

Presidential Address: The American Head and Neck Society Legacy



Clinical Care, Teaching, and Research: Staying the Course During Stormy Times

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It is somewhat of an understatement to say that this past year has been a challenging one on multiple levels, *challenging* being the euphemism in vogue for *difficult*. As the medical environment has degenerated, I began to develop a steadily escalating commitment to deliver to you a stimulating, positive, uplifting presidential address, but as I began to dissect out the components of our present medical environment, I became mortified with fear that I could not fulfill this task, somewhat paralyzed as I physically sat down to construct this presentation. It is no secret that organized medicine has been a prime target of a witch hunt by a society that, despite the addition of initially perceived “revolutionary” approaches to the administration of health care, has provided no sustaining solutions to any of the issues germane to the escalating cost of medical care or the fiscal and resource burden of treating the uninsured. And no one has been more consistently confronted with this dilemma in a more dramatic way than the head and neck surgeon.

CONFIDENCE IN THE FACE OF ADVERSITY

We have become somewhat anesthetized to the constant threats from Washington of additional Medicare payment reductions as well as to threats of cuts from our own state Medicaid organizations. Most of you are aware of the last-minute aversion of an additional 4.4% reduction in Medicare payments, but you must also be cognizant of the fact that additional reductions loom on the horizon.

One cannot help but recognize the increasing population of uninsured patients, especially those who are able to provide essentials for their families but are unable to protect their health, especially against the fiscal burden of a catastrophic illness such as a head and neck cancer. The pain and disgust associated with unknowledgeable, disinterested, fiscally motivated, nonphysician, so-called medical personnel is ever increasing, as is

the slow but evident degradation of the trust and confidence of the patient in his or her physician and hospital. This growing distrust is a real and demoralizing fact of life for the practicing physician.

And if this were not enough, add the escalating cost of malpractice insurance, the need for tort reform, the lack of a sustaining resilience of our economy and that of the rest of the world, in conjunction with the recent exposure of the duplicity and immortality of “big business,” the fall of the Enrons, WorldComs, and Health Souths in our society, and you compound the instability and distrust in an already jittery population. Nor can we ever dismiss 9/11 and its sequelae, and more recently, the invasions and takeover of Afghanistan and Iraq as contributors to uncertainty, fear, and reluctance to trust.

Those of you who know me recognize that my basic demeanor does not permit me to follow blind optimism. I am originally from New York, you know, and I honestly wondered how I was to create a positive “spin” to such a confluence of

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negative occurrences that appeared to be creating another “perfect storm.”

IN UNITY, STRENGTH

Nothing heals the soul more than the recognition and celebration of one’s successes, and clearly we as a society and a specialty have much to celebrate. I wish to share some of the more important of these positive developments with you today.

I first began to picture all of you in the audience today, a group of dedicated and determined physicians who 50 years ago would only acknowledge each other in negative ways and surely never be seen in the same room, dealing with similar medical and social issues. Because of the inability of general surgeons and otolaryngologists to cooperate professionally, the Society of Head and Neck Surgeons and American Head and Neck Society were independently established. By the early 1970s, the leaders of both separate societies began to recognize the strength and value of collaborating with each other, and in 1972, for the first time, both society councils met and planned a joint scientific meeting that was held in 1973 at the Homestead in Virginia.¹

One of the first significant acts performed by this newfound partnership was the creation of the Joint Council for Advanced Training in Head and Neck Surgery, and the leadership of this important group was placed in the hands of Dr John Lore. Those of you who have been fortunate enough to know Jack, as he prefers to be called, can well imagine the energy and enthusiasm that he brought to the leadership of this training council, focusing and educating head and neck surgeons to excel beyond the mediocrity of the “dabblers,” as he described those who treated head and neck cancer without an appropriate knowledge base and expertise.^{1(pp99-108)} There is little doubt that the efforts of this council set the tone for future governing bodies of subspecialty otolaryngology fellowships and compelled dedicated members of both societies to function together in a meaningful way. This council now exists as the Advanced Training Council, which I had the privilege to chair, constantly working to monitor and modify the ever-changing needs of advanced head and neck surgical education. This joint effort has been the foundation of our education and clinical excellence initiative.

In 1970, Dr George Sisson, whom we all recognize as one of the giants in the development of head and neck surgery within otolaryngology, was clairvoyant in his recognition that the divisive issues that had originally mandated the formation of 2 separate societies would ultimately dissipate, and he wrote “we have talked seriously about amalgamating the two societies. This has not happened at this time, there are advantages to having two societies. I believe, however, that at some future date, we shall unite.”^{1(pp93)} And that elusive future date occurred in 1998, when a unified head and neck society, the American Head and Neck Society, was born through the efforts of many, including Charles Cummings, John Saunders, Jonas Johnson, Ron Spiro, and Tom Robbins, to name a few. We must continue to recognize and celebrate this “burying of the hatchet” for the sake of pool-

ing resources and combining efforts to improve the care for the head and neck patient.

When challenged with a losing record and concern about his team’s performance, the thoughtful coach refocuses on the fundamentals of the game that originally brought success. As we are now being challenged on multiple fronts, I too would like to take a few moments to return to our foundation and the fundamentals that have been instrumental in sustaining the success of our specialty and our society: patient care, education, and research. I choose a limited sample of seminal events and influential leaders to make a statement that in no way represents a comprehensive history of all the successes of our specialty, but rather provides an overview of the great practitioners and important occurrences to inspire us to move forward during these trying times.

ON THE SHOULDERS OF GIANTS

A comprehensive accounting of the development of our specialty was delivered by Jatin Shah² in 1998, as the Hayes Martin Lecturer at the last meeting of the Society of Head and Neck Surgeons. While I refer you to this manuscript for the complete iteration, there are a few of our predecessors and colleagues whose efforts I would like to highlight as representative of the work of many in our specialty.

Across all surgical disciplines, the head and neck surgeon has long been recognized as the most committed and dedicated to patient care. Whether it be the legend of Hayes Martin, the aura and brilliance of John Conley, the directness of Max Som, the erudite style of John Kirchner, the dynamism of Paul Ward, or the imposing presence of our guest of honor this year, Robert Cantrell, all of these men, and so many more, represented an unrelenting commitment to the relief of human suffering and the improvement of the quality of life of those stricken with cancer of the head and neck. The creation of the multidisciplinary specialty clinic, as advocated by Shah, Sisson, Ogura, Jesse, and Goepfert, for example, set the tone for the recognition by the surgeon that head and neck cancer is not solely a surgical disease and created an example at each of their institutions of cooperation of diverse personalities and treatment approaches, all with a singular goal: the best care for the patient. This model is now the model for all oncologic systems for clinical cancer care teams throughout the medical community.

As the extent of surgical resections grew and the boundaries of surgical abilities expanded (as exemplified by Paul Donald’s aggressive challenge of the accepted parameters of skull-base resections³), reconstruction marvels, like the deltopectoral flap by Bakamijian et al,⁴ became a beginning rather than an end point for the more sophisticated head and neck defect reconstruction. And whether you give the credit for the discovery of the concept of the myocutaneous flap to Biller⁵ or Ariyan,⁶ there is no question that this innovative concept laid the groundwork for the next generation of tissue transfer, the microvascular free flap.

Those of you who have had the opportunity to learn of the initial work of Panje,⁷ Hayden,⁸ or Urken⁹ recognize the vast improvements these men have effected in

function and quality of life through the many modifications in the application of surgical technique to the treatment of complex head and neck defects. And we cannot overlook the perseverance of Steiner¹⁰ and his followers, ultimately showing us the potential use of the laser for resection of advanced malignancies of the upper aerodigestive tract, or the groundbreaking work by Wolfe and his colleagues¹¹ in defining, coordinating, and ultimately reporting the potential organ-sparing advantages of chemoradiation in treating advanced laryngeal cancers. This single multi-institutional study has provided the foundation for innumerable protocols seeking less destructive treatment options for the cure of advanced-stage head and neck cancer, always with the betterment of patient care as top priority.

And last but not least have been the recent publications, stimulated by Weymuller,¹² providing the beginnings of the quantification of quality of life parameters. These issues have always been subjectively considered by the head and neck surgeon, but they are now being measured by new objective instruments.

EDUCATION AND WELL-FOUNDED RESEARCH

Certainly, the practitioner's knowledge and understanding has always been of paramount importance to the Society. The pilgrimages of motivated surgeons to the practice centers and operating rooms of physicians like Hayes Martin, John Conley, and Eugene Myers have shown the dedication of significant numbers of "students" to learn and promote solid principles and teachings.

The Joint Training Council in 1972 was the obvious beginning of a long and continuous Societal commitment to education. The concept and the ultimate creation of the International Conference on Head and Neck Cancer must be credited to Paul Chretien, with the initial conference held in 1984 sponsored by both societies. At that time, there was no concept of the ultimate participation and success of these meetings nor of the level of effort and commitment that would ultimately be demonstrated by devoted people like Bill Fee, Helmuth Goepfert, Mike Johns, Elliott Strong, Charlie Cummings, Jay Shah, Jonas Johnson, Ashok Shaha, Ernie Weymuller. Our next meeting, in August 2004, will continue to attract the best in our field worldwide, this time to Washington, DC, and continue our legacy of excellence.

Equally important, and complementary, have been the basic research conferences, the brainchild of Greg Wolfe in 1980 and continued every 4 years with the support of individuals like Tom Carey, Stinson Schantz, and, more recently, Betty Steinberg. Research that has focused particularly on the recognition of genetic markers as potential therapeutic modifiers holds great promise for the treatment of head and neck cancer. It was not that long ago that the level of sophistication of head and neck cancer research was limited to analysis of cells grown through many passes in culture or tumors grown in nude mice. We now recognize the association of papillomavirus DNA and oropharyngeal cancers¹³ and the potential value of the association of p53, epithelial growth factor receptor, cyclin D₁, and transforming growth factor α as

possible biomarkers for treatment failure.¹⁴ Both societies have been long supporters of this type of research.

From meager beginnings, our Society has established an enviable array of research awards to stimulate and support residents, fellows, and junior faculty. The Young Investigator Award is a \$10 000-per-year award granted yearly for up to 2 years to candidates or full members at the fellow or assistant professor level. The Surgeon Scientist Career Development Award, also offered in conjunction with the Academy, is a 2-year, \$35 000-per-year nonrenewable award granted every other year to those beginning the clinician-scientist career track. And the Pilot Research Grant is a 1-year, nonrenewable \$10 000 maximum grant offered to residents, fellows, and junior faculty.

More recently, Synthes has provided a \$15 000-per-year grant, renewable for a second year, open to medical students, residents, fellows, and assistant professors for research related to head and neck reconstruction after ablative cancer surgery. The Ballantyne Resident Research Grant is a pilot grant of \$10 000 for 1 year only to support a resident research application. And last but not least, is the American Head and Neck Society–American College of Surgeons Career Development Award that was developed with the strong support of Gerry Healy, a regent of the American College of Surgeons. This is a \$40 000-per-year award for 2 years, available every other year, designed to support head and neck research by a member or candidate member of both the American College of Surgeons and the American Head and Neck Society who is a full-time faculty member within 5 years of training completion.

It is very evident that the strong evolution of the recognition and support of clinical and basic science research in the head and neck by this Society now provides an opportunity for all, from the medical student level to the assistant professor, to begin a successful research career. We should all take pride in the development and initial success of these programs.

WE ARE THE BRIDGE TO THE FUTURE

The challenges are clear. It is difficult enough to gain attention for treatment and research in head and neck cancer when it is such a relatively rare disease compared with lung, breast, prostate, and colon cancer. Add to this the fact that there is now a predicted shortage of physicians in cardiology, gastroenterology, and neurosurgery, combined with the continual effort on the part of the federal government to decrease its support for residency programs, the plight of those with this apparent "orphan illness" could easily be overlooked.

We must, each and every one of us, become engaged in our process of improvement. In the year 2000, Jesus Medina¹⁵ in his presidential address suggested that we monitor our educational programs and modify them as dictated by the needs of society at large and the strengths of those interested in our specialty.¹⁵ Additionally, last year, Keith Heller¹⁶ challenged us to get involved by mentoring and inspiring the best and the brightest in our medical schools and residency programs to pursue a career in head and neck surgery and to fully engage in the de-

cision-making process of how medical care will be delivered in the future.¹⁶

Sir Winston Churchill wrote, in 1930, "Enter upon your inheritance; accept your responsibilities."¹⁷ We must embrace the strong legacy handed down to us by the leaders of both our societies as the basis for our present unified one, a template by which to guide our designs for a successful future based on focus and excellence in patient care, education, and research. We must recognize our inheritance, nurture it, and make it more valuable than when we received it. It is our responsibility and calling. And when all is said and done, we must continue with an unwavering dedication to the improvement of the care of the head and neck cancer patient. It is our legacy.

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