Presidential Address

On Leadership, P Values, Cancer, and Family

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I WOULD LIKE TO begin this address by thanking and acknowledging the officers of the Midwest Surgical Association. The President serves a one-year term of office, and the duties of the President pale in comparison with the tasks of these other stewards of the organization. Our Treasurer oversees its financial viability for 3 years courting potential liaisons with the IRS and other irritating nuisances. Our Recorder has the simple task of keeping the entire scientific program running smoothly. Our Secretary is the communication center of the Association—a job well done is rarely noticed while one done poorly can destroy an organization. Our American College of Surgeons Representative conveys our concerns to the College and keeps us informed as to the activities of the College. And finally, although not an officer, our Local Arrangement Chair simply transforms the idea of a meeting into a practical reality. There are so many others who work diligently and quietly without fanfare—our program, membership and editorial committees, our councilors. All of these individuals labor to satisfy the wants and needs of the organization while the President has, with minor exceptions, one duty: to give a Presidential Address. It is thus appropriate that this solitary task, the Presidential Address, impart a sense of dread and trepidation. Having read many of the Presidential addresses of this and other organizations, I soon realized that this anxiety is almost universal. I found little comfort in reviewing all of these talks—they were thoughtful, researched and serious—as the saying goes, "a tough act to follow." One of this association's former Presidents even took on the lofty assignment of lecturing another president, the President of the United States, on both the problems and solutions to health care, not once but twice![1,2] This degree of self confidence does not bring consolation. So as August 15th loomed ever closer, with apprehension as my crutch, I have chosen to share with you some thoughts, some opinions, some reflections on what has been important to me over the past two decades.

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On Leadership

"The price of greatness is responsibility"
—Winston Churchill

Dr. Claude E. Welch wrote in his autobiography, *A Twentieth Century Surgeon,*[3] "A surgeon must be able to do many things, but first and foremost he must be able to operate." I would paraphrase this quote: A *leader* of surgeons must be able to do many things, but first and foremost he or she must be able to operate. Most of us have had the good fortune to associate with surgical leaders at some time during our careers. I have had the benefit of a 20-year association with my partner, associate, and Chairman, Jerry Shuck. Surgical leadership can be measured in many ways. In recognition by other surgical leaders—Jerry has been president of the Central Surgical Association and Chairman of the American Board of Surgery. Surgical leadership can be measured by the growth of one's associates—under his tenure, which now is 20 years as Chairman at Case Western Reserve University (CWRU), Jerry was responsible for 10 faculty achieving the rank of Full Professor, three faculty named as Chairmen of Departments of Surgery, and eight faculty elected to the American Surgical Association. His tenure as Chairman at CWRU is the third longest in its 157-year history. Jerry recently gave tribute to his chief of 6 years, William Altemeier, describing him as being quiet and soft spoken, traits Jerry may have learned from Dr. Altemeier. He also indicated that his chairman was not easily available, did not pass out compliments, and rarely spoke to residents except chief residents. Fortunately, these traits remained securely with Dr. Altemeier. Jerry Shuck loves the interaction with students and residents. He glows whenever a resident or faculty receives an honor or gives a presentation. He has held fast when resources have been nonexistent and when it would be easier to say "the hell with it all." If Booker T. Washington is correct, "I have learned that success is to be measured not so much by the position that one has reached in life as by the obstacles which one has overcome while trying to succeed," Jerry has been immensely successful.

Surgical leaders come in all shapes, sizes, colors, and genders. This is a leader I have come to know, a leader who gave me my first and present job, a leader who had faith in an inexperienced rookie, a leader who can operate.

On Writing

I would like to summarize five publications that have changed the course of medicine over the last century. In 1896 George Thomas Beatson described a 33-year-old mother of two children with a rapidly recurring breast cancer following mastectomy.[4] He made the observation that changes in the breast during lactation resembled the changes which were seen in cancer of the breast. "We have, under both of these conditions, the same proliferation of generations of epithelial cells which block the ducts and fill the acini of the gland; but in the case of lactation they rapidly vacuolate, undergo fatty degeneration, and form milk, while in the carcinoma they stop short of that process, and to make room for themselves, they penetrate the walls of the ducts and the acini and invade the surrounding tissues."[4] This observation and his awareness of the husbandry practice of removing the ovaries of cows after calving to prolong the production of milk led him to the hypothesis that oophorectomy might be beneficial in arresting cancer of the breast. He tested the hypothesis by performing bilateral oophorectomy in this young woman, who became the first patient to benefit from the hormonal manipulation of advanced breast cancer.

In 1929 Werner Theodor Otto Forssman addressed the problem of the inability to deliver drugs to the heart during cardiac arrest.[5, 6] His methods were alarmingly simple. He initially had one of his surgical colleagues puncture his right arm vein with a large-bore needle and then introduce a ureteral catheter for a distance of 35 cm. His colleague was reluctant to continue the experiment so during the next attempt Dr. Forssman self-administered local anesthesia, performed a "cutdown" on his own forearm, introduced the catheter its whole length of 65 cm, walked to the X-ray department, and verified the presence of the catheter in the right side of his heart, the first heart catheterization (Fig. 1). In 1956, 27 years after his publication, Forssman received the Nobel Prize sharing it with Andre Frederic Cournand and Dickinson Woodruff Richards, Jr.

In April 1955 Robert M. Zollinger and Edwin H. Ellison reported before the American Surgical Association on two patients with benign ulceration of the upper jejunum associated with extremely high gastric acid production.[7] Today it would be a true rarity for anyone in medicine to be unaware of the Zollinger-Ellison syndrome, although the disease may never be encountered even in a busy medical or surgical practice. Dr. Zollinger acknowledged that the association of an adenoma of the pancreas with this hypersecretory state was not initially recognized by either himself or Dr. Ellison but was suggested to him by Dr. Hilger Jenkins during a meeting of the American College of Surgeons. While this uncommon disorder will forever be associated with the names of Zollinger and Ellison at least nine patients with duodenal or jejunal ulcers associated with hypersecretion, hyperacidity, and pancreatic tumors were identified and reported upon before Drs. Zollinger and Ellison presented or published this landmark paper.

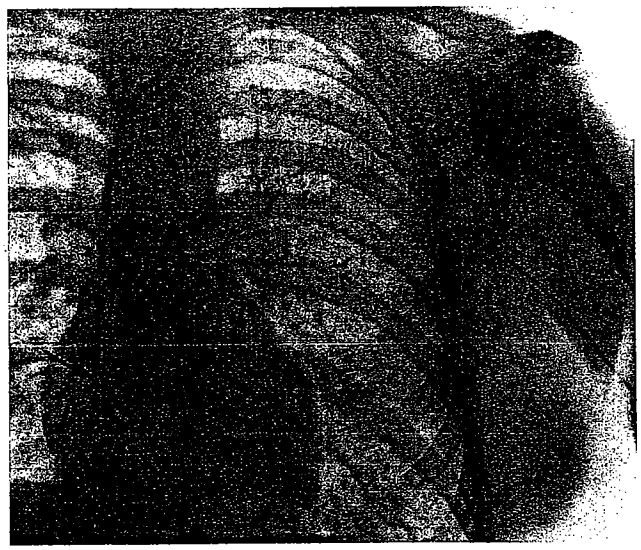

FIG. 1. Radiograph of the first heart catheterization taken in 1929. The arrows trace the path of the ureteral catheter into the right side of the heart which Dr. Forssman introduced by a "cutdown" in his own left arm.[5]

In 1956 Drs. Merrill, Murray, Harrison and Guild reported in *JAMA* the first successful homotransplantation of the human kidney between identical twins.[8] Dr. Murray later received the Nobel Prize for this work.

The last paper is that of Norman Nigro and colleagues on the combined therapy for cancer of the anal canal.[9] These authors reported on three patients with anal cancers who received what was at that time the unconventional treatment of chemoradiation prior to abdominoperineal resection. One of the three patients refused surgery when both her symptoms and the cancer disappeared following chemoradiation; the other two patients had no evidence of residual cancer in the operative specimen following abdominoperineal resection. Although presented as a "Preliminary Report" at the American Proctologic Society in 1973 this study now serves as the standard of care for patients with anal cancer, *i.e.*, chemoradiation alone with preservation of the rectum.

Why have I chosen these five papers? What important lessons do they provide? These manuscripts describe important observations that profoundly changed the course of medicine, yet none contained more than three patients. They fit the definition of single or multiple case reports. There is no mention of a *P* value in any of the papers. Two of the five reports were subsequently recognized by the Nobel Prize Committee. In one manuscript the authors were neither the first to recognize the problem nor the first to report upon it, yet the syndrome will forever be associated with their names. These comments are in no way meant to disparage the laboratory experience and its product. They are meant as an encouragement to do what we do best as surgeons: to observe our experience and to record it.

". . . Knowledge and Experience do not necessarily speak the same language. But isn't the knowledge that comes from experience more valuable than the knowledge that doesn't?"[10]

In my experience we learn more by writing than we do by reading. Writing enriches us and sometimes it enriches our fellow man. Simple ideas can have profound implications. How many times have we intended to write about an idea, an observation, a clinical experience, only to procrastinate and see our good intentions in print by some other author? In 1978 when I was a resident I heard a lecture by Dr. Charlie Hubay who was one of my mentors. I can remember him showing this slide (Fig. 2), which was somehow miraculously recovered from the archives of University Hospitals of Cleveland since Charlie died in 1991. Dr. Hubay indicated that during an aortogram of this dog in an experiment performed years earlier, the coronary vessels were visualized. He commented that this coronary angiogram predated the work of Mason Sones Jr., the father of coronary angiography. I have no way to verify this claim. But if true, how might history have been changed had this finding been published rather than relegated to a missed opportunity?

Since I've turned this into a day of story telling let me share one more historical account with you. Do you know about the greatest Hungarian physician, the man who has been called the "savior of Mothers"?[11] If you should have the opportunity to fly on Malev Airlines, you will meet him in their video portraying the greatest Hungarian leaders of all times. A museum in Budapest named in his honor sits on the banks of the Danube in tribute to him. His name is Ignaz Semmelweis, a gynecologist who in the 19th century changed medicine. Semmelweis was a Lecturer in the First Obstetric Clinic, University of Vienna. As Lecturer he was responsible for daily rounds in preparation for the professorial rounding, assisting at operations, clerical work, instruction of medical students, and performance of autopsies of any patients who died on the ward. With the exception of the latter duty he was a current day resident. Because of his clinical duties Semmelweis was able to observe a remarkable difference in the mortality of women admitted to the two obstetric clinics. In the First Obstetric Clinic where he worked, the mortality of the mothers during childbirth was 11.4 per cent while in the Second Obstetric Clinic during the same period the mortality associated with childbirth was 2.7 per cent. The mortality was so high in the former that women in labor did everything possible to avoid admission to the First Clinic. Yet just the opposite should have occurred since the First Clinic was staffed by the more "professional" staff, the obstetricians and medical students, while the Second Clinic was managed only by midwives, not doctors. Semmelweis eventually realized that the high mortality was actually caused by the medical students and doctors themselves who would perform vaginal examinations on these pregnant women without washing their hands despite having just completed autopsies on the many women who had died in the clinic. These obstetricians and medical students were inoculating these healthy patients with the bacteria which had caused the death of the autopsied women; the mid-

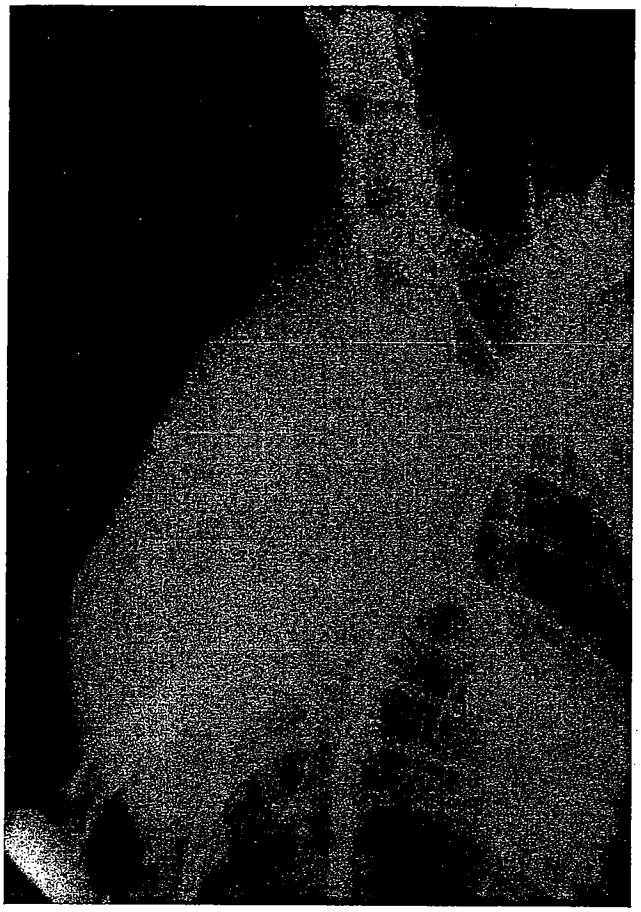

FIG. 2. Aortogram of a dog demonstrating opacification of the coronary artery (arrow).

wives did not participate in the autopsies explaining their lower mortality rate. Semmelweis went on to verify this hypothesis in experiments using rabbits and eventually insisted on chlorine hand washings before examining any patient. Despite a dramatic decrease in mortality with this regimen he was criticized by his envious professor and eventually fired from his post. Semmelweis avoided personal recognition and initially failed to share these dramatic findings with the rest of the world through publication. "Semmelweis made a fatal mistake by omitting to publish his discovery in a full, authentic text. He wrote private letters about it to his friends because as he said later: '*my whole nature repulses from any kind of paper warfare.*' "[12] Many of you are probably familiar with some or all of this fragment of medical history. I quiz my own residents and students about Semmelweis any time an opportunity to wash one's hands is missed. What you may not be familiar with is some of the repercussions of this simple act of hand washing in Semmelweis' own time and his failure to publish. While the significance of these observations and experiments were well known in Vienna the rest of the world initially failed to benefit from this important discovery. Dr. Michaelis, director of the Obstetric Hospital at Kiel, learned about the discovery through a letter sent to him by one of his subordinates who was studying in Vienna. Michaelis immediately instituted the practice of hand washing at his hospital and verified the dramatic results. Unfortunately a beloved relative had died of childbirth fever just a few weeks earlier. Michaelis was so tortured by this death, which might have been avoided had he known about the simple benefit of handwashing, that he committed suicide a few months later.[11]

One final thought about writing: Rejection is simply an opportunity to revise and try again. A lifetime batting average of 333 nearly assures one of entry into the Baseball Hall of Fame; two rejections for every three submissions is not a bad batting average especially if you have learned something from those two strikeouts. And then there is the story of the young author, a single welfare mother living in poverty. Nine publishers rejected her first manuscript. You know her today as J.K. Rowling, the creator of Harry Potter.

On Cancer

I have struggled with cancer in both my personal life and my professional career. Lessons were learned from each encounter. Let me share with you some simple insights, first from my family and then from my surgical practice.

The dates June 13, 1994, December 30, 1995, and March 18, 1997 mark my family's failure in its struggle with cancer. My mother, father, and sister, respectively, died on those dates eliminating those first-degree blood relatives from my life in the short span of less than 3 years. My mother was a lifelong smoker who developed an adenocarcinoma of the lung. Two operations and 2 years later, lymphangitic spread caused her death and my children had their first-hand experience observing the misery of terminal cancer. After the initial diagnosis was first made, my mother stopped smoking but a lifelong habit caused her to return to cigarettes even before this lethal malignancy had a chance to recur. My father also smoked most of his early life. A veteran of World War II, cigarettes were standard issue. However, my dad saw a close friend, another smoker, die of laryngeal cancer, and from that day onward he never touched another cigarette. Despite over 25 years of abstinence, in 1994 he experienced hematuria, the presenting manifestation of his bladder cancer, another malignancy associated with smoking.

Dr. Douglas Dorner entitled his 1991 Presidential Address to the Midwest Surgical Association *Of Cigarettes and Surgeons.*[13] I would encourage each of you to reread it and make it available in your waiting areas. To borrow a quote from Dr. Dorner's address, "Smoking cigarettes might be the single, dumbest, legal thing a person can do." Our lifestyle does influence our destiny, whether it be obesity, alcohol excess, promiscuity, or tobacco. Each of us as physicians must use every patient encounter to encourage smoking cessation. If we defer this responsibility to our colleagues in primary care we do a disservice to our patients.

My sister, Joanne, was a healthy grade-school teacher who neither smoked nor consumed alcohol excessively. A rare tumor, a sarcoma of the ovary, caused malignant ascites, which was misdiagnosed as a benign process, fibroids of the uterus. Despite three aggressive operations, this malignancy took her life when she was 50 years old. With my sister's death, I grope for messages, for any lessons to be learned. One obvious lesson is that while a healthy lifestyle limits our risk from the common causes of illness and death it does not guarantee us protection from cancer.

Let me share some of my experience as cancer surgeon. B.G., a 34-year-old body builder, presented with colicky left-sided flank pain which was misdiagnosed as musculoskeletal in origin. Eventually with the development of nausea, vomiting, and shaking chills a CT scan was performed demonstrating an abscess next to the descending colon, and a barium enema was consistent with either a neoplastic or inflammatory mass in that same area. I performed an en bloc resection of the left colon, abscess cavity, and abdominal wall; pathology showed a moderately differentiated stage II adenocarcinoma with perforation and 39 nega-

tive lymph nodes. This young man has outlived his X-rays which were destroyed several years ago since his surgery was performed in 1986. Fourteen years postop with no evidence of disease we can be reasonably confident that this man is cured of his cancer. What simple truth can we learn from this case? The first principle of any oncologic surgery is local control of the disease. Our love affair with technology must not interfere with this basic truth.

I first met J.M.C., a 60-year-old gentleman, in 1985 for evaluation of a level IV melanoma which had been excised from his toe. I performed a ray amputation which healed uneventfully. Four years later he experienced rectal bleeding; evaluation disclosed a rectal cancer at 11 cm. I performed a low anterior resection and pathology demonstrated a T_3 moderately differentiated adenocarcinoma with extensive lymphatic vascular invasion. Twenty-six lymph nodes were identified of which 23 were positive. Postop adjuvant chemotherapy and radiation were administered. Both clinical and laboratory evaluation has failed to disclose any recurrence of either the melanoma or the rectal cancer; this patient is alive and well today 15 years after his melanoma and 11 years after his rectal cancer.

R.C. was an 83-year-old female who presented with abdominal pain and obstructive jaundice. No mass was seen on CT scan but ERCP demonstrated a stricture in both the distal common bile duct and the pancreatic duct. She underwent an uncomplicated pyloric-sparing Whipple resection. Pathology confirmed the presence of a 2-cm moderately differentiated adenocarcinoma of the pancreas with seven of 12 positive lymph nodes. Adenocarcinoma extended to within one mm of the inked superior margin with all other margins negative for carcinoma.

J.S. is a 55-year-old male who had an identical presentation. He also underwent an uncomplicated pyloric-sparing Whipple resection. Pathology showed a 3-cm moderately differentiated carcinoma also with a close margin and positive lymph nodes. Neither patient received postoperative adjuvant therapy. Both of these patients had stage III pancreatic cancer and both underwent successful Whipple resections. However, R.C., the 83-year-old female, developed a clinical recurrence at 9 months and died 1 year after her resection while J.S., despite a localized recurrence 4 years postoperatively, is alive today, 62 months after his pancreatic resection.

What simple truth can we take away from these patients? Statistics address the prognosis of groups of patients, not individuals. Avoid eliminating hope for any individual if the possibility of survival exists. The question which I dread most when talking to patients is "how long do I have to live?" My response is always "it's impossible to tell." If I quote statistics I always include a discussion of those patients who defy the odds.

On Family

I would like to conclude this address on a topic that is most dear to me—family, not just the narrow definition "a group of persons, consisting of parents and their children" but the more general connotation "any class or group of like or related things." Jerry Shuck in his Presidential Address to the Central Surgical Association, *Random Musings on "Why,"* addressed the question of why we join surgical societies.[14] The reasons as one might expect are myriad. However, the Midwest Surgical Association provides a motive that is somewhat unique among surgical societies. The Midwest creates the opportunity to combine the professional activities of its membership with the social activities of spouses, children, relatives, and friends, that is it combines work with play. It accomplishes this unique function without shortchanging either the professional or the family mission. In my experience this marriage by a surgical association of profession and family is rare, speaks to the unique value of the Midwest Surgical Association, and should make each of us proud of our membership. I would suggest that the Midwest Surgical Association could very well be a paradigm for each of us in our professions. The work of surgeons is important, stressful, and rewarding but never an excuse to destroy our families. It is no surprise that our society, this family that we call the Midwest Surgical Association, meets in the summer, when our children and spouses, friends, and relatives can travel together.

Finally let me mention my own family. Like yours they have been there waiting for me when emergencies occurred and when meetings drone on. My daughter Beth has become so much closer to Kathy and me since she has left home for college. I delight in her excitement and her energy. Our son Chris will be leaving us in one week for college. Chris loves to do so many of the things I delight in; I'll miss his companionship but look forward to his growth. My wife Kathy has been an incredible fountain of emotional support—during those frustrating times when I needlessly worried about complications which never occurred as well as living through the ones that did. She gives me all the reasons I need to not spend a minute longer than necessary at the hospital.

I apologize for such a rambling dissertation, but the Association can rest assured that next year's Presidential Address, as previous addresses, will be more erudite than this year's. Although my words have been laced with opinion, anecdotes, and a few facts, they come from the heart. I want to sincerely thank the membership for the honor of serving as President.

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