaching, research, diagnosis, and therapy for cancer. They recognized that these contributions are essential for proper patient care and stated: be it "Resolved, that the American College of Surgeons continues to support standards of excellence for surgeons involved with cancer education, research, diagnosis, and treatment, and that these surgeons are competent to act as members of the multi-disciplinary cancer team as surgical oncologists." The previous James Ewing Society, primarily a society of oncologic surgeons and other certified oncologists, changed its title to The Society of Surgical Oncology. The Society of Surgical Oncology has strengthened its multi-disciplinary approach to cancer control by the addition of outstanding radiation therapists, medical and immuno-oncologists to the Society. The Society of Surgical Oncology has an improved relationship with the National Cancer Institute and its Division of Cancer Treatment, headed by Dr. Vincent DeVita. The Society has made available to Dr. DeVita specifically identifiable surgical oncologists for consultative and planning purposes and some have been added to the editorial advisory board of the *Journal of Cancer Treatment Reports*. The American Cancer Society has modified its Junior Faculty Clinical Fellowships which are 3-year appointments; they now require that the candidates either be eligible for their boards in their specialty or, if they have completed their boards, be considered as applicants in institutions only capable of supplying the 3-year specialized program for the fellow in his oncologic field. The American Cancer Society also modified its 1-year Clinical Fellowship Program at the last meeting of the Board of Directors in February. The awards will be made only to training programs that provide 12 consecutive months of training devoted solely

to oncology in the designated specialty or subspecialty of cancer therapy. This means that most of the institutions previously having surgical oncology fellowships are going to have to reorganize their surgical program so that the trainee has a full year of surgical oncologic training. Along with the other hard-working committees who are involved in the reorganization of this Society, the Committee on Membership Qualifications for The Society of Surgical Oncology has developed qualifications for eligibility for entry as a surgical oncologist. These qualifications include board certification by the American Board of Surgery or equivalent, completion of 1 year of specialized training in surgical oncology, at least 2 years of oncologic experience following completion of the training period, and involvement in a certain volume of surgical oncologic operative procedures. The majority of time the member's will be devoted to surgical oncology and activity in developing publications on cancer in national medical journals. The membership qualifications for specialists in the Society other than the surgical oncologist is relatively simple, inasmuch as almost all of them are certified in subspecialty oncologic organizations. Though these proposed qualifications for membership in the Society for the trained surgical oncologist may be modified in the future, they provide a framework for the identification of the surgical oncologist by specifying the minimal criteria for eligibility as a surgical member of The Society of Surgical Oncology.

I confess I am slightly disturbed that all of the members of The Society of Surgical Oncology, other than the surgical oncologists (and the tumor pathologists), are specifically certified by their American Boards or subspecialty boards as to their therapeutic identity. While I realize that at this time certification of the surgical oncologist is indefinitely deferred, I strongly believe that it is the responsibility of this Society to continue to develop criteria for the education, training, and clinical activities for surgeons in this Society in hopes of accelerating some future form of certification for its members.