

PRESIDENTIAL ADDRESS

The Privileges and the Responsibilities of a Surgical Oncologist

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A surgical oncologist should teach at the undergraduate or postgraduate level, play a leadership role in oncology in either the community hospital or in an academic institution, encourage or participate in basic or clinical oncologic research, and foster interdisciplinary cooperation with the other oncologic specialists. The surgical oncologist should take an active role in educating the general surgical community through programs of the American College of Surgeons Commission on Cancer. Professional recognition of Surgical Oncology should be secured through the examination of surgical oncologists. The privilege of being a surgical oncologist carries with it the responsibility of recognition, certification, increased research effort and team involvement for optimal cancer care.

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IT HAS BEEN a great honor, indeed, to serve as the 37th President of the Society of Surgical Oncology—a society of over 800 prestigious physicians—leaders in this field. It is a great privilege also, to preside over the meeting here in New York City this year: for 1984 marks the centennial of the founding of Memorial Hospital, which grew to become the Memorial Sloan-Kettering Cancer Center, as we know it today. How appropriate that two of its alumni organizations, the Society of Surgical Oncology and the Society of Head and Neck Surgeons, should choose to hold a joint meeting during the week that marks the 100th anniversary of the hospital.

Our organization was founded in 1946 as the James Ewing Society by many of Dr. Ewing's Associates and their fellows to perpetuate the "Chief's" high ideals and concepts in oncology. Dr. Ewing was privileged to study in Europe early in his postdoctoral years and shortly thereafter (in 1902) received a Cancer Research Grant from the Huntington Fund, thereby launching his career in oncology. He became the first Professor of Pathology

at the Cornell University Medical College at age 33 and throughout his career demonstrated exemplary oncologic responsibility as a clinician, a researcher, an author, a leader, and a visionary. In his book entitled *Neoplastic Diseases*, Ewing described oncology as the most complex and fascinating field in pathology. It was "Cancer Man Ewing" who proposed an affiliation of the Memorial Hospital with Cornell University. He was one of the founders (in 1913) of the organization, which grew to become the American Cancer Society, and was also one of the founders of the Bone Tumor Registry of the American College of Surgeons. One can now appreciate why Cancer Man Ewing was honored on the cover of *Time* magazine when he retired from Cornell in 1932. Sadly, the disease to which he devoted a lifetime of study was to cause his demise in 1943. For all his ideals and achievements, it is indeed a fitting tribute to remember Dr. James Ewing as the father of oncology.

As the inheritors of Dr. Ewing's legacy, the members of this society shoulder the enormous responsibility to continue his tradition of excellence. Dr. Ewing's tradition leads our members to continuously update our knowledge of oncology. Dr. Ewing's tradition drives us to apply this specialized knowledge at the clinical level so that today's cancer patients may benefit from all knowledge that is available today. Finally, Dr. Ewing's legacy also propels our membership toward further advancement through research to benefit tomorrow's cancer patients.

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Let us reflect for a moment upon the professional profile of a surgical oncologist, typical of the membership of our society. He or she is a board qualified general surgeon or subspecialist with additional postgraduate training in surgical oncology. This surgeon also possesses knowledge of current techniques and treatment by radiotherapy, chemotherapy, and immunotherapy. To remain at the leading edge of our specialty, the training committee of our Society of Surgical Oncology has skillfully outlined modern guidelines. Six training programs are now sanctioned by the Society of Surgical Oncology, and this number should grow significantly in the coming years. Recently, we have observed a trend in some medical schools to establish a section or a division of surgical oncology with a dual purpose: first, to focus upon and influence oncologic education at the undergraduate and postgraduate level and, second, to train specialists in surgical oncology.

The privilege of being a surgical oncologist carries with it a dedicated professional responsibility. One of the most important of these is a teaching role with medical students, residents, and fellows, not only to stimulate their interest, but also to share with them our specialized knowledge. We must educate and involve surgeons in the oncologic discipline; we must encourage and carry on research in basic and clinical areas; we must participate in and foster interdisciplinary cooperative studies. We must attend and participate in symposia devoted to surgical oncology and exchange ideas with other experts in our profession throughout the country, and even beyond its borders. Most significantly, we must provide leadership to the modern cancer treatment teams in our community hospitals.

I do not envision that current efforts to establish recognition of surgical oncology as a specialty will eliminate the operative treatment of common cancers by general surgeons and surgical subspecialists. Instead, our efforts should greatly expand the involvement of all surgeons in protocol studies, restore the role of the surgeon in the team management of all cancer cases, and relegate the surgical management of the uncommon and complex cancer cases to the surgical oncologist. Because at the current time surgery is the treatment of choice for an overwhelming majority of curable cancer patients, surgery will play a prominent role in cancer management in the future. If earlier cancer diagnosis through screening of high-risk populations was to be successful, the surgical caseload would significantly increase. It is probable that future trends in surgical management will become more individualized according to stage and will be more team-integrated.

The surgical community has been much too slow to adapt to the changing oncologic scene. In the past decades, the American Board of Radiology has recog-

nized and certified the therapeutic radiologist, the American Board of Medicine has recognized and certified the medical oncologist, the American Board of Pediatrics has recognized and certified the pediatric oncologist; all have provided responsible leadership in their fields. In contrast, only the American Board of Obstetrics-Gynecology has acted for the surgical specialist by recognizing and certifying the gynecologic oncologist. This inertia is difficult to justify since the role of the surgical oncologist has been clearly documented by our Society and recognized by the National Cancer Institute. Furthermore, the surgical oncology movement is now international in scope, with societies in England, Europe, and Japan. All of these societies are aware of the need to recognize the surgeon. Our Society of Surgical Oncology is leading the way.

With this in mind, let us review recent developments in the US in this area of medicine.

In 1976, the National Cancer Institute recognized the need to foster the growth of surgical oncology within the multidisciplinary fields of oncology. Therefore, it established a surgical oncology subcommittee in the division of cancer treatment.

In 1977, the National Cancer Institute funded 21 of 57 applicants to pursue surgical oncology studies for an aggregate stipend amount of 1.6 million dollars.

In 1978, the Division of Cancer Research Resources and Centers (DRRC) of the National Cancer Institute sponsored a workshop and established some education guidelines for surgical oncology. During the same year the Society of Surgical Oncology established a surgical oncology personnel resources and government relations committee which, after a study, concluded that: (1) The US has a shortage of surgical oncologists; (2) the deficiency is most probably due to a lack of training and funding opportunities in academic centers to allow the recruitment of young surgeons into this discipline; (3) the number of surgeons involved in clinical investigations in oncology is grossly inadequate; and (4) the Society of Surgical Oncology should sponsor a workshop to find a solution to these problems.

In 1980, the workshop of the Society of Surgical Oncology, held in Chicago, reviewed current surgical oncology research efforts. A surgical oncology research development subcommittee was established by the Board of Scientific Counselors of the Division of Cancer Treatment under the auspices of the National Cancer Institute. A formal proposal for grant support for surgical oncologic research development was formulated, and 14 of 21 requests for application for research development were funded in the aggregate sum of \$481,000.

In 1981, 9 of 51 RO1 (traditional) grants were funded for \$1,100,000; and 1 of 6 PO-1 (Program project) research grants was funded for \$916,000.

In September 1983, the Society of Surgical Oncology held a workshop in Buffalo, New York, entitled "Surgical Oncology—Progress and Plans." At the conclusion of that workshop, the following action items were recommended.

1. Professional recognition of surgical oncology should be secured through examination of surgical oncologists.

2. All medical schools should establish divisions or sections of surgical oncology within the department of surgery to impact the medical school curriculum, to reestablish the surgeon's role in multidisciplinary cancer care, to strengthen the oncologic experience of all surgical program trainees and, if feasible, to establish a post-residency training program in surgical oncology consistent with the Society's training guidelines.

3. Surgical oncologic research must be promoted through increased surgical participation in cooperative protocol studies, greater representation of surgical oncologists on grant review committees, training of surgical oncologists through post-residency programs, and through increased funding commitments from sources such as the National Cancer Institute, American Cancer Society, and other organizations.

4. Surgical oncologists should participate in a variety of cancer control activities at the hospital, regional, state, national, and international levels and should participate in patterns of care studies utilizing existing data bases.

5. A survey should be done in order to project the future need for surgical oncologists, both academic and community.

6. The Society should establish interaction with other oncologic disciplines through liaison representation, joint meetings, and combined cooperative studies.

7. The Society should expand its continuing educational activities for surgical oncologists, and its membership should take active roles in educating the general surgical community through programs of the American College of Surgeons Commission on Cancer and other groups.

I strongly endorse all of these recommendations. I know that the membership approves them, and I trust that the leadership of our organization will be responsible for their implementation.

Since the Buffalo workshop was held, a committee has been appointed to plan the certification process for surgical oncologists. A survey of surgical oncology in our medical schools has been funded by the Society of Surgical Oncology and is in the planning stage. Dr. DeVita and the National Cancer Institute staff were most supportive of our workshop conclusions and have discussed many of the Buffalo recommendations at the January 1984 meeting of the National Cancer Advisory

Board. Medical schools can now apply for professional oncology education grants (R-25) to provide support for predoctoral oncologic curriculum development, as well as for faculty costs for undergraduate medical education. The Surgical Oncology Research Development Subcommittee (SORDS) of the Board of Scientific Councilors of the Division of Cancer Treatment has urged greater funding for surgical oncology programs in both the clinical and research areas. It is clearly recognized that the establishment of cohesive surgical oncology units in the primary training institutions is of central importance to firmly establish surgical oncology as a recognized surgical specialty. Additional support mechanisms currently available from the National Cancer Institute include the following. (1) KO8: Clinical Investigator Awards for postgraduate research training; (2) T32: National Research Service Award for pre- and postdoctoral trainees; (3) (F32, F33): National Research Service Awards for individual postdoctoral research awards; and (4) Cancer Center Core Grants for Fellowship Awards.

Dr. DeVita has recommended that the highest priority be given to research training for surgical oncologists so that surgeons can compete on an equal footing with other medical scientists in research activities in cell biology, immunology, carcinogenesis, and other basic science areas. Now that professional interest has been kindled in our surgical specialty and is gaining momentum steadily, our Society of Surgical Oncology must play an instrumental role in focusing that attention onto appropriate areas of concern.

During my tenure as your President, the following questions have been formulated that will require the attention of the Society of Surgical Oncology in the future:

1. How many surgical oncologists are needed for our community hospitals where 85% of cancer is now treated? What should be their leadership role?

2. How do we stimulate careers in surgical oncology for physicians who are now in surgical training?

3. Can patterns of care studies evaluate quality of oncologic surgical treatment? When can less extensive surgery be done without sacrificing cure? What procedures are necessary and cost-effective in follow-up after oncologic surgery? How do we encourage universal use of the American Joint Committee (AJC) cancer staging?

4. How can more surgeons be convinced to enter patients on protocol studies? Can we learn from the Childrens Cancer Study Group experience?

5. How can we promote the Cancer Management Course of the American College of Surgeons? Should there be an oncologic Surgical Education and Self-Assessment Program (SESAP) exam for the nononcologic surgeon?

6. Should the Society of Surgical Oncology consider joining a coalition of oncologic societies to solve common problems such as treatment of local recurrences, cost effectiveness of cancer care, psychosocial issues, screening for second cancers, and related matters?

7. Should there be primary, secondary, and tertiary centers for cancer care as there are for trauma?

The membership of the Society of Surgical Oncology has now reached a pivotal decision point regarding the future of surgical oncology. Recognition by the medical community is long overdue; certification will allow surgical oncologists to enjoy the privileges of their specialty and join the already "recognized" oncologists such as the medical, radiation, pediatric, and gynecologic oncologists in the fight against cancer. Clearly, the graduates of the six recognized surgical oncology training programs sanctioned by the Society deserve certification when they pass a qualifying examination.

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with it the responsibility of recognition, certification, increased research effort, and team involvement for optimal cancer care.

Surgical oncologists should now be responsible for the implementation of the Buffalo workshop recommendations. Major emphasis in that workshop has been placed on the university surgical oncologist, but the community surgical oncologist should also play an expanded role in community cancer care. Teamwork means multidisciplinary care and should be given more than lip service. The era of the oncologist who, by himself, treats all cancer is fast-disappearing and may be replaced by the subspecialist, using one or more treatment modalities applied to one region such as breast, head and neck, thoracic, *etc.*

To serve as your leader during the last year has been a rewarding experience for me personally, as well as professionally. May I urge that all of you put renewed vigor into carrying out your responsibilities in cancer control during the 1980s and beyond.