

Presidential Address

The Society of Surgical Oncology and the Commission on Cancer: Progress Through Synergism

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The 1998 Presidential Address highlights the history of The Society of Surgical Oncology and the Commission on Cancer of the American College of Surgeons, cites specific examples of progress through synergism, and discusses some of the many challenges facing surgical oncologists in the future. These include the necessity to synergize in clinical trials, to accelerate the diffusion of knowledge into the practicing community, and to redefine surgical oncology and its relation to general surgery and the American Board of Surgery. **Key Words:** Surgical oncology—Synergism—Clinical trials.

In preparing for this presidential address, I was particularly interested to learn what Dr. William MacComb, the first president of The Society of Surgical Oncology, said back in 1940, because I had served as a surgical oncology fellow under Dr. MacComb at M. D. Anderson Hospital in 1970. Much to my dismay, no record of his address could be found in the medical literature. In fact, no presidential address was delivered to this Society and published until 1966.¹ Dr. Glen Leak, a surgical oncologist from Buffalo, New York, delivered the presidential address entitled “James Ewing Society, 1940–1966” at the 19th Annual Scientific Session of The Society. As noted in an excerpt from the meeting of the Executive Council in January 1966, “it was voted that an annual message should be received by the members of The Society from the President.” Dr. Leak went on to observe that “the vote, needless to say, was not unanimous. There were two ‘nay’ votes cast—one by the president, the second by the president-elect, who was already wor-

rying about what he was going to say next year.” I can assure you that, although its preparation was sometimes painful, I bring you the 1998 Presidential Address with enthusiasm and a genuine sense of honor.

The Society of Surgical Oncology and the Commission on Cancer—two great organizations I have had the privilege of serving—have had a profound influence on cancer control in this country and abroad. Often this has been achieved through a synergistic relationship. Webster defines synergism as “an interaction of discrete agencies such that the total effect is greater than the sum of the individual effects.” Progress should be easily defined but can be elusive. Alfred North Whitehead, an English philosopher, observed, “the art of progress is to preserve order amid change and to preserve change amid order.”² For the members of our organization, order represents our training and experience. The preservation of change, amid order, implies the willingness to change our approach to the management of the cancer patient despite our training and experience.

Dr. C. Rollins Hanlon, a former Director of the American College of Surgeons, emphasized the importance of looking back at a national organization’s history as the best guide for setting the course for the future of the organization. Delivering the 1982 presidential address to the American Surgical Association, he said “reviewing the association’s first century and observing how successfully it has accomplished its true mission, I simply

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advocate a hard look at the historic functions and capacities of this body as a guide to its future course."³ I think that's good advice.

It is my intent in this presidential address to highlight the history of The Society of Surgical Oncology and the Commission on Cancer of the American College of Surgeons, to cite specific examples of progress through synergism and discuss some of the many challenges facing us in the future. These include the necessity to synergize in clinical trials, accelerate the diffusion of knowledge into the practicing community, and redefine surgical oncology and its relation to general surgery and the American Board of Surgery.

The Society of Surgical Oncology was originally organized "to further the knowledge about cancer and to associate in membership all those who received their training in cancer at Memorial Hospital" (New York, NY). Dr. MacComb wrote the following note to Dr. James Ewing on June 11, 1940:⁴

Dear Dr. Ewing,

The graduate fellows of Memorial Hospital met at luncheon yesterday and organized a Society. Twenty-three members were present. The purpose of this Society is to promote good fellowship and to perpetuate the ideals and ideas of the Hospital and the Fellowship as you envisioned it. We have named this organization the James Ewing Society as a tribute to your leadership and we hope that the efforts of the Alumni thus united, will bring honor to you.

Progress was slow in those early years, but Leak was able to highlight three major accomplishments in his 1966 presidential address.¹ He described the success of the Papanicolaou smear, the link between the early detection of asymptomatic cancer and the highest 5-year cure rates, and that cigarette smoking was a major factor in the production of lung cancer.

As cancer centers proliferated, the James Ewing Society expanded its membership beyond the walls of Memorial Hospital, but despite significant contributions to the cancer literature, an identity crisis seemed to pervade the organization in the 1970s and 1980s. Unable to achieve subspecialty board certification, The Society's name was changed and several presidential addresses dealt with the definition and importance of the surgical oncologist. As the 1990s began, membership had grown only modestly; in 1992, we lost \$12,000 in operations and had only \$20,000 in reserves. But as we approach the second millennium, we are a strongly revitalized organization. Surgical oncology is no longer a self-serving, self-descriptive term used by our members. Surgical oncologists are highly sought-after in academic centers and

in the community setting. Fellowships in surgical oncology are intensely competitive and attract the best and the brightest. Patients are becoming increasingly sophisticated in their choice of cancer surgeons. I submit that The Society of Surgical Oncology, in and of itself, has enabled its members to align themselves unambiguously as surgical oncologists with referring physicians and patients. There is no longer an identity problem. A key to this success has been the dramatic expansion of our membership, increasing from 889 in 1991 to 1,655 today, and a equally dramatic improvement in our financial picture.

In 1998, at least 80% of cancer patients in the United States are diagnosed and managed in 1,481 programs approved by the Commission on Cancer. The high standards set by the Commission enable the surgical oncologist to synergize by practicing in an optimal environment. Regular surveys by the Commission's field staff assure that the necessary elements and personnel are in place to render the highest quality care for cancer patients in the approved programs.

Identity has also been a problem with the Commission on Cancer, which has itself undergone three name changes in its history. Its precise age is disputed, ranging from 76 to 85 years. Let's take another look at its mission statement to better understand the sum of its parts and its synergy with The Society of Surgical Oncology. The Commission on Cancer is dedicated to the goal of reducing the morbidity and mortality caused by cancer, through prevention, monitoring and reporting of care, standard setting, and education. This modernized mission statement does not reflect the earliest history of the organization. Patients and their families did not want to hear the word "cancer" in those days. The Cancer Campaign Committee under the leadership of Dr. Thomas S. Cullen was appointed at the 3rd Clinical Congress of Surgeons of North America. This committee eventually became (in 1912) the Commission on Cancer and actually preceded the formal establishment of the American College of Surgeons in 1913. The original mission of this committee was professional and public education.

In 1922, Dr. Ernest Codman, father of the modern registry system, founded the first registry for bone sarcoma. Interestingly, this was done in collaboration with Dr. James Ewing, representing the earliest example of synergy between the two groups.

The Approvals Program dates back to 1930 when, with the encouragement of the American Cancer Society, the College was asked to set standards, and survey and approve cancer clinics.⁵

The Field Liaison Program was founded in 1947 under the leadership of past SSO president Danley Slaughter.

Tumor registries became a required component of cancer programs in 1956. Patient care evaluation studies were initiated in 1976 and the National Cancer Data Base was founded in 1989. After careful planning, the American College of Surgeons Oncology Group was funded by the National Cancer Institute, to begin operations in April 1998 under the chairmanship of Dr. Samuel A. Wells, Jr.

The Society of Surgical Oncology and the Commission on Cancer have played a central role in the advancement of knowledge about cancer. Consider, for example, the evolution of the Scientific Program of The Society of Surgical Oncology from retrospective analysis of the diagnosis and management of a variety of malignancies to prospective randomized clinical trials, basic science, translational research, and minimally invasive techniques. This year's scientific symposium is full of clinical trial information, and the results of three new trials will be reported in the plenary sessions. Dr. Robert Witten, the Director of the Division of Cancer Treatment and Diagnosis at the National Institutes of Health, will update us on NCI clinical trials, and Dr. Wells will deliver the John Wayne Clinical Research Lecture entitled "The Importance of Clinical Trials in Cancer Research." Similarly, basic science and translational research findings comprise 35 presentations, and Dr. Richard Klausner will deliver the American Cancer Society Basic Science Lecture. The Society is actively engaged in teaching hands-on technology in areas such as ultrasound, stereotactic core needle biopsy of the breast, sentinel lymph node biopsy for melanoma and breast cancer, and endosurgery.

The Commission on Cancer's educational contributions mesh well with those of The Society of Surgical Oncology. In fact, approximately 65% of the 116 members of the Commission on Cancer are members of The Society of Surgical Oncology. Many are responsible for organizing and/or participating in the postgraduate courses and symposium presented at the Annual Clinical Congress and the spring meeting. In addition, members of our Society have filled leadership positions in registry education and international cancer management courses. During my tenure as Medical Director of the Cancer Department of the American College of Surgeons, seven chairmen and vice-chairmen of the Commission on Cancer have been influential members or officers of The Society of Surgical Oncology.

The National Cancer Data Base has now collected extensive data on 6 million cancer patients,⁶ the largest cancer database in the world. Through good planning and cooperation with software vendors, all cancer cases can now be electronically submitted to the National Cancer Data Base rather than the previous requirement of 25

consecutive patients in the patient care evaluation studies. This reporting has been a requirement of the Commission since 1996 and is accomplished with much more ease by the tumor registrars than with the previous Patient Care Evaluation Studies. The National Cancer Data Base could not exist without the Approvals Program. Certified tumor registrars represent the backbone of this reporting system. Population-based state registries and the Surveillance, Epidemiology, and End Results (SEER) Program also rely heavily on registries approved by the Commission on Cancer. The annual budget of the National Cancer Data Base is approximately \$1 million, which is one-twentieth that of the SEER Program. The NCDB is not population-based but collects data on at least 60% of newly diagnosed cancer patients in the United States. The SEER Program collects population-based data on approximately 14% of the US population. The NCDB is cosponsored by the American College of Surgeons and the American Cancer Society. Generous volunteerism and support by the approved hospitals enables the Commission to collect extensive data for about \$1.75 per patient. Since its inception in 1989, there have been 212 publications from the National Cancer Data Base.

Standards of care, practice guidelines, critical pathways, and best practice parameters are very much in vogue. Despite criticisms about "cookbook medicine," these programs have been largely successful in improving the quality of care at a lower cost. Both The Society of Surgical Oncology and the Commission on Cancer have made significant contributions to this effort, including SSO practice guidelines,⁷ standards for breast cancer management approved by both organizations,⁸ and the delineation of appropriate and inappropriate use of stereotactic core needle biopsy of the breast.⁹ The Standards Committee of the Commission on Cancer acts as a clearinghouse for evaluating practice guidelines and publishes selected examples on its Web site. The Cancer Liaison Program consists of approximately 2,300 multidisciplinary physicians and has been responsible for the highly successful Triad Program, working in partnership with the tumor registry community and the American Cancer Society. The new cooperative group at the American College of Surgeons will rely heavily on this network.

Of the many challenges we face for the future, I would highlight three: surgically oriented and led clinical trials, faster diffusion of new discoveries to the practicing community, and a redefining of surgical oncology.

At the present time, only 2% to 4% of patients with common malignancies are enrolled in clinical trials. The National Surgical Adjuvant Breast Program (NSABP)

under the leadership of Dr. Bernard Fisher has been notably successful in redefining the biology of breast and large-bowel cancer and in evaluating adjuvant therapies. The American College of Surgeons Oncology Group will be primarily focused on answering surgical questions. The 50,000 fellows of the College come from all surgical disciplines and include surgeons from academic centers and from the community. The Commission on Cancer has been the flagship clinical program of the American College of Surgeons since 1913. The National Cancer Data Base is well-established and the Cancer Liaison Network provides a group of multidisciplinary physicians distributed over a wide geographic area, many of whom are already participating in clinical trials or are anxious to become involved. By virtue of their special interest in cancer, the members of The Society of Surgical Oncology have already and will continue to assume leadership roles in this new cooperative clinical trial venture. I anticipate that the knowledge generated through these trials in future years will provide much of the educational curriculum for The Society of Surgical Oncology and the Commission on Cancer. The National Cancer Data Base will then be in a position to measure outcomes through their well-established mechanism of tracking patterns of care, identifying deficiencies, and refocusing educational programs offered through The Society of Surgical Oncology and the Commission on Cancer to bring practices in the United States up to standard. Clearly, this represents continuous quality improvement of care for the cancer patient.

The second major challenge will be to accelerate this diffusion of knowledge. It is interesting to note that it took only about 18 months to convert the standard of care for cholecystectomy to the laparoscopic approach rather than the open approach. Other examples of relatively fast diffusion are stereotactic breast biopsy and sentinel lymph node biopsy. Stereotactic core needle biopsy of the breast got off to a slow start but rapidly gained momentum in both the radiology and surgical communities. Sentinel lymph node biopsy for melanoma, pioneered by past president Donald Morton and originally presented at this Society's Annual Scientific Symposium, has become the standard of care for melanoma and is rapidly moving in that direction for breast cancer. Let's contrast that with breast conservation treatment (BCT). By 1989, six prospectively randomized clinical trials demonstrated statistical equivalence in local control rates and survival between mastectomy and breast-conserving treatment for carcinoma of the breast.¹⁰⁻¹⁵ Information from the National Cancer Data Base indicates rather slow acceptance of this technique and wide geographic variations. Guidelines for breast-

conserving therapy were developed in 1992 by the two Colleges and widely disseminated.⁸ A highly detailed study of breast cancer patients was conducted in 1995 in a collaborative effort by the American College of Surgeons and the American College of Radiology to determine patterns of care and to evaluate guideline adherence (Morrow M, Winchester DP, et al, unpublished data); 17,931 patients with stage I and II breast cancer treated at 827 institutions in 1994 were studied. Only 7,914 (44.1%) had BCT. Patients with favorable histologies (tubular, mucinous, intracystic, n = 840) were more likely to undergo BCT than those with other histologies (n = 17,062; P < .0001). These results indicate that surgeons continue to use BCT primarily for patients with favorable breast cancer, in spite of guidelines and data from randomized trials indicating that AJCC stages I versus II and histologic type should not be used as selection criteria for local therapy. This misunderstanding is a major factor responsible for low national rates of BCT.

Another example of the lack of response to the spread of information is noninvasive breast cancer. With the advent of screening mammography, ductal carcinoma *in situ* of the breast was diagnosed much more frequently as a pure entity, in contrast to most previous cases in which "intraductal carcinoma" represented both invasive and noninvasive disease. Early reports in the 1970s indicated a near-absence of axillary nodal metastasis in pure DCIS.¹⁶⁻¹⁸ Again, the National Cancer Data Base provided information on patterns of care indicating gross overutilization of axillary lymph node dissection for pure DCIS.¹⁹ Although there has been a progressive decrease in axillary lymph node dissection since 1985, fully 30% of patients were still undergoing this procedure in 1995 (unpublished data, National Cancer Data Base, D.P.W., principal investigator). Finally, data are largely lacking from clinical trials on the identification of subsets of patients with DCIS not requiring radiation therapy. NSABP-B17 has been reported²⁰ and indicates a need for radiation therapy, but several other clinical trials have not yet matured. Despite this relative lack of information, the National Cancer Data Base indicated that only 54% of patients undergoing breast conserving surgery for DCIS were receiving postoperative radiation therapy in 1995.¹⁹ It seems like it's either too much or too little.

There are, no doubt, many explanations for this slow diffusion and acceptance but change must be effected through education. Charlotte Brontë, in her epic novel *Jane Eyre*, said that "prejudices, it is well known, are most difficult to eradicate from the heart whose soil has never been loosened or fertilized by education; they grow there firm as weeds among stones."²² We must, as

educational leaders from both The Society of Surgical Oncology and the Commission on Cancer, continue to educate ourselves and our peers.

Finally, I would like to comment on the redefinition of surgical oncology and the evolving relationship between surgical oncology and the American Board of Surgery. Although there has been some skepticism, the leaders of this Society firmly believe that the expansion of our membership has been accomplished carefully, with appropriate attention to the guiding principles and mission of the organization. The expansion of the definition of surgical oncology has, in fact, enhanced our ability to fulfill our mission. It has also defined our relationship to general surgery and the American Board of Surgery, to the research enterprise, and to other oncologic subspecialties. All of this is embodied in a profile of our 1,655 members. They include the "traditional" surgical oncologist with 1 to 4 years of formal surgical oncology training after a general surgical residency, and the general surgeon who had no formal surgical oncology training after residency, but has a demonstrated commitment to surgical oncology, including 6 years of practice with a major interest in surgical oncology, a minimum of three publications on cancer in peer-reviewed national journals, evidence of continuing commitment to surgical oncology (as demonstrated by activities such as oncologic teaching or research, involvement in American Cancer Society activities or in the Commission on Cancer, American College of Surgeons, and a leadership role in hospital or community cancer activities), or evidence of original contributions to cancer. Our members also include general surgeons who have devoted at least one additional year in basic science cancer research; surgeons who have completed fellowships in colorectal surgery, breast surgery, or other special areas; and colleagues in oncologic surgical subspecialties (e.g., thoracic, gynecologic, urologic, musculoskeletal, and neurosurgery). In addition, subspecialists in other disciplines with a primary interest in oncology have become members (e.g., surgical pathologists). Our members are now widely distributed in both the academic and community settings. They are thus in a position to exert leadership in raising the bar for standards of care for patients with a wide variety of malignancies.

The issue of establishing a separate board for vascular surgery within the American Board of Medical Specialties has been addressed recently by the American Board of Surgery. During this process, the Board revisited its relationship to surgical oncology. In a milestone action at the January 1998 Board of Directors meeting, the American Board of Surgery established sub-boards for specialties currently awarded certificates by the American

Board of Surgery and Advisory Councils for the maturing fields of surgery which are not certified.

Vascular surgery now has sub-board status in the American Board of Surgery. Surgical oncology, recognized by the American Board of Surgery as a "maturing field," will now have an advisory council which will relate to the various committees and Board of Directors of the American Board of Surgery. The issues to be considered by the Advisory Council include, but are not necessarily limited to, the following:

1. Training in oncologic surgery
2. Nominating consultants with surgical oncologic expertise to the qualifying Examination and the Recertification Examination Committees
3. Relationship to other components of surgery and other specialties

The composition of the Surgical Oncology Advisory Committee will be:

1. The Director of the American Board of Surgery who represents The Society of Surgical Oncology (chairman)
2. A senior American Board of Surgery Director with an established practice and recognized expertise in Surgical Oncology
3. Three appointees from the surgical oncology community
4. The Chair of the American Board of Surgery (or designee)
5. The Executive Director of the American Board of Surgery (ex-officio)

By virtue of this action, it is noteworthy that The Society of Surgical Oncology has appropriately been recognized as the national organization representing the discipline of surgical oncology.

All of this represents an important step forward for Surgical Oncology. It does not, however, necessarily represent a step toward certification of surgical oncologists by the American Board of Surgery. It is clear, and I think laudatory, that the American Board of Surgery is intent on maintaining the integrity of general surgery. And it is perfectly compatible with The Society of Surgical Oncology's redefinition of the surgical oncologist and The Society's mission. In effect, the disciplines of general surgery and surgical oncology are synergizing to improve the care of the cancer patient. The general surgeons committed to a career in surgical oncology by virtue of training and experience can upgrade the oncologic skills and knowledge of the general surgeon. This will occur through role-modelling and education in any

practice setting (urban, rural, academic), and through surgical oncology's new relationship with the American Board of Surgery. Certification of the general surgeon by the American Board of Surgery in the future will require a more rigorous and relevant oncologic knowledge base.

In conclusion, I hope that I have left little doubt in your minds that The Society of Surgical Oncology and the Commission on Cancer can and have made a difference. As described in the *New York Times* on January 3, 1998, there are exciting opportunities ahead and medical research is likely to get more money from the government. Our basic science lecturer, Dr. Richard D. Klausner, is quoted in that article as saying that "we are in a golden age of discovery, one unique in human history."²¹

Our James Ewing Laymen's awardee this year, Illinois Representative John E. Porter, in the same article stated that he "supports doubling the NIH budget in five years within the overall context of a balanced budget."²¹

On a personal note, I would like to thank the members of The Society of Surgical Oncology and the American College of Surgeons for allowing me to act in a leadership position for both organizations. It has been a source of great personal and professional satisfaction and enrichment for me. I am also indebted to my family and the support staffs of both organizations.

There has been progress. Dr. Leak noted back in 1966 that combined modality therapy had cured some and given comfort and palliation to many. He said that "we may not have added time to life, but we certainly have added life to time." Today we are on the threshold of some great discoveries, poised to truly "add time to life" through prevention and new therapies, but we are always mindful of our responsibility to "add life to time."

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