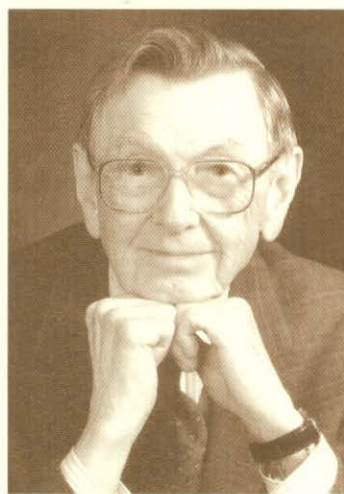


Doctor Honoris Causa

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Doctor Honoris Causa

ROBERT E.
SCULLY

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PRESENTACIÓ
DE
ROBERT E. SCULLY
PER
JAIME PRAT

Excel·lentíssim i Magnífic Senyor Rector,
Doctors del Claustre de la Universitat Autònoma de Barcelona,
Digníssimes Autoritats,
Estimats Amics, Senyores i Senyors,

L'oportunitat de retre homenatge al mestre constitueix, sense cap mena de dubte, un dels actes més gratificants de la vida acadèmica. Per aquest motiu, desitjo agrair al claustre de doctors l'ocasió que m'ofereix de presentar-hi el professor emèrit de patologia Robert E. Scully, de la Universitat de Harvard, amb motiu del grau de doctor *honoris causa* que avui li concedeix la Universitat Autònoma de Barcelona. En aquesta breu dissertació intentaré reflectir els mèrits acadèmics i humans que el fan mereixedor de tan alta distinció.

El doctor Scully va néixer l'any 1921 a Pittsfield, a l'estat de Massachusetts, en el si d'una família d'origen irlandès que s'havia establert als Estats Units cap a mitjan segle XIX. Va quedar orfe de pare molt aviat i la seva infantesa va transcórrer amb el seu germà George sota l'estricta vigilància de la seva mare, una dona de gran enteresa, mestra d'escola, de qui va rebre una educació que estimulava l'esperit de sacrifici. Els bons resultats no es van fer esperar: primer al College of the Holy Cross dels jesuïtes de Worcester (1941), i més tard a la Facultat de Medicina de la Universitat de Harvard (1944), el jove becari Robert E. Scully es va graduar amb els màxims honors i distincions acadèmiques. Si a Harvard va tenir com a professors grans figures de la medicina dels Estats Units, com Cannon o Minot, durant la seva residència als hospitals Peter Bent Brigham, Children's Hospital, Free Hospital for Women i Boston Lying-In, va poder aprendre amb els grans de la patologia de l'època, com S. Burt Wolbach, Sidney Farber i Arthur Hertig. Malgrat tot, la seva veritable *alma mater* acabaria sent l'emblemàtic Hospital General de Massachusetts, on fa gairebé cinquanta anys que hi treballa i que només va abandonar per servir com a tinent mèdic a la guerra de Corea. Al «Mass General», i sota la tutela dels professors Tracy Mallory, Benjamin Castleman i Joe Vincent Meigs, comença la seva singular aventura amb els tumors del tracte genital femení i especialment els de l'ovari.

Els puc assegurar, sense cap mena de dubte, que, gràcies a les contribucions científiques del professor Scully, avui és possible entendre la patogènia i la conducta biològica d'una gran varietat de càncers ginecològics i de lesions precanceroses. De la seva col·laboració amb el professor John McLean Morris, en va resultar la descripció de dues noves alteracions intersexuals: el gonadoblastoma i la feminització testicular. Amb el professor Arthur Herbst va descriure, el 1970, el primer model de carcinogènesi transplacentària en humans deguda a la ingestió materna d'estrògens sintètics (dietilstilbestrol). A més a més de realitzar les primeres descripcions de la literatura d'un gran nombre de neoplàsies, com l'adenosarcoma, el tumor ovàric associat a la síndrome de Peutz-Jeghers, el tumor annexal wolffià i molts d'altres, el professor Scully ha

coordinat, durant més de trenta anys, des de l'Organització Mundial de la Salut i com a autor de les dues edicions del fascicle sobre tumors ovàrics de l'Institut de Patologia de les Forces Armades dels Estats Units, l'elaboració de classificacions i terminologies tumorals que permeten aplicar a les pacients un tractament més adequat.

El doctor Scully ha rebut nombrosos premis i honors per les seves contribucions a la patologia del càncer, entre els quals cal destacar els doctorats *honoris causa* de la Universitat de Leiden, als Països Baixos, i del College of the Holy Cross de Massachusetts; l'establiment de la Robert E. Scully Fellowship in Gynecological Pathology a la Universitat de Harvard, el premi F. W. Stewart del Memorial Sloan-Kettering Cancer Center, l'Honorary Fellowship del Royal College of Pathologists, la Maude Abbott Lectureship de la United States Academy of Pathology, i el premi al Distinguished Pathologist, que també li va ser atorgat per aquesta societat.

A més a més d'haver publicat quasi cinc-cents articles científics, el professor Scully és conegut pels metges de tot el món com l'editor —des de 1974— del «Case Record of the Massachusetts General Hospital», que es publica setmanalment al *New England Journal of Medicine*, una de les revistes mèdiques més prestigioses dels Estats Units. L'interès i la varietat d'aquests casos, que s'han anat adaptant progressivament a la medicina dels nostres dies, reflecteixen l'ampli coneixement mèdic del doctor Scully. A més a més de seleccionar cada cas per a la presentació setmanal, la correcció d'aquest abans de publicar-lo l'ha obligat a haver d'aprofitar la mínima oportunitat que se li presenti per dur a terme la seva incessant tasca editorial. Per exemple, enmig de la confusió habitual que acostuma a haver-hi mentre s'esperen les maletes a la sala d'un aeroport internacional, els qui a vegades l'acompanyem ja no ens sorprenem de veure'l treure tranquil·lament la seva cartera i continuar la seva feina editorial ignorant tot el que l'envolta. El seu gran sentit de la responsabilitat docent l'ha portat a impartir classes, seminaris i conferències a gairebé tots els fòrums mèdics internacionals; i per això es compten per desenes els patòlegs de tot el món que, com en el meu cas, han assistit al «Mass General» per rebre els seus ensenyaments.

La vinculació del professor Scully al Departament de Ciències Morfològiques de la Universitat Autònoma de Barcelona i al Servei de Patologia de l'Hospital de la Santa Creu i de Sant Pau és estreta i duradora. Si bé la metodologia emprada va canviant amb el temps, el nostre projecte original, inspirat en les contribucions científiques del professor Scully, continua sent el mateix: l'estudi patogenètic, clínic i patològic dels principals càncers ginecològics.

Diferents membres del nostre departament han pogut beneficiar-se també dels ensenyaments del professor Scully; entre ells, el doctor Xavier Matias-Guiu, professor titular de la Universitat Autònoma de Barcelona, i la doctora Esther

Oliva, qui, després de finalitzar la seva residència i *fellowship* a l'Hospital de la Santa Creu i de Sant Pau, es va incorporar al Departament de Patologia de l'Hospital General de Massachusetts, on treballa en l'actualitat. Tant la doctora Oliva com el doctor Matias-Guiu han realitzat estudis sota la supervisió del professor Scully, alguns dels quals s'han dut a terme en col·laboració amb el nostre departament. El professor Scully també ha participat activament en diferents cursos de postgrau organitzats pel nostre servei, als quals han assistit centenars d'especialistes de Catalunya i de la resta de l'Estat.

Però, qui és realment el doctor Scully?

Avui dia existeix un acord general entre els patòlegs (sobretot els dels Estats Units) a pensar que Robert E. Scully és, si no el millor, un dels millors patòlegs quirúrgics d'aquest segle que finalitza i un dels diagnosticadors del càncer més grans de tots els temps. El doctor Scully posseeix una memòria fotogràfica de tal calibre que qualsevol imatge histològica o publicació científica que examina es manté arxivada en la seva ment per sempre. Tant és així que, fa vint anys, quan no teníem Internet i disposàvem de molt pocs ordinadors, els qui treballàvem amb ell no teníem necessitat d'anar a la biblioteca. En teníem prou de visitar els arxius de Scully. Allí hi havia tota la literatura mèdica d'interès, classificada, anotada i comentada de pròpia mà, en grans arxivadors metàl·lics que s'acumulaven pels passadissos del departament. El doctor Scully és com una Internet errant. Es recorda de tot el que ha vist i llegit. Per això mai no errava un cas. El seus diagnòstics eren com trets precisos. *The bullet*: així l'anomenaven els residents de Patologia de l'Hospital General de Massachusetts. «Did you show it to the bullet? What did he say?», deien amb respecte i admiració. Però malgrat aquesta estranya habilitat innata, ningú no l'ha sentit dir mai: «You are wrong». No, al contrari, la seva actitud era sempre molt humil: «Well..., you may be right..., but I would phrase it differently», deia quan opinava justament el contrari que el seu interlocutor, sense ferir mai la seva dignitat.

El mestratge del doctor Scully en l'ús oral i escrit de la llengua anglesa és antològic i mereix una menció especial. Bob no és un orador brillant perquè sacrifica tota l'ampul·lositat i evita el més mínim efecte escènic en nom de la claredat i d'una millor comprensió de les seves idees. Quan parla, les paraules sorgeixen en un ordre perfecte per formar frases gramaticalment impecables que no necessiten correccions ni marrades dialèctiques. Seria, sens dubte, la ruïna o la frustració d'un assessor d'imatge dels nous temps. El mateix li passa quan escriu. Els seus dictats no requereixen modificacions. Fa vint-i-cinc anys que utilitza cada dia el llapis vermell per editar la conferència clinicopatològica setmanal. Sumen gairebé un total de 1300 manuscrits que, com he dit abans, versen sobre les especialitats mèdiques més disperss, i als quals s'afegeixen

centenars d'articles originals, revisions i editorials que ha editat acuradament des de la primera fins a l'última pàgina. Tots els qui li lliuràvem manuscrits ens esforçàvem a escriure'ls tan bé com podíem. Però el que per a nosaltres era perfecte, a punt per enviar a l'editor, ell ens ho tornava guixat de color vermell. Tot vermell! I sense espais en blanc per la multitud d'anotacions marginals. Un mar de correccions; i no tan sols de l'idioma, sinó també del contingut. L'empipament inicial s'atenuava immediatament en comprendre que gràcies als seus oportuns suggeriments i modificacions millorava notablement el contingut i la presentació de l'article.

No és, doncs, estrany que un metge patòleg amb unes qualitats tan excepcionals com les del doctor Scully, amb aquesta memòria capaç de reproduir instantàniament els traços morfològics tot just percebuts en una fugaç ullada al microscopi, pogués descriure per primera vegada una infinitat de malalties neoplàstiques que fins aleshores eren desconegudes. Tot és ben comprensible. Tampoc no sorprèn la seva enorme i transcendent producció científica, les desenes de milers de consultes (quasi trenta mil casos difícils) rebudes des dels llocs més variats del planeta i ateses immediatament de forma desinteressada, tractant per sobre de tot d'ajudar les pacients, o el fet que hagi dictat cursos, conferències i seminaris davant les audiències més variades dels cinc continents.

A més a més, la seva dedicació a la patologia i a la medicina ha estat absoluta. Durant quasi cinquanta anys, va treballar no només els dies laborables, sinó també els diumenges i festius, i gairebé mai no va tenir vacances. Treballar durament?, seria una manera suau de descriure el seu gran esforç continuat. «I am so far behind...!», responia quan se li insinuava que es prengués uns dies de descans.

El que sí que resulta sorprenent és que un home amb aquestes qualitats intel·lectuals, que han estat punt de referència per a patòlegs, ginecòlegs, endocrinòlegs, oncòlegs i molts altres especialistes de la medicina del nostre temps, sigui, a més a més, una gran persona que prefereix passar desapercibuda; una persona senzilla dotada d'un fi sentit de l'humor amb qui un s'ho passa bé petant la xerrada o prenent unes copes. Això sí, és inusual. Segons la meua opinió i la de tots els qui ens sentim cofois de ser-ne deixebles i amics, aquesta és la veritable grandesa de Robert E. Scully («RES» en el nostre argot familiar); un autèntic *gentleman* de la patologia i de la medicina del nostre temps; un home bo i generós, dotat d'un enorme sentit de la responsabilitat docent; un veritable mestre i un model de professor universitari digne d'emulació.

Per tot això, Excel·lentíssim i Magnífic Senyor Rector, demano que el professor Robert E. Scully sigui investit en el dia d'avui amb el grau de doctor *honoris causa* per la Universitat Autònoma de Barcelona. Moltes gràcies.

DISCURS
DE
ROBERT E. SCULLY

PATHOLOGY. A CELEBRATION OF THE 20TH CENTURY AND CHALLENGES FOR THE 21ST

Reflections at the millenium

I apologize for being unable to speak Catalan, being a typical unilingual American. My address has not been translated for you because, as Cervantes has said, reading a translation is like looking at a Dutch tapestry from the reverse side – although the figures remain visible, they are dull and full of threads instead of being bright and sharp.

The subject I have chosen is worthy of a symposium featuring experts in the many aspects of pathology. All I hope to achieve in a half hour is to discuss a few of those aspects based on my experience as an American pathologist who began his academic career in the middle of the twentieth century and is about to end it in the early years of the twenty-first. I shall focus on communication between the pathologist and the clinician, which, I believe, is essential for optimal patient care, but is becoming more and more difficult in this new information age of the 21st century. Secondly, I shall comment on the need to improve and standardize terminology so that all physicians can share in the rapidly accumulating medical knowledge. And finally, I shall proclaim the joys and rewards of practicing pathology and sharing its exciting moments with one's colleagues and one's trainees, the pathologists of the future.

Much of my career has involved the microscopic diagnosis of specimens removed by surgeons, so-called surgical pathology. It has had an interesting history in the United States, which has been mirrored in many other countries, but not in all of them.

As the 19th century was ending, most American pathologists had a paramount interest in infectious disease, the leading cause of death at that time. For example, William T. Councilman, our first full-time Professor of Pathology at Harvard Medical School, devoted most of his investigative career to the pathology of yellow fever, scarlet fever, diphtheria and other infectious diseases that were prevalent during his lifetime. A few decades after the pathology of these diseases had been thoroughly studied, a number of academic pathologists began to shift their attention to neoplastic disorders. Their focus, however, was elucidating the cellular origin of tumors and assigning names to them. For example, at the Massachusetts General Hospital our first full-time Chief of Pathology, James Homer Wright, in the first decade of the 20th century identified multiple myeloma as a tumor of plasma cell origin and neuroblastoma as a neoplasm of primitive nerve cells. He, like his contemporaries, however, had very little interest in the care of the patients who had provided him with his specimens. During this era of investigative academic pathology, the real surgical pathologists were surgeons, who usually spent a year or two in Europe studying

not only under professors of surgery, but also in the laboratories of the great pioneers of pathology. On their return to the United States well trained in pathology they began to practice surgical pathology as a subspecialty of surgery. They respected the academic pathologists for their science, but were more interested in microscopic observations that were pertinent to the care of their patients rather than to the origin of their tumors. An interesting corollary to the practice of surgical pathology by surgeons during that era is that most of the early books written on surgical pathology both in Europe and the United States were authored by surgeons and not fully trained pathologists. Indeed, the only book on "surgical pathology" ever produced by a staff member of the Massachusetts General Hospital was published in 1897, and was written by arguably the greatest surgeon in the history of our hospital, Dr. J. C. Warren. He had trained in pathology under both Rokitansky and Virchow, and may have been the first surgeon to perform needle biopsies and use frozen sections to guide his surgical therapy, way back in the 1880's.

As pathological knowledge increased rapidly and could no longer be assimilated by surgeons "swamped in a mass of clinical detail", as Dr. Warren had described his own predicament, most surgeons gradually surrendered their pathology practices to fully trained pathologists, who then began to play a gradually expanding role in the care of the patient. The transition of surgical pathology from the surgeon to the pathologist remains incomplete in some countries, however, where the term "surgical pathologist" still denotes a surgeon who also practices pathology.

More important than the technical definition of a surgical pathologist is his perception by other physicians, which can either enhance or diminish his contribution to patient care. Sadly, some surgeons, although their numbers appear to be diminishing, still regard a surgical pathologist as an elite laboratory technician with a medical school diploma who has little or no interest in patients but only in identifying diseases and assigning names to them. In contrast to this denigrating concept is the one that my mentors, particularly Dr. Benjamin Castleman, my chief during the early years of my academic career, taught me by their example, namely, that a surgical pathologist is a physician who has one eye on the microscopic slides of the patient, and the other on the patient. Sir William Osler had this concept in mind when he labeled the pathologist "a clinical microscopist", and Dr. Warren a century ago defined the pathologist as an essential player in the provision of patient care.

The surgeon demands and deserves to have all the information he needs from the surgical pathologist so that he can provide the best care to his patient, but he must be continuously reminded that communication relevant to patient care is a two-lane highway on which he, as well as the pathologist, must travel. In a number of cases, clinical data, and sometimes detailed clinical data, are essential for the pathologist to make a correct diagnosis. Occasionally these data are as

important as the microscopic findings in making the final diagnosis. For example, when my co-authors and I first described the postoperative spindle cell nodule, a benign process simulating a malignant tumor, the only criteria by which we could differentiate the lesion from a malignant smooth muscle tumor were the history of a prior operation for a benign disease at the same site, and regression of the lesion despite treatment that would be inadequate for a malignant tumor. St. Luke the physician was not addressing modern-day surgeons when he wrote in one of his gospels "give and it shall be given unto you", but his message is appropriate in the context of modern communication between the surgeon and the pathologist.

I began my career in surgical pathology at the Massachusetts General Hospital in 1950 during what I consider to be the golden age of surgical pathology. Dr. Joe V. Meigs, an eminent surgeon, who was then chief of our gynecology division and who is best known for his description of the so-called Meigs' syndrome (a fibromatous ovarian tumor, ascites and pleural effusion reversible by removal of the tumor), had relatively recently relinquished his role as the hospital expert on the pathology of gynecological tumors, about which he had written a book; and I was selected to become the new expert. Dr. Meigs, however, retained his deep interest in pathology after my arrival. He and his associates and pupils were frequent visitors to our pathology laboratory, where they would discuss with my colleagues and me the impact of our microscopic findings on the prognosis and treatment of their patients.

Unfortunately, subsequent years have witnessed a gradual erosion of this intimate exchange of information between the surgeon and the pathologist. With the explosive increase in medical knowledge in the latter part of the 20th century and the torrent of new medical journals, some of them excellent, other abysmal, surgeons have found it difficult to keep abreast of advances in their own fields, and impossible to assimilate progress in pathology as well. At the same time the progressive bureaucratization of medical practice with its attendant paperwork, has taken a heavy toll on both the surgeon's and the pathologist's time. As a result, surgeons visit our laboratory to review microscopic slides far less often than in the past. So, just as Dr. Warren warned 100 years ago, surgeons and pathologists are in danger of drifting apart.

In most cases now, surgeons rely almost entirely on pathologists' printed reports to obtain the information they need to treat their patients. Unfortunately, however, this information is often inadequate for patient care, at least partly because of the deterioration of intimate communication between pathologists and surgeons. Recently, the College of American Pathologists, as well as other pathology organizations, has begun to address this problem. The College has assembled committees of experts in pathology, surgery and radiology to develop cancer practice protocols, which instruct surgeons about what important information they should furnish pathologists, and in turn educate pathologists

about what information should appear in their reports. Check sheets have also been devised to guarantee that the pathologist provides all the information that is essential for patient care.

Despite these efforts to design optimal surgical pathology reports, a recent study from Yale Medical School has shown that pathology reports that appear to pathologists to be carefully organized and precisely worded are, surprisingly, often confusing to surgeons, even when they are asked to read them carefully in a relaxed ambience, away from the hectic atmospheres of their offices or hospital wards. Solving this growing problem of communication between the surgeon and the pathologist is of utmost importance and a challenge for the new information age of the 21st century. The surgeon and the pathologist must constantly remind one another about the need to communicate, and efforts must be made to utilize the rapidly improving communication technology to meet this challenge.

One problem in communication that has accompanied the recent explosion of medical knowledge is scientific terminology, a subject that has engaged my interest throughout most of my career. In the 1950's, the World Health Organization (WHO) became concerned that there were numerous differences in the terms being used for cancers at various sites from one country to another, causing problems in the performance of epidemiologic studies and in comparisons of various types of cancer therapy. To remedy the situation it established 17 international centers for the classification and nomenclature of cancers of major sites. Six to eight experts from various countries were selected to meet several times and formulate an internationally acceptable classification and terminology for each cancer site after exchanging microscopic slides and comparing diagnoses on large numbers of tumors. The final product was then published by the WHO with color photomicrographs of the tumors.

On the recommendation of Dr. Lauren V. Ackerman I was selected as a co-chairman of the committee on classification and nomenclature of ovarian tumors, along with Professor Sergei F. Serov of Russia. At our first meeting in Geneva in 1963, we were fortunate to have the guidance of representatives of the Cancer Committee of the International Federation of Gynecology and Obstetrics (FIGO), which had already been devising classifications and staging systems of gynecological tumors for over 30 years. Our final WHO classification was published in three languages in 1973.

The WHO classifications have been widely accepted throughout the world even though they are not perfect, and some experts, who were not on the WHO Committees, have disagreed with individual terms. Not surprisingly, a number of factors contribute to imperfections in the final product of international committees. Among them are chauvinism, egoism, and rivalry or even animosity between individual committee members. An equally important problem is the influence of external events on committee decisions. For example, our WHO committee chose the term "borderline ovarian tumor" over "tumor of low

malignant potential” by a vote of 4 to 3 after only a brief discussion on Friday afternoon as the members were looking nervously at their watches, anxious to get to the airport. At least, the term that was selected led to a humorous comment on tumor nomenclature when a disapproving gynecologist subsequently stated that “there are no borderline tumors, only borderline pathologists”.

A more remarkable defining event occurred at a 1985 FIGO Cancer Committee meeting in Berlin, which I had attended as a representative of the International Society of Gynecological Pathology. The committee was trying to reach agreement on the maximal dimensions allowable for the diagnosis of microinvasive carcinoma of the cervix. Two of the experts, who had done considerable research on this question, dominated the discussion. One favored 10 mm in width and 5 mm in depth, and the other 7 mm in width and 7 mm in depth. After an hour's debate neither protagonist was willing to compromise. Finally, and miraculously, at 11:50 a.m., a costumed young lady entered the room and announced “lunch will be served in 10 minutes”. There was an almost instant consensus that microinvasive carcinoma of the cervix should not exceed 7 mm in width and 5 mm in depth. Thus, the medical world had a definition devised by experts, and the experts had their lunch on time.

Despite the unusual and sometimes comical pathways to the conclusions of international committees, their terms and definitions have proved effective in facilitating communication among physicians throughout the world, fostering clinical and scientific progress. For example, although it now has two subdivisions, the 1985 preprandial definition of microinvasive cervical carcinoma has persisted to this day, and interestingly, the physician who considered the WHO ovarian committee members “borderline pathologists” called me many years later to ask my opinion about treatment of a “borderline ovarian tumor” in a member of his family.

Despite the valiant efforts of the WHO and other international organizations, some national groups have recently been altering classifications and diagnostic terms unilaterally. A prime example is the committee that devised the Bethesda system for reporting the results of cytological examination of the female genital tract. The committee was sponsored by the American National Institutes of Health. Unfortunately, its members ignored the efforts of other national and international organizations to standardize terminology, and their final report led to the same types of international communication problems that antedated the WHO publications. Terminology and definitions of precancerous lesions of the uterine cervix now differ from one country to another, and a major long-term research project in the United States investigating the efficacy of screening for cervical cancer had to be discontinued abruptly because of the confusion engendered by the Bethesda system. The tragedy is that there was no necessity for a change in terminology in order to achieve the otherwise laudable goals of the committee. The lesson to learn from the Bethesda system is that great caution

should be exercised in the future before altering well established terminology without international approval. Attempts to achieve international consensus may delay decisions on terminology for a few years, but it is rarely essential for optimal medical care to change a term or a classification within a shorter period of time.

Another retrogressive step in terminology is the proliferation of newly created terms for both newly discovered tumors and old tumors with already well-established names. It is obvious to anyone with a reverence for language and a special interest in nomenclature that many of the new terms being coined not only fail to describe accurately the essence of the entity they are intended to define, but also betray their creators' ignorance of the meaning of the words included in their terms. It should not be unreasonable to require a physician or a group classifying or naming a disease to consult a general dictionary as well as a medical dictionary before proposing a new classification or a new term.

Journal editors and reviewers bear considerable responsibility for this increasing problem by accepting papers that contain poorly conceived terms. New terminology as well as other aspects of submitted articles should be evaluated critically in the future, and failure of authors to heed a recommendation to alter or eliminate a proposed term should be regarded as justification for rejection of a paper.

The remarkable advances in medical knowledge in the latter half of the 20th century and the problem of communicating them to the medical profession have been mirrored in the Case Records of the Massachusetts General Hospital, clinicopathological conferences that have been published weekly in the *New England Journal of Medicine* for over 75 years, and that a distinguished medical historian has regarded as the twentieth-century grandchild of Morgagni's: "The Seats and Causes of Disease Investigated by Anatomy", which was published in 1761.

These clinicopathologic conferences, or puzzles, in which a physician is presented the details of a patient's disease and is asked to make a diagnosis, which is then confirmed or corrected by the pathologist, were conceived around the turn of the last century, when medical education was shifting from a description of diseases to a discussion of the patients who had those diseases. The conferences were founded by Dr. Richard C. Cabot, one of the great physicians and diagnosticians of the early part of the twentieth century. During his tenure as editor of the published versions of the conferences, he was able to discuss almost all the cases himself. With the passage of time and the evolution of specialization in medicine and surgery, however, he realized that other physicians could give more erudite discussions and make more confident diagnoses on many cases, and he and his successors gradually turned to specialists, and even subspecialists to discuss the cases. When I became editor of the Case Records over 25 years ago, my predecessor had just changed the venue

of the conference from a general hospital auditorium to small conferences rooms where specialty rounds were held, and those in the audience as well as the discussers were specialists. One of my first decisions as the new editor was to reverse that policy, which tended to divert the teaching value of the conferences away from generalists, now called primary physicians in the United States, and medical students.

Since specialists and subspecialists prefer to direct their remarks to their peers rather than to primary physicians or medical students, and since the *New England Journal of Medicine* is a general medical journal and not a specialty journal, I continue to make every effort as editor of the Case Records to simplify and clarify the specialists' discussions to make them more comprehensible to the primary purveyors of patient care and the physicians of the future, and at the same time leave intact the specialized information of the discussor of the case.

The surgical pathologist is continuously being confronted with evaluation of the potential diagnostic role and cost-effectiveness of new tools and new techniques that continuously appear in the medical literature. In the past, some of these innovations, such as electron microscopy, and later, immunopathology, had been touted as much more scientific and hence, potentially more informative diagnostically than pouring colored dyes on "thick" sections of human tissue. Unfortunately for the advancement of medicine, these glowing predictions have been deflated by the passage of time. As we all know now, electron microscopy helps the surgical pathologist relatively rarely, and helps the clinician even less often. Although immunohistochemistry has had and continues to have a greater diagnostic impact than electron microscopy, over-reliance on it at the expense of careful evaluation of routine microscopical slides has not only dulled the pathologist's mastery of routine microscopy, but has also dug deep holes in patients' wallets.

A welcome consequence of the survival of old-fashioned light microscopy as the gold standard of pathological diagnosis is that the pathologist, unlike any of his fellow physicians, retains the pleasure of brightening each day by enjoying the brilliantly colored patterns of human disease, a microcosm of the splendors of nature. Ramon y Cajal, the great Spanish microscopist, referred to the brain as his flower garden. I can assure you that flowers are still blooming in every area of the body, and new species continue to be discovered as routine microscopy has survived as the major contributor to new information of clinical significance. Important scientific knowledge still lurks within the routinely stained microscopical slide. One must recall that the Barr body, which had been languishing, lonely and neglected on the nuclear membrane long before Virchow had looked at his first cell, was not recognized until over a century later, when its discovery ushered in the era of genetic research in the field of normal and abnormal sexual development. Although conventional light microscopy may not be immortal, no credible replacement has as yet appeared on the horizon, and

this ancient approach may have the same life expectancy in pathology that the physical examination has in clinical medicine.

Academic pathology in the twentieth century has been an exciting career. Each day has provided an opportunity to add a small piece to the enormous puzzle of human disease. Whenever one is successful in so doing he may, as Ramon y Cajal has so lyrically described it, experience the thrill of discovering an uncharted island or a virginal forest that has been waiting from the beginning of time for someone to contemplate its beauty.

Finally, as Herbert Spencer, the 19th century philosopher, has said "we are the descendents of the past and the parents of the future, and our thoughts are as children born to us, which we may not carelessly let die". We must transmit not only what our mentors and their mentors have taught us, but also what we have learned ourselves, to younger generations of pathologists. Some teachers achieve this goal by delivery exciting and inspiring lectures. As you have no doubt learned in the last half hour, I don't belong in that category. I have tried to compensate for this deficiency, however, by teaching by example. In my contact with trainees, I have strived to impart to them my concept of surgical pathology as clinical microscopy, my devotion to careful thought and clear writing, and the necessity of remaining receptive to the opinions of others even though they disagree. As Charlie Chan, a fictional cinema detective of the early twentieth century so aptly put it in one of his movies, "Human mind like parachute; works best when open". Equally important as these intellectual approaches to pathology has been continually dramatizing to the younger generation of pathologists one's unabated joy in the every-day practice of pathology.

Many of those who have studied under me have subsequently pursued highly successful careers. Among them is my promoter, Dr. Jaime Prat, who has organized one of the finest patient-care and research pathology laboratories in all of Europe. He will continue to be a leader in pathology in the 21st century. One of the deepest satisfactions of my career as a teacher has been observing trainees, such as Dr. Prat, grow into world-renowned pathologists, and assuming or perhaps only dreaming that I may have had a small role in their development.

CURRICULUM VITAE
DE
ROBERT EDWARD SCULLY

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- Born: August 31, 1921, Pittsfield, Massachusetts
- 1941 *AB magna cum laude*, College of the Holy Cross
- 1944 MD, Harvard Medical School
- 1944-1947 Intern and Resident in Pathology, Peter Bent Brigham Hospital and Children's Hospital
- 1947-1948 Resident in Pathology, Free Hospital for Women and Boston Lying-In Hospital
- 1948-1949 Resident in Pathology, Pondville Cancer Hospital, Norfolk, Massachusetts
- 1950 Diplomate, American Board of Pathology (Anatomic Pathology)
- 1950-1956 Assistant Pathologist, Massachusetts General Hospital
- 1952-1954 Captain, MC USAR, 406 Medical General Laboratory, Toyko, Japan
- 1957-1959 Associate Pathologist, Massachusetts General Hospital
- 1959- Pathologist, Massachusetts General Hospital
- 1946-1947 Assistant in Pathology, Harvard Medical School
- 1947-1954 Instructor in Pathology, Harvard Medical School
- 1950-1952 Instructor in Pathology, Tufts Medical School
- 1955-1958 Clinical Associate in Pathology, Harvard Medical School
- 1958-1964 Assistant Clinical Professor of Pathology, Harvard Medical School
- 1964-1969 Associate Clinical Professor of Pathology, Harvard Medical School
- 1969-1971 Associate Professor of Pathology at the Massachusetts General Hospital, Harvard Medical School
- 1972-1992 Professor of Pathology at the Massachusetts General Hospital, Harvard Medical School
- 1992- Professor of Pathology at the Massachusetts General Hospital, Harvard Medical School, Emeritus

MISCELLANEOUS POSITIONS

- 1963-1964 President, New England Society of Pathologists
- 1963-1975 Co-chairman, WHO Scientific Group on Histological Nomenclature and Classification of Ovarian Tumours
- 1967-1970 Editorial Advisory Committee, *Atlas of Tumor Pathology*
- 1983 Armed Forces Institute of Pathology
- 1970-1980 Associate Editor, *Human Pathology*
- 1980- Editorial Board, *Human Pathology*
- 1972-1974 Associate Editor, Case Records of the Massachusetts General Hospital, *New England Journal of Medicine*
- 1974- Editor, Case Records of the Massachusetts General Hospital, *New England Journal of Medicine*
- 1972-1998 Head, Collaborating Center, WHO Scientific Group on Histopathological Nomenclature and Classification of Testicular Tumours
- 1971- Pathologist, Registry of Clear Cell Adenocarcinoma of the Genital Tract of Young Females
- 1971-1982 Member, Task Force of the American Joint Committee for Cancer
- 1985- Staging and End Results Reporting (Gynecologic Sites)
- 1972- Consulting Pathologist, Gynecologic Oncology Group
- 1977-1997 Editorial Board, *Gynecologic Oncology*
- 1977-1982 President, International Society of Gynecological Pathologists
- 1978-1982 Chairman, Nomenclature and Staging Committee, Society of Gynecologic Oncologists
- 1979-1999 Member, Cancer Committee (Council on Pathology Practice) College of American Pathologists

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- 1980-1984 Editorial Board, *Journal of Soviet Oncology*
- 1981- Editorial Board, *International Journal of Gynecological Pathology*
- 1982- Chairman, Nomenclature and Staging Committee, International Society of Gynecological Pathologists
- 1982-1984 Executive Committee, International Society of Gynecological
- 1986-1990 Pathologists
- 1986-1993 Member, Clinical Awards Committee, American Cancer Society
- 1986-1990 Member, Research, Development and Strategic Planning Committee, American Society of Clinical Pathologists
- 1987-1993 Council on Anatomic Pathology, American Society of Clinical Pathologists
- 1987-1989 Quality Assurance Committee, American Society of Clinical Pathologists
- 1988-1993 Educational Materials Advisory Committee, American Society of Clinical Pathologists
- 1988-1995 Member, American Joint Committee on Cancer
- 1992-1998 Chairman, Quality Management Anatomic Pathology Expert Review Panel, ASCP
- 1993-1996 Executive Committee, American Joint Committee on Cancer
- 1994 - Editorial Advisory Board, International Correspondence Society of Obstetricians and Gynecologists
- 1997- Consultant Editor, *Annals of Diagnostic Pathology*

AWARDS AND HONORS

- 1972 Award of Nassau and Suffolk County Societies of Pathologists, New York
- 1973 Honorary Fellowship, The Chicago Gynecological Society
- 1974 Foundation Prize, American Society of Obstetrics and Gynecology (with Arthur L. Herbst, M.D. and Stanley J. Robboy, M.D.)
- 1975 Honorary Membership, Central American Association of Pathology
- 1980 Fred Waldorf Stewart Award, Memorial Sloan-Kettering Cancer Center "for advancing knowledge of human cancer"
- 1981 Joanne Vandenberg Hill Award and William O. Russell Lectureship, M.D. Anderson Hospital and Tumor Institute, The University of Texas System Cancer Center, Houston, Texas "for outstanding achievement in pathology"
- 1982 Honorary doctorate of Medicine (*Doctorem Honoris Causa*), University of Leiden, The Netherlands
- 1983 Sir Thomas and Lady Edith Dixon Lectureship and Medal of Ulster Medical Society, Belfast, Ireland
- 1983 Arthur Purdy Stout Award and Lectureship, American Society of Clinical Pathologists
- 1985 Honorary Fellowship, The Philippine Society of Pathologists
- 1987 Joseph Bolivar DeLee Humanitarian Award, Chicago Lying-In Hospital, Pritzker School of Medicine, The University of Chicago
- 1987 Honorary Fellowship, European Society of Gynaecological Oncology
- 1989 Shields Warren Memorial Lectureship and Medal, New England Deaconess Hospital, Boston
- 1990 Honorary Fellowship, American Gynecological and Obstetrical Society

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- 1991 H. P. Smith Distinguished Pathology Educator Award
of the American Society of Clinical Pathologists
- 1992 Maude Abbott Lectureship of United States and Canadian
Academy of Pathology
- 1992 Honorary Doctorate of Science (*Doctorem Honoris Causa*),
College of the Holy Cross, Worcester, Massachusetts
- 1992 Honorary Fellowship, the Royal College of Pathologists
of Australasia
- 1992 Distinguished Service Award of the American Society
of Clinical Pathologists
- 1993 Establishment of Robert E. Scully Fellowship in Gynecological
Pathology, Massachusetts General Hospital
- 1994 Honorary Membership, Pathology Association of Rosario,
Argentina
- 1995 Founding Member, Japan Academy of Surgical Pathology
- 1996 Honorary Membership, Mexican Society of Pathology
- 1996 Honorary Fellowship, Royal College of Pathologists
- 1998 Distinguished Pathologist Award, United States and Canadian
Academy of Pathology
- 1998 President d'Honneur, European Congress of the French Society
of Gynecology

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