

The Role of the Surgical Oncologist in the Community Hospital

Presidential Address

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I am grateful to all the members of the Society of Surgical Oncology for allowing me to serve as your president this past year and to the executive council and committees for their guidance and help in directing the Society's affairs. Twenty-eight years ago, I became a member of the Society, and it has been a major factor in my professional growth.

Before starting on the main theme of my address, I wish to review with you some aspects of surgical oncology that James Ewing and his associates shared. The concept of the multidisciplinary approach was Dr Ewing's brainchild as he gathered experts to staff the Memorial Hospital in New York City. Decision making based on combined expertise and wide knowledge of the pathology and natural history of cancer lifted treatment out of its old custodial care role to a challenging, exciting, and progressive level. Catalyzed by the discoveries of antibiotics, safe blood transfusions, and fluid and electrolyte balance, the surgical cure for cancer advanced rapidly on many fronts. Many of these cancer surgeons, who devoted all of their professional time to treating only patients with cancer, sought recognition of their expertise. I quote from the minutes of the 1946 James Ewing Society business meeting:

The question of recognition of fellows trained at Memorial Hospital by the American Board of Surgery was again raised. It was the consensus that the James Ewing Society should make every effort in the future to help in the initiation of the establishment of a Board of Oncology. Dr Whipple is to be consulted and asked to advise and to participate in this movement. On motion by Dr Rekers, seconded by Dr McNeer, the president was instructed to appoint a

committee to investigate and study the question of the establishment of a Board of Oncology.

That was 40 years ago, and the desire for professional recognition remains largely unsatisfied. The American College of Surgeons, through its postgraduate courses in surgical oncology, the Surgical Forum, and the new Cancer Management course, has recognized surgical oncology as a distinct specialty. The fear of fragmentation of general surgery by further certification is repeatedly expressed in the February 1986 *Bulletin of the College of Surgeons* and by Eugene Bricker in his presidential address to the American Surgical Society. Our Society has laid all the necessary foundations for added certification. A 1978 workshop in conjunction with the National Cancer Institute resulted in a definition of the term *surgical oncologist* and established criteria for adequate postresidency fellowship programs. In a workshop in 1983 held at Roswell Park Institute, Gerald Murphy clearly stated that "the field of surgical oncology should be recognized through professional certification and recertification or its equivalent by the Society of Surgical Oncology." The deliberations of these workshops resulted in training guidelines, curricula, and eight surgical oncology fellowship programs that remain under the careful surveillance of Robert Schweitzer and the training committee. An examination for graduate fellows has been prepared with the cooperation of the National Board of Medical Examiners. These considerable accomplishments by the past leadership of the Society are now in limbo awaiting the Board of Surgery's decision on special certification. We hope that the Board will agree that by issuing its own certificate of special qualification in surgical oncology, it may prevent the bleeding away from general surgery of thyroid, parathyroid, parotid, and oral cancer surgery to otolaryngologist-head and neck sur-

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geons; soft-part sarcomas to orthopedists; and breast cancer to gynecologists.

For the past 30 years, I have practiced surgical oncology in the community hospitals of the Miami area. As in other areas, only 20% of the patients with cancer are treated in the definitive comprehensive cancer center associated with the University of Miami School of Medicine. The remaining 80% are treated in community hospitals by competent board-certified physicians. It is in the community hospital setting that professional recognition of the surgical oncologist takes on added importance. The patient suffering from a complicated problem that may require surgery is often at a loss to seek expertise for his or her problem. The increasingly sophisticated patient seeks board-certified help, having learned that his or her medical oncologist and radiation oncologist are indeed board certified. The assurance from the prestigious American Board of Surgery that the physician has special qualifications in surgical oncology can help the patient choose a consultant. Thus, the certificate is a public service as well as a peer recognition of special expertise. Walter Lawrence has surveyed the university surgical programs and has detailed the role of the surgical oncologist in that setting. However, the vast majority of patients with cancer are treated in non-university-affiliated community hospitals by technically competent, board-certified surgeons. The surgical oncologist, by virtue of special attributes that were so clearly outlined by Condit Moore in his 1981 presidential address, can be the spark plug of an active cancer program approved by the American College of Surgeons. Rather than functioning as an adversary or competitor of the general surgeon in the hospital, the surgical oncologist should freely provide thoughtful second opinions and consultations without unnecessarily usurping these cases. By demonstrating familiarity with the natural history of cancer, by feeling at ease—by virtue of a basic science background—with new concepts of tumor biology, and by performing technical procedures above and beyond the ability of the average general surgeon, the surgical oncologist can assume a leadership role in the surgical treatment of complicated advanced or mis-handled cancer cases. I think one of the most important functions of the surgical oncologist in the community hospital is to rekindle the general surgeon's interest and involvement in the treatment of cancer.

By developing a hospital cancer program with its cancer committee, tumor registry, and multidisciplinary tumor conference, the surgical oncologist can work within a framework that has proven value. In southern Florida, there has been a surge in new hospital cancer programs resulting in part from the need to stay competitive with other hospitals in the area and in part from enlightened

patients requesting that their treatment take place in a hospital with a cancer program. Administrators alert to the marketing advantage of the program are eagerly providing financial support. They recognize that of the 5000 hospitals in the United States, approximately 1200 have approved tumor programs and 80% of the patients with cancer are treated in these hospitals. The multidisciplinary cancer conference, as a component of the hospital cancer program, has become a valuable resource of the community hospital in managing its patients with cancer. In my role as South Florida Liaison Director for the American College of Surgeons, I have noted the decreasing role of the general surgeon in the establishment and conduct of the hospital cancer programs. The term *liaison fellow* had to be enlarged to include the term *liaison physician* because so many of the leaders of programs were not fellows of the American College of Surgeons but rather radiation oncologists or medical oncologists. In many hospital tumor programs, the absence of general surgeons from the cancer conferences is an ongoing problem. In this setting the surgical oncologist can act as a representative of general surgery at the multidisciplinary conference, and by example and by judicious case presentations requiring surgical expertise, the surgical oncologist can encourage attendance at these conferences and directly improve the treatment of patients with cancer in the hospital.

The follow-up of the surgically treated cancer patient is facilitated by the automatic recall system of the tumor registry in the community hospital. Continuous surveillance of these patients for local recurrence, new primary lesions, and preventive measures can best be performed by the surgical oncologist because his or her knowledge of the vagaries and natural history of cancer is surpassed by no other specialty. To perform surgery and then turn the case over to the medical oncologist converts us to mere technicians. Dr Ewing, following this precept, set up follow-up clinics at Memorial Hospital where patients were followed up for decades and personally examined by the giants of the time: Martin, Adair, Brunschwig, Pack, Coley, and others. The data collected from these follow-up clinics have had profound influence on our present day practice.

The clinical trial has revolutionized in two decades our approach to the treatment of breast cancer, and whether we agree with them or not, new icons with "body by Fisher" are replacing our old beliefs. The surgical oncologist in the community hospital should encourage participation of general surgical colleagues in such clinical trials and, by example, demonstrate the benefits of better patient care and follow-up generated by these programs. By playing this role, the surgical oncologist can help restore surgery to its rightful leadership position in the treatment of cancer.