

The Society of Surgical Oncology at a Crossroads: Thoughts for the Future

Presidential Address

Blake Cady, MD

I am deeply honored by being elected president of the Society of Surgical Oncology. In my most extravagant dreams as a college and medical student or surgical resident, I never envisioned being so honored or rewarded. I fully recognize, as in so many careers, that I was lucky enough to be in the right place at the right time. Having taken 5 years to get through high school, I was lucky enough to have two teachers who pushed me ahead and into Amherst College. As a slightly better-than-average college student and without French or German courses usually required, I was lucky enough to make my selection of medicine as a career change from psychology late enough so that Cornell University did not see my organic grades before accepting me! My luck persisted, though sometimes in obscure ways, by not being accepted at either my first or second choice of internship. I arrived at Boston City Hospital under the guidance of Gardner Childs at the Tufts University surgical program. Luck continued when, on returning from the Berry plan in the Navy and missing a Tufts reappointment because of a resident numbers crunch, the Harvard Surgical Service at Boston City Hospital welcomed me into their program soon to be headed by William McDermott. When finishing at Boston City Hospital, several of us, Gene McDonough, Harry Goldsmith, and Sterling Tignor, discussed the idea of training at Memorial Hospital and then returning to Boston City Hospital to develop a combined surgical cancer program. I was particularly attracted to the idea of bringing rational thought to surgical management of cancer, which I felt was notably absent at that time. As the Memorial Hospital traineeship finished, Neil Sedgwick from the Lahey Clinic approached me because of the clinic's need for someone trained in cancer surgery to pick up the position



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vacated by Elton Watkins, who had to give up operative work because of advancing arthritis. With the opportunity to operate on, analyze, and describe the enormous clinical material at the Lahey Clinic, I was able to continue as a student of the clinical biology of human cancer, a field of such continued tragedy and challenge that it easily provides the intellectual interest, patient gratification, and personal pleasure to support a career. I am still excited by a clinical week such as one this past April when, on successive days, I operated on a patient with difficult insulinoma of the left side of the uncinate process of the pancreas utilizing intraoperative ultrasound; a patient with a large adenoma of the ampulla of Vater that had

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produced biliary and pancreatic obstruction, yet was amenable to local transduodenal resection with sphincteroplasty of both ducts; a 74-year-old woman with metastatic colon cancer by means of right hepatic resection; and two patients with breast cancer in an early stage that required careful local excisions. Forty-five minutes of discussion with each patient with breast cancer and her family to help her choose from the wide variations in therapeutic options is an important part of current surgical oncology and an interesting study in human dynamics. I like to think that all this is almost too much fun to be paid for! Willie Mays marveled that he could make such a good living at what was pure pleasure! For me, this is the case with surgical oncology—a field of wide practical knowledge and application that helps individual patients in their personal battles with fear and mortality. Patients with cancer provide the opportunity to work with the ultimate issues of life, and with empathy and trust, these encounters provide extraordinary personal experiences and relationships for surgeons. I am constantly in awe of the daily courage of patients dealing with these diseases.

Before moving on to my view of the crossroads at which the Society of Surgical Oncology lies, I wish to honor by mention a few of my surgical mentors, as Brad Aust so beautifully did last year: Frank Glenn was chairman at Cornell University when I was a student and gave a glimpse of the discipline and precision of a Halsted-style residency. Gardner Child continued this lesson, only in the jungles of Boston City Hospital rather than the manicured magnificence of New York Hospital. Bill McDermott, my later chief at Boston City Hospital and the New England Deaconess Hospital, demonstrated the political and intellectual skills, as well as the Irish love of language, that enabled him to thrive in the disparate worlds of Harvard University and the Boston City Hospital simultaneously. Bill Rogers, a Memorial Hospital graduate, first encouraged me at Pondville Hospital to a career in cancer surgery, as did Ernie Daland, the grand old man of Massachusetts surgical oncology. Henry Randall was an early inspiration in his concern for medical students, residents, and the training process, and his commitment to a scientific approach to physiology. The many surgeons at Memorial Hospital were instrumental in shaping my career and cancer interest; Jerry Urban, Willet Whitmore, Walt Lawrence, and George Pack, particularly, combined extraordinary knowledge and surgical precision and skill. Daniel Catlin at Memorial Hospital and Richard Overholt at the New England Deaconess Hospital were kind enough to encourage and support my first paper projects. Finally, Neil Sedgwick of the Lahey Clinic and Cliff Franseen at the New England Deaconess Hospital revealed that careful operative planning, combined with superb technical skill, can lead to expeditious operations and surgery as pleasure in performance and teamwork. Of course, there are many others in this audience and elsewhere too numerous to mention who have knowingly or even unknowingly contributed to my education and development. This particularly applies to the many residents I have had the pleasure (and sometimes pain!) of working with and from whom I continue to learn. To them all, I give thanks and appreciation. Dan Coit and Mike Stone, both graduates of our New England Deaconess Hospital surgical program, I had hoped to attract back to Boston. Dan was persuaded to stay in New York, but Mike is now my associate. They both represent the ideal young surgical oncologist—thoughtful, analytical, technically adroit, and wonderful in dealing with patients.

Needless to say, I especially owe a debt to my long-suffering wife and children. Bets has tolerated, not always quietly, the long hours and the sometimes total preoccupation that surgery seems to elicit.

Let me move on to my personal analysis of where the

Society of Surgical Oncology came from, where we are now, and where I feel we should go. I take personal responsibility for my suggestions that may provoke dismay and disapproval but I hope also debate; they grow out of my long contact with members of the Society of Surgical Oncology executive committee as they have tried to plan the course of our Society and professional field. Next June it will be 50 years since a group of Memorial Hospital surgeons founded our society, first called the James Ewing Society. On a sad note, this year marked the death of Bill MacCoomb, one of those founders and three-time president of the Society of Surgical Oncology. A link to our past has been broken. Although beginning as an alumni society, farsighted leadership soon began encouraging membership for surgeons not trained at Memorial Hospital and then began meetings at locations other than Memorial Hospital. This initial upheaval in the society direction was nothing compared with the angst and turmoil that culminated in the 1975 annual meeting when the executive committee recommended and the membership approved the name change to the Society of Surgical Oncology. The prolonged prior debate and discussion, not all of it supportive needless to say, demonstrated the deliberate attempt of the farsighted leadership at that time to expand our influence broadly and project ourselves onto the national and even international scene. Ed Scanlon, the president at the time, really put this change together as a response to contrary internal pressures, but other key players who supported his efforts were Don Morton, Murray Copeland, Harvey Baker, Walt Lawrence, and Bill MacCoomb. Concerted and deliberate efforts were made to encourage basic and clinical science in our programs and rational debate in our meetings to make ourselves acceptable to the larger surgical community, particularly the academic community. With this background and with these goals, our organization has succeeded enormously. Who would have thought even 10 years ago that almost all medical schools are now anxious to have sections of surgical oncology, and that patients now ask for consultations with surgical oncologists.

In a sense, we are the victims of our own success at creating such a vital professional organization and field. For instance, we were only able to accept for this program in San Francisco 46 of over 200 abstracts submitted, a mere 22%, because the Society of Surgical Oncology meeting has become a prestigious and privileged forum for displaying professional achievements. We are now recognized as the premier organization of professionals dealing with research in surgical treatment of cancer. We have served as a model for similar societies in Europe, Asia, and South America. We have focused attention on a surgical subspecialty that increasingly attracts graduates of surgical programs who wish to work with more definition to their efforts but still keep the breadth and excitement of a wide-ranging surgical practice. We have made clear that the enormous complexity of cancer surgery, and management with colleagues in other disciplines, requires specialized training and knowledge. We have arrived at the point where we were knocking at the door of the American Board of Surgery for consideration of a separate designation recognizing our special knowledge, skills, and responsibility in dealing with clinical problems, and intellectual and scientific challenges in the field of cancer.

We have also arrived at the point of meeting together with other premier organizations that deal with cancer: the American Society of Clinical Oncology and the American Association for Cancer Research. We only lack the radiotherapeutic professional societies to make our spring festivals completely comprehensive, multidisciplinary, and interdisciplinary. We need to convince our radiotherapist friends to join in this long-term goal and create a "cancer week" of professional and

intellectual feasting in pursuit of a common goal. With success, however, comes responsibilities, and we will miss opportunities and growth if we continue to do in the future only what we have done with increasing success in the past.

The American Board of Surgery will turn down our request for specialty designation, but this provides an opportunity to analyze our future directions and exert more control of our destiny. While recognizing that many of the factors mitigating against our attempt at formal recognition are political and competitive, we should nevertheless use this as opportunity and not regret. We recognize the need for the American Board of Surgery to keep the field of surgery as broad and intact as possible, and the dismay that has been created by some of the ways the special certifications have been used in a competitive world. Inability to achieve special status with official accreditation or certification, however, alerts us to the pitfalls of too narrow a view of our goals and at the same time allows us to define ourselves and control our own future more completely.

What are our professional strengths and how can we use them in the most comprehensive way to further the cause of the patient with cancer? How can we demonstrate to society and to our surgical brethren that our vision is broad as well as deep? How can we interact with our colleagues in other disciplines to convince them that we have more than a parochial interest in the patient with cancer. How can we harness the unique knowledge and talents of our members to address public policies and clinical and scientific debate with recognition of the fact that our concern is the disease and its harsh consequences and not our narrow financial or territorial interest? We can only do so by defining ourselves more broadly. Our stated purpose in the society bylaws is, "to further the knowledge of cancer," a rather spare description of where we have been and where we should go. I propose we deliberately redraw our self-described mission by adding phrases such as "and provide national leadership in the surgical community and the public so as to encourage the most competent policies in cancer management through prevention, detection, and efficient effective therapy in the surgical and multidisciplinary care of the cancer patient." We must act as leaders and define ourselves as leaders to be viewed as leaders. To be leaders, we must set standards of performance not only indirectly through publication of articles outlining the latest series of cases or educational efforts, but by drawing up standards of surgical performance and disseminating them to the wider surgical community. The American College of Surgeons has been reluctant to engage in standard setting in specific clinical areas because of their diverse constituencies, expense, fear of legal consequences, and reluctance to intrude. However, last summer the American College of Surgeons cosponsored a workshop on quality assurance in cancer care with the American Cancer Society. This workshop, like so many other recent movements in professional and regulatory organizations, such as the JCAHO and the ACCC (whose recent president was Irv Flemming), display concern about appropriateness and quality of care. As the premier surgical organization dealing with cancer, we need to seize this leadership role by forming task forces to develop standards of performance in the common cancers. The fact that controversy surrounds many aspects of care in these cancers should not dissuade us from defining more than just minimal standards but contemporary comprehensive standards of performance for the surgical community. Such standards must recognize the danger of fixing in stone aspects of care in rapidly evolving clinical fields. What to do with such tracts once they are developed remains an issue. Leadership in surgical care of cancer should involve more than just distribution to and attention from our own society. We need to address the greater surgical commu-

nity. Our members, particularly Dick Wilson, Charles Balch, and Bob Beart, were instrumental in developing the American College of Surgeons cancer management course; and Art Holleb and David Winchester were instrumental in developing the quality assurance workshop just mentioned. As a society, however, we need to assume responsibility for educating and advancing cancer management for the entire general surgical community. Standard setting is an appropriate vehicle for such a liaison with the wider field of surgery and to be expected of a leadership organization.

We should never be accused of competing against general surgeons but must assume the role of support of those on the front lines—the community and general surgeons of the country. We should educate, train, set standards, support through consultation and referral, and manage complicated, difficult tumor problems, but always be humble enough to realize that the vast majority of cancer cases will always be managed by the first line of surgical defense, the community surgeon. With approximately 150 000 new patients with breast cancer and colon cancer each year and with the numbers rapidly increasing because of the aging and increasing population, it is obvious that the vast majority of these patients will always be operated on by general surgeons. By 1990, there will be an estimated 1 400 000 patients with cancer, resulting in 630 000 deaths—a huge work load. Cancers of the stomach and pancreas and melanomas will also continue to be, and should be, the province of general surgeons. Liver metastases from colon cancer, however, will, for the most part, be operated on by members of this society, but we have an obligation to educate the general surgical community as to the appropriate follow-up, diagnostic evaluation, therapy, and referral of patients with colorectal cancer so that hepatic resections are conducted on an appropriate and selected group of patients.

Another implication of standard setting is testing or self-evaluation and the focusing of personal educational efforts. Thus, I propose we continue the path established by Charles Balch under the guidance of the executive committee of the Society of Surgical Oncology by continuing our comprehensive test vehicle for surgical cancer care, but use it in a fashion established by the SESAP from the American College of Surgeons as a method for our members as well as the general surgical community to judge their knowledge and focus their education and learning in cancer management. Quality assessment is the name of the game in medicine and surgery in the future, and we can become leaders only if we exert such leadership in individual surgeon quality assessment done privately. Although much of the expense of such a test can be retrieved in the fees for its administration, the society will obviously incur expenses in developing and maintaining such a program. We would encounter problems in using such a test as membership qualification or certification, but we should certainly expect an excellent standard of performance for our training program graduates. By utilizing the test as a private educational vehicle, however, and not as an exclusionary certification, we can fulfill our leadership role in education and not encourage inappropriate legal interpretation.

Our Society's direction in developing surgical oncology training programs has borne fruit in the nine programs already established and the several programs awaiting approval. The willingness to refuse approval to programs not meeting our standards is an example of standard setting, leadership, and maturity. This effort, so long headed by Bob Schweitzer of the education committee, began after a workshop sponsored by Margaret Edwards at the National Cancer Institute with Ed Scanlon, Walt Lawrence, Lasalle Leffall, and others. The training community and program are now under the direction of Bernie Gardner and must be continued and strengthened. Certainly, over the years ahead more

programs will be added, but we must recognize that there are inherent limitations in this effort. No surgical oncology training program can detract from the general surgical residency in the same institution or interfere in the training of the chief general surgical resident. Never will we be able to graduate enough trained surgical oncologists from such programs to satisfy the clinical cancer needs of the country. Instead, our responsibility as a leadership society should be to deliberately educate our graduates to return to the community and academic centers to exert their influence. In a survey recently undertaken by the education committee, it was found that the vast majority of the graduates of our training programs in the past few years have developed academic careers, and by implication have not only become busy practitioners in surgical oncology but educators and researchers. Our mission has been successful, therefore, but only a small number of graduates finish each year—about 30 currently—and if 15 programs eventually are recognized, perhaps only 40 to 50 will graduate each year. With a surgical career of perhaps 30 years, we will never exceed 1000 active graduates of surgical oncology training programs at one time, less than 5% of all general surgeons. One in 20 surgeons may be an appropriate goal in terms of numbers to support our general surgical colleagues in dealing with patients with cancer. If we decide the manpower requirements needed to support surgical cancer care in the general surgical community, we can become more rational about how many training programs and how many trainees we should support to carry out our goals.

There is a problem in defining our membership elaborated by this understanding of our training program production. Current membership requirements include at least 1 year of surgical oncology training, and although this has been interpreted liberally by the membership committee in the past, we need to recognize that many of our natural surgical leaders do not take separate and defined surgical oncology training; thus, graduates of some of the premier American surgical programs may well continue in academic or clinical careers without specific postgraduate education in research or clinical areas. Recently, the executive committee accepted a productive clinical career of at least 6 years devoted to cancer surgery as satisfactory evidence of experience equivalent to a surgical oncology fellowship in terms of qualifying for Society of Surgical Oncology membership. As in the past, not every graduate of our training programs will be eligible for Society of Surgical Oncology membership since we, most importantly, require evidence of productive inquiry as evidenced by writing papers, conducting research, and contributing to the cancer effort in communities, the American Cancer Society, and the American College of Surgeons. Continued evidence of scholarship in cancer management should be our prime goal in evaluating surgeons for membership rather than just participation in one of our training programs. We must never exclude the most likely potential leaders in surgery from membership because of narrow technical requirements, and we must not succumb to pressure for membership from candidates, members, or training directors just because of the fulfillment of a training requirement without substantial evidence of scholarly activities. Over time, I believe, we should become more restrictive in membership so that we continue our path toward academic and clinical leadership and away from our origins as an alumni society. We should as an ideal, however, continue to strive to be broadly educated and broadly experienced surgical oncologists, although our membership will have men and women more narrowly focused in their interest, such as breast or colon specialists.

Research should be a role of leadership, and the Society of Surgical Oncology should appoint a research committee of young investigators to develop and sponsor protocols that

may impact on clinical cancer care by surgeons. Such research could utilize membership contributions of cases, the tumor registry system of the Commission on Cancer, or local interest by members. Projects might focus initially on limited defined problems in clinical management to exercise and perfect such a sponsored clinical research process. For instance, outcome in terms of hospital stay, cost, patient satisfaction, and long-term benefit could be analyzed in postmastectomy reconstruction done immediately or delayed. The variety of continence-preserving rectal operations could be documented in terms of numbers and outcome, obtaining a broader survey then could be obtained from a single institution. Acceptance by surgeons and patients of the utilization of adjuvant therapies could be measurements. How many patients with colon cancer are receiving 5-fluorouracil therapy postoperatively that is of unproved benefit, for instance. The advantage or disadvantage of following up patients who have colorectal cancer with or without careful carcinoembryonic antigen monitoring or patients who have breast cancer with or without routine radiological or laboratory testing would lend itself to society-sponsored research projects. Specific significant problem areas that may not attract research support from ordinary granting agencies should be suitable for our support. Data collection and statistical analysis for such research projects could undoubtedly be negotiated with cooperative groups, the American College of Surgeons, individual institutions, or the Society of Surgical Oncology itself. With experience and continued support and development of a smoothly functioning research process involving our membership, more elaborate projects could be undertaken. Projects should have immediate clinical application for all surgeons caring for cancer problems and not be focused on uncommon or esoteric aspects of interest only to a small number of consultant, tertiary cancer surgeons. Such evidence to us and the general surgical community of willingness to use our membership in a scientifically and clinically productive way would also establish our broader leadership commitment.

As the "spokesperson" for general surgery, we should be prepared to deliver, with appropriate attention to the public press, "white papers" on controversial and contemporary cancer subjects that affect surgeons. For instance, the recent inopportune "Clinical Alert" from the National Cancer Institute regarding the adjuvant therapy of node-negative patients with breast cancer clearly needed a response from some expert and interested surgical body. The Society of Surgical Oncology should accept that leadership role and responsibility and have a mechanism developed for appropriate responses to such public issues. Here was a unique opportunity for us to speak as leaders of the surgical community and respond for them. The fact that surgeons—who have always treated the node-negative patients with breast cancer largely by themselves—were excluded from the mailing list of that "Clinical Alert" indicates the need for general surgeons to have a spokesperson on cancer affairs. That bypass of surgeons in itself was a sad commentary on the status of the surgical community in cancer affairs and evidence of the lack of appreciation of the unique role general surgeons have in treating patients with cancer, particularly when over 90% of cures in solid tumors are achieved by surgical efforts.

As an example of our distinctive role as surgeons in cancer management, we need to appreciate that perhaps only 10% to 20% of common cancers are operated on by our Society members, whereas the chemotherapy of patients with cancer is overwhelmingly given by members of the American Society of Clinical Oncology. Essentially, all radiotherapy treatments are given by members of the radiotherapeutic societies. Our medical oncology and radiotherapeutic colleagues consider themselves as experts in all cancer cases—a severe disadvan-

tage to the surgical community in dealing with patients and the public. The average general surgeon feels less able to compete in expertise with members of medical oncology and radiotherapeutic societies and takes a less active role in planning complicated contemporary therapy or dealing with the less common situations. General surgeons may feel less comfortable in offering patients professional advice in multidisciplinary management because much of their time also requires dealing with other surgical management areas besides cancer. The disciplines of chemotherapy and radiotherapy are more narrow in knowledge and perhaps more effective in dealing with the public granting agencies and the regulatory bodies. Because of chemotherapy's and radiotherapy's use of seemingly more sophisticated high technology equipment, chemicals, and publicity, and because our technological advances are more hidden from public view since our patients are asleep, we face more of a challenge. Thus, we must exert our impact on cancer management through the general surgical community with our Society of Surgical Oncology membership. We must provide the guidance, education, and standards to a larger group that has less focused interest on cancer problems and many more competing demands such as trauma, vascular diseases, and infection. If we perform our functions well, we can be acknowledged as their mentors and guides, but we must be careful to keep our constituency and responsibility clearly in mind so that we are not accused of competition or opportunistic, acquisitive behavior. One way to establish that attitude is to avoid a focus on financial aspects of our service. Indeed, we should ensure that for the common cancers our fees are not greatly out of line with the average community fees for procedures. The concept of a resource-based relative value scale should be accepted in principle for remuneration. I personally believe that some form of the Resource-Based Relative Value Scale concept is equitable and rational for a fee structure. We should scrupulously avoid any suggestion that we are using our society membership for economic gain or advantage. Such a clear statement of purpose will help in our efforts to ensure that we are looked on as a professional and intellectual organization and not as a vehicle for fee enhancement and competition. Our extra effort, training, and sophistication we would expect to be recognized in handling reoperative, complicated, or unusual cancer cases. Exenteration for rectal cancer certainly needs to be recognized as a procedure that requires extra resources and training and experience, but such an operation does not compete with the general surgical community and exemplifies the unique talents of the true surgical oncologists.

As a corollary to this need to exert our impact on cancer problems through the general surgical community and our general surgical partners, we should be prepared to defend

them in the legal arena. Since our profession is under assault by a hazardous, even treacherous, legal climate, it is our obligation to defend our general surgical colleagues through education and standard setting and direct service as expert witnesses when warranted. For instance, one of the most common malpractice actions is failure to diagnose breast cancer, yet in my experience, almost all these cases occur in women with inflammatory disease or diffuse invasive lobular carcinoma that do not present in a common or usual way and are deceptive and therefore hard, if not impossible, to diagnose. We need to communicate to the general surgical community as well as the legal community that these are cases that are impossible to diagnose early and that, indeed, outcome is so bad that slightly earlier diagnosis would make no difference. Unfortunately, a few members of our Society serve as frequent plaintiff experts, giving testimony that most of us would consider as beyond reasonable conclusions from the facts. Here is an area of leadership in educating the legal and general surgical community that we can easily adopt and promote with direct and early favorable effect.

We might also consider a public interest-type campaign to raise the status and recognition of the general surgeon in routine cancer care. Such a public education and public relations campaign would obviously involve a great deal of money but would yield immediate benefits in terms of helping to establish the surgeon as the prime contact point for cancer management and the day-to-day expert in routine cancer problems and ourselves as leaders in surgical cancer care.

What will such a multifaced mission involve on our Society's part? Certainly, it will cost money, and increased dues will be needed to accomplish the tasks suggested here. Even more than money, it will involve time on the part of members for the commitment to act as leaders in the realm of standard setting, test development, education, public policy, and, finally, research. Does the Society share this view of our challenge in the future, or is this analysis peculiar and isolated? I propose wide discussion of these issues, contact and communication with our executive committee, and, if desired, new or expanded roles for our Society. The membership will provide the ultimate motivating force, so your voices need to be heard.

This, then, I view as the crossroads that our Society of Surgical Oncology approaches, which in many ways is the result of our success, growth, and increasing stature. I would propose that the bylaws be changed so that our purpose reads, "To provide leadership to the general surgical community and the public by education, standard setting, innovation, consultation, and research, so the preeminent role of surgery in the cure of cancer continues through increasing knowledge and with multidisciplinary management."