

Presidential Address: Surgical Oncology- Expectations for the Future

LASALLE D. LEFFALL, JR, MD

FIRST, I WANT TO EXPRESS my sincere gratitude and thanks to the members of the Society of Surgical Oncology (SSO) for according me the very high honor of serving as your president. Furthermore, I would like to express my thanks to the members who have done so much to foster the growth of our Society. Without your support, nothing substantial could have been achieved. As some measure of thanks to my mentors in surgical oncology, I would like to dedicate my remarks to them. The Society continues to be representative of surgical oncology on a national basis. There has been steady increase of non-Memorial graduates in the Society; they comprise about 60 percent of the total membership. A review of the current membership list of over 700 shows this fact with respect to any previous or present affiliation with Memorial Hospital (MH) (Table 1). Although our name has been changed from the James Ewing Society Inc. to the Society of Surgical Oncology Inc. (founded as the James Ewing Society), we must be vigilant in our efforts to have true multidisciplinary representation and participation in our Society. This must be a firm and resolute commitment. We have made contact with surgical oncology societies in some foreign countries. These efforts should be intensified. Having common objectives, these societies could serve as a catalyst for international surgical oncology research programs.

One of the most noteworthy events in our ranks during the past year was the workshop on graduate education in surgical oncology sponsored jointly by the Society of Surgical Oncology and the Division of Cancer Research, Resources and Centers of the National Cancer Institute. This workshop was held at the National Institutes of Health in Bethesda,

Maryland, on September 5 and 6, 1978. The purpose of the meeting was to discuss the role of the surgical oncologist in various settings as regards teaching, research, and administration and to establish training guidelines for the education of surgical oncologists. The workshop participants agreed that a surgical oncologist should be a well-trained general surgeon or other surgical specialist with broad interests and expertise in oncology obtained through special postgraduate training that gives him exposure to other oncologic modalities and allied health disciplines. Although the role of the surgical oncologist may vary in different settings, the educational program should be similar for all surgical oncologists and should include the following:

1. Adequate clinical resources in the institution. These clinical resources include a sufficient variety and volume of clinical material, access to all diagnostic and treatment disciplines, and various basic science resources that would allow a well-rounded program.
2. A cancer program approved by the Commission on Cancer of the American College of Surgeons.
3. A two-year program of broad training on a surgical oncology service in addition to the time required to make the individual eligible for certification by the American Board of Surgery or other surgical specialty Board.
4. An adequate operative experience that should include standard curative and palliative procedures as well as the more unusual radical operations with formal documentation of the total operative experience.
5. Exposure to basic and clinical research.
6. Interaction with other surgical specialties related to cancer.
7. A full-time assignment to radiation oncology and medical oncology services preferably early in the training program and of sufficient duration to permit the trainee to gain confidence and knowledge in these disciplines.
8. Adequate and continued exposure through the entire course of the program to pathology, including anatomic pathology, clinical immunology, and microbiology.

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Professor and Chairman, Department of Surgery, Howard University College of Medicine.

Address for reprints: LaSalle D. Leffall, Jr., Department of Surgery Howard University Hospital, 2041 Georgia Avenue, NW, Washington, D. C. 20060.

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TABLE 1. Composition of Society Membership and Relationship of Memorial Hospital (MH) and Non Memorial Hospital Affiliation

Type of membership	Associated with MH	Not associated with MH
Active	244	338
Inactive	7	21
Corresponding	3	18
Senior	68	47
Honorary	0	6
TOTAL	322	430

9. Adequate exposure to the non-clinical and allied health disciplines which would be provided in part by some formal structured course work over the entire span of the training program.

10. A formal audit of the progress and learning process by means of formalized evaluation testing methods developed by the program director for every aspect of the program.

The effectiveness of the training program can be evaluated by 1) reviewing the details of the program itself and 2) by evaluating the physician completing the program. Some method of identifying expertise in the field of surgical oncology is desirable. Although formal certification might be the ultimate goal, the formation of a separate, independent specialty Board is not desirable at this time. Less formal recognition of expertise might be achieved by membership in the Society of Surgical Oncology whose specific criteria for membership are the training, background, and actual professional functions of the applicant. Continued study and reappraisal of these training guidelines are essential.⁵

Recognizing the importance of maintaining proper liaison with governmental agencies that interact with the SSO, the Executive Council recommended the establishment of a Government Relations Committee. This Committee called attention to the discrepancy between the amount of surgery done for cancer in the United States and the paucity of funds allocated for training grants and research in surgical oncology. Another problem facing the surgical oncologist is that site visits are frequently performed by non-surgeons, sometimes producing an unfair evaluation of surgically oriented research projects. It is essential that a cadre of surgical oncologists be available for site visits with programming well in advance to enable them to fulfill their duties. The Committee asked the American Cancer Society for greater support of surgical oncology training and research projects. In order to achieve the objectives of the Government Relations Committee, the Society approved the formation of a Surgical Oncology Training and Research Task Force. The task force would bring together a group of surgical oncologists in a work-

shop to define areas of research and ways in which the surgical oncology community can be more involved in research programs of the NCI. The long range goal of this workshop would be to develop more formal ways of including the surgical oncology community in such research programs.

With the development of a research plan, the surgical oncologist has this opportunity for discovery and the creation of new knowledge. The dividends of this research can be highly rewarding. This Committee should be knowledgeable about legislative aspects of funding to help obtain funds from local, state, and federal agencies. This newly formed Government Relations Committee will be of great value in our hopes for the future. The NCI has created a special surgical oncology extramural section in the Clinical Investigation Branch that will be responsible for developing surgical oncology programs and relationships between the NCI and outside surgical oncologists. The NCI has developed a specific request called a "Request for Grant Application" (RFA) for proposals for new approaches in surgical oncology. These are not contracts but investigator initiated grants. As an initial effort, one million dollars has been allocated for both clinical and laboratory research projects. This is a beginning, but much more money is needed. The SSO would like to thank the leadership of the NCI for its support, cooperation, and willingness in discussing matters of mutual concern. The Society anticipates even closer ties with the NCI in the coming years.

A joint meeting of surgical committee chairmen of cancer cooperative groups and representatives of the National Cancer Institute was held in September, 1978. One of the goals of the newly formed Government Relations Committee is to increase the NCI's support of cooperative groups and surgeon participation in them. At this meeting, it was decided that surgeons should be in positions of leadership within their cooperative groups; be active participants on committees and subcommittees; attend and participate in group meetings; initiate and write surgical and multimodal protocols, whether primary or adjuvant; seek out and encourage those who have the expertise and interest to write protocols; and be involved in the early staging of any surgically managed malignant disease. Some topics that need further study and discussion as related to cooperative trials are the role of the surgeon in clinical trials; the role of the surgeon in protocol design (relationship to other modalities); the best means of surgical quality control; surgical workshops as a method for standardizing operative techniques; surgical morbidity and mortality report forms; the best methods for establishing communication for surgeons in the cooperative groups; and guidelines for funding of the surgery committees and the

individual surgeon contributions. To achieve the best results for our patients, surgical oncologists must become more involved in research and protocol studies.⁶

One of the great stumbling blocks to truth is the inherent error of undisciplined observation. Anecdotal accounts of clinical results have little scientific validity and should be avoided. Participation of surgical oncologists in controlled clinical trials is mandatory if reliable data are to be developed. The prospective randomized clinical trial is perhaps the most important way to approach treatment questions. The surgical oncologist must serve as the liaison between research and clinical practice. He will be called upon to identify those patients who could benefit from additional forms of therapy. Above all he has a vital educational role to play. The oncologic surgeon must join with his colleagues in other disciplines; otherwise he will be excluded from their clinical trials and their financial support from both governmental and non-governmental agencies who are sponsoring such trials. Failure to become a member of the therapeutic team initially will make it more difficult to join with that team in an effective way at a later time.⁷

It is only by active participation of all members openly expressing their concerns that we can remain in the vanguard of current oncologic thought relating to improving diagnostic and therapeutic modalities. Full discussion of issues must occur. However, once the membership decides on a course of action, all of us must join forces as a team to accomplish our goals. We must speak with a strong, unified voice in matters concerning surgical oncology. Above all, we must avoid the inertia of the discontent. Such inactivity bodes ill for our cause.

A study of the history of our Society—especially a look at James Ewing—gives some perspective to our achievements and some expectations for the future. It was aptly stated by Goethe that the history of science is science itself. On 12 January 1931, Ewing's picture appeared on the front cover of *Time* magazine. "Not many men have received such formal homage while they were still alive," wrote *Time*, adding, "Professor Ewing thinks that the United States is far from being properly mobilized for its cancer war. He wants mightier weapons than any now available—6 cancer institutions each endowed with \$10 million. He would have them scattered across the country, fortresses wither crusaders might rally, whence they might sally."¹¹ What if he could now see the 21 comprehensive cancer centers in our country along with numerous other specialized cancer facilities as community cancer centers, cancer institutes, and research institutes. Surely he would laud this as a step in the right direction, but he would encourage the granting of the needed financial support for these institutions to perform their tasks properly.

In November 1931, Ewing spoke at the inaugural



James Ewing.

ceremonies of the Research Hospital of the State Institute for the Study of Malignant Disease in Buffalo, New York. He pointed out the precedent established by the New York legislature in committing funds to cancer research. "I do not look for any startling discoveries," he said "reduction of the cancer mortality will come chiefly from separate factors." Thus he emphasized that the cancer struggle would be a marathon not a sprint. He thought well-founded the search for chemotherapeutic agents which "may someday be successful," and also the possibilities of enhancing "Nature's own devices."¹⁴ In light of current knowledge, Ewing's ideas about the possible role of chemo- and immunotherapy appear prophetic. It is most fitting and appropriate that although the Society's name was changed four years ago the name of James Ewing remains an integral part of our official name—The Society of Surgical Oncology (founded as the James Ewing Society, Inc.). James Ewing was one of the founders (1913) and for many years an important driving force of the American Society for the Control of Cancer, the precursor of the American Cancer Society. He was also one of the founders of the Bone Tumor Registry of the American College of Surgeons.

Ewing's long fight against cancer is best summed up in something he himself said at the banquet when he

became head of Memorial Hospital. No more profound question was ever put than that which Cain sneeringly addressed to Jehovah: "Am I my brother's keeper?" Ewing's gaze swept the ballroom filled with friends as he gave this answer "Yes, by Jove, I am."³ This response reminds us that we must never forget the human side of cancer. We must exhibit the sensitivity, hope, and compassion that will show genuine concern for our patients.

In the course of human existence, what is important is not so much intellectual superiority or charismatic presence but rather something the Romans called *gravitas*—patience, stamina, and good judgement. But the prime virtue is courage because it makes all other virtues possible. As a surgical oncologist treating patients with cancer, I have seen the human condition in peril. I have seen the stubborn persistence of hope when under ordinary circumstances there should be no hope. I have seen patients who seem to regard life itself as a constant opponent. I have seen an exhibition of faith that comes from those of strong moral fiber. I have seen the eyes of patients that seem to ask questions with the dignity of mute entreaty. I have seen a demonstration of courage that defies description. And when I see these and more, it lets me know that as oncologists we must be more sensitive, more caring, and more compassionate to the patients committed to our care. Perhaps, the French Jesuit philosopher Teilhard de Chardin expressed it best when he said, "Someday after mastering the winds, the waves, the tides and

gravity, we shall harness for God the energies of love and then for the second time in the history of the world man shall have discovered fire." It was that love and that fire that James Ewing thought so important if we are to give patients the very best care.

"The approval of one's fellow men is a legitimate ambition of every right minded person"—said Ewing at his testimonial dinner—"and from this standpoint, I am bold enough to regard the compliments of this occasion. . . . Man is just what his friends make him. My friends have done well by me."² And we can add that his friends will continue to do well by him, by exerting their energy, concern, passion, and personal commitment to his dream—the never-ending struggle to conquer cancer. And that is the essence of our expectations for the future.

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