Papers Read Before the 43rd Annual Cancer Symposium of the Society of Surgical Oncology, Washington, DC, May 19 to 22, 1990—Part I

Wither, Whether, or Whither Surgical Oncology

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According to Webster, the verb *wither* indicates that something has become dry and sapless or has lost vitality, force, or freshness. Is surgical oncology withering? One can find evidence that this might be so. The American Board of Surgery has recently denied a Certificate of Additional Competency in Surgical Oncology. After a period of growth, the membership of our society has plateaued in the last 2 to 3 years, with the number of members entering barely balancing the number superannuated because of age. The care of the cancer patient seems in many instances to have become more and more fragmented. I encountered a patient the other day at my own hospital who was under chemotherapeutic care by our Section of Medical Oncology for a lesion of the head and neck. The patient had a recurrent carcinoma that was obstructing his hypopharynx, and the Ear, Nose, and Throat Service was asked to do a direct laryngoscopy for evaluation and biopsy. The General Surgical Service was requested to do a gastrostomy, and no one on the Surgical Oncology Service was asked to give an evaluation as to whether the patient's recurrent disease was operable or not. Not too many years ago, all of these functions, including the chemotherapy, would have been administered by the same individual.

There is a decreasing need for radical procedures in many areas of solid tumor therapy, such as the breast. At the same time, many skills of importance to the surgical oncologist, such as the various flexible endoscopies, are flowing into other nonsurgical specialties.

Again, according to Webster, *whether* is a conjunction used as a function word with a correlative *or* or an indirect question involving alternatives. Well, what is the alternative to the surgical oncologist? One could interpret the recent decision on the part of the American Board of Surgery as meaning that the alternative is the general surgeon, and it is certainly true that the general surgeon has over the years been the major therapist for solid tumors and still commands the techniques with the highest cure rates in almost all such cases.

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Perhaps the alternative is the medical oncologist. Much as we surgeons may suppress the thought, the fact is that patients will always select a nonsurgical or a minimal surgical solution for their problems if they are convinced that it offers a similar result. While such alternatives are not available for most solid tumors today, the ultimate and happiest outcome for all of us will be when solid tumors can be cured by appropriate medication.

It may be that the ultimate oncologist has not been achieved as yet and will be an expert in immunotherapy, endoscopy, and some other unnamed and undiscovered therapy for the cancer patient.

With these bleak thoughts in mind, we come to the final word, the adverb *whither*, defined by Webster as meaning to

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what place? To what situation, position, degree, or end, or, to put it more colloquially, where do we go from here?

You may be surprised that, although I have fought vigorously in the past for a Certificate of Added Competency in Surgical Oncology to be appended to the Surgical Board, I now believe that this would be counterproductive to the field of general surgery as a whole. There are some such certificates that are divisive and that divide up fields that general surgery already controls. An outstanding example of this is the Certificate in Vascular Surgery, which drives a wedge between vascular surgery and all the rest of general surgery, where it once belonged. A Certificate of Added Competency in Surgical Oncology would probably accomplish the same thing. It would not be fitting, I believe, to insist that all of the tumors of general surgery be treated by the surgical oncologist. This would, in fact, deliver the coup de grace to the Surgical Board.

I hasten to point out that there are areas in which a certificate is enormously effective in retaining general surgery areas that are being or have been separated from our field. I would describe such certificates as defensive in nature, and the first and most obvious for the surgical oncologist would be in the area of head and neck surgery. A second, less thought-of, certificate would be one of added competency in thoracic surgery as a "general thoracic surgeon." I recognize that our colleagues on the thoracic board would not look on such a certificate calmly or with equanimity, but the fact is that for the average cardiothoracic surgeon, the field of thoracic surgery seems to have lost its allure, and the patient with cancer of the lung is often underserved. Most individuals who have cardiothoracic boards perform cardiac surgery, and those who do not are often considered as having "flunked the course." There is a growing demand countrywide, as I see it reflected in letters to me, for residents who have had experience in and are willing to do thoracic surgery. I suspect that this is an area that should be considered as one that can be drawn into the field of general surgical oncology. The politics of such an attempt are certainly too complex to discuss here, and it may be too complex to achieve, but it would be an exciting endeavor and probably would result in better service to the patients with carcinoma of the lung. My plea would be that a certificate in head and neck surgery and/or one in noncardiac surgery would have the same defensive posture for the general surgeon that has already been adopted by the certificates for critical care and hand surgery, ie, to reserve to general surgery an opportunity to work in those areas that are rapidly being drawn away by other specialties.

Recognition for the surgical oncologist can still be achieved through programs inspected and approved by our society. This is a task that we should accept gladly, one that adds a special responsibility for us. The fellows we train should be familiar with the now-unusual aspects of surgical care of the cancer patient, hepatectomy and treatment of recurrent lesions. They should have personal knowledge of some aspects of chemotherapy so that it does not become a total mystery reserved only for their medical colleagues. Arterial infusion chemotherapy comes easily to mind, but this also applies to some aspects of adjuvant chemotherapy.

On another front, what should we do about our plateauing membership? Inspection of our criteria for membership suggests that this phenomenon is largely self-inflicted. We have managed to construct a series of criteria for membership that excludes individuals across the country who consider themselves surgical oncologists and who in fact have substantial recognition for their cancer work in their states or regions. We must remember that we are the only society that represents surgical oncology in this country, and we should make it easier, not harder, for the genuine surgical oncologist to be a member. I detect some movement in our society and among our officers in this direction, and I think that should this occur, our brief plateau in membership will disappear and a healthy increase will follow. If this society intends to work successfully on behalf of the surgical oncologist, it must represent most of them.

Finally, a word about clinical trials. Surgical oncologists, with a few rare exceptions, have almost totally withdrawn from this arena other than as an appendage to projects of others. We need to stimulate our bright young members to enter this field, not only as part of a program but as principal investigators. The solid tumors that come to the general surgical oncologist are the most common tumors. A shift of only a few percent in survival in carcinoma of the breast or colon represents a remarkable salvage of human lives. The National Service Adjuvant Breast Program has demonstrated the feasibility of such studies, and we must encourage our members to remain involved not only in following the protocols of others but in devising new ones as well.

So what are my hopes and visions for the future into which we are venturing? I would hope that we will find ourselves a growing and vigorous society composed of general surgical oncologists who have added competency in either carcinoma of the head and neck or chest and who have the skill and interest and motivation to devise new combinations of therapy from the infinite possibilities being presented to us by modern medicine. This may seem like a Pollyannaish vision to some, but it is worth striving for; otherwise we have nothing to lose but our specialty.