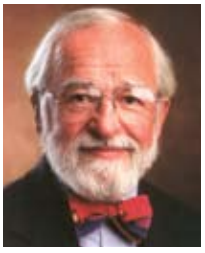
A WAY WITH WORDS | Leon Speroff, MD, describes the growth and evolution of reproductive endocrinology



Leon Speroff, MD
Professor of Obstetrics and Gynecology
Department of Obstetrics and Gynecology
Oregon Health and Science University
Portland, Oregon

Marc A. Fritz, MD
Professor, Department of Obstetrics and Gynecology
Division Chief, Reproductive Endocrinology and Infertility
University of North Carolina
Chapel Hill, North Carolina

Leon Speroff, MD, has played a dynamic role in the field of reproductive endocrinology from its inception. A keen observer and gifted raconteur, Dr Speroff has contributed enormously to the subspecialty through his prolific writing and decades of teaching. Recently, Dr Speroff spoke with Marc A. Fritz, MD, about his illustrious career—and what the future holds.

MAF: What led you to focus your interest on reproductive endocrinology?
LS: My father was a bona fide Marxist and I inherited a radical streak from him. At Case Western Reserve University School of Medicine, I learned about Grantly Dick-Read and natural childbirth, which in 1960 was an anti-establishment movement. This appealed to me, so I decided to study obstetrics and gynecology (ObGyn). When I began my residency at Yale, I met assistant professor Nathan Kase, who fired me up about reproductive endocrinology and helped me map out my future in the field. After my father, Nate was the most profound mentor in my life.

MAF: How did the subspecialty of reproductive endocrinology first become formally established and how were its forefathers themselves first certified?
LS: The discipline of ObGyn was being threatened by special interests and splinter groups. In the early 1970s, the American Board of Obstetrics and Gynecology decided to create subspecialties, which kept the discipline together and also created new opportunities for teaching and research. This was the same reason for the development of the affiliated societies of the American Society for Reproductive Medicine in the 1980s.

Of course, there was the problem of how to certify the first reproductive endocrinologists! The board asked some of the early pioneers to define what made a reproductive endocrinologist and to develop a certification process. Since there were no official fellowship programs that first year, we were judged on our experience outside of residency. I was a 1-year fellow at the Worcester Foundation for Experimental Biology in Massachusetts and a research associate in the ObGyn department at Columbia University. After passing a written test, I went to Chicago for an oral exam. There was a shortage of oral examiners, so my panel was made up of an internist, a medical endocrinologist, and Georgeanna Seegar Jones.

MAF: Your textbook *Clinical Gynecologic Endocrinology and Infertility* is the most widely read subspecialty book in the world. It was first published in 1973 and had 266 pages.
LS: And cost $17!

MAF: Today, it has 1152 pages and costs significantly more. How did it all begin?
LS: In 1972, Bob Glass approached me in the hallway at Yale. He and Nate Kase were writing a textbook on endocrinology, and Bob asked me to join them, saying that they met every Thursday evening to work on it. During our first meeting, I asked what they had done so far—and the answer was nothing! Being a compulsive organizer, I took the project over, which is how my name got to be listed first on the textbook.

A student always does the artwork so that we can work closely together. We submit a finished product to the publisher—the time between the last tweak of the manuscript and publication is only about 3 months.

I think the key to the book's success is its readability. We focus on the clinical

lessons, and because we do all of the writing ourselves, we can avoid redundancy and inconsistency. I also avoid typical medical jargon—I prefer to use meaningful statements with a supporting reference.

MAF: Is there significance to the color scheme of each edition?
LS: Yes! The first edition was supposed to be a dark Yale blue. The editor drove up from Baltimore to personally give me my copy—and the light blue cover was the first thing I noticed when he handed it to me. He almost had a heart attack. The second edition was green and yellow, representing the University of Oregon. The third was brown and orange for the Cleveland Browns. The fourth really was Yale blue. The fifth was red and black for the Portland Trail Blazers. The sixth was Yale blue adorned with the Macedonian star. The seventh edition is North Carolina Tar Heel blue.

MAF: You've chaired departments at Oregon Health and Science University and at Case Western. How has this role changed over your career?
LS: When I was a chair at Oregon in 1976, my responsibilities were teaching, research, and clinical care. In 1990, for a variety of reasons, academic medicine came to rely on clinical income for funding. The chair position evolved into a business function—keeping the department in the black and handling income and expenses. These days, many faculty members see patients every day to bring in revenue, and this compromises our mission of research and teaching. Pick up any medical journal—65% of our clinical research papers come from foreign countries.

MAF: How has assisted reproductive technology (ART) affected the specialty of reproductive endocrinology?
LS: ART has become a prominent feature of the specialty because it generates so much more revenue than other aspects, such as contraception, menopause, or endocrine disorders. Do I think this is good? No. This is not an attack on the field; rather, it reflects the problem of how academic departments are funded. Some people think infertility should be its own subspecialty, separate from reproductive endocrinology. I think that would be a mistake. Someone who understands all aspects of infertility is able to provide the best patient care.

MAF: You've also been actively involved in the controversies about the risks and benefits of postmenopausal hormone therapy (HT). How do you view the issue now?
LS: I'm proud to have been among the first people to understand and speak out about the limitations of the Women's Health Initiative (WHI). Unfortunately, the WHI investigators seem to have a vested interest in promoting a negative view of HT. The first 3-year follow-up after the cancellation of the estrogen-progestin arm was recently published in *JAMA*.[1] The authors emphasize the greater incidence of cancer among the participants. However, if you read the paper accurately, this increase is not statistically significant; it was influenced by a lesser number of cancers in the control group. The authors emphasized an increase in lung cancer, but they referenced only 1 supportive chart review and neglected numerous studies that disagreed with their findings. It is imperative that people in our field study research outcomes objectively in order to provide the best care for our patients.

Two questions about HT remain: Does estrogen therapy given to young, relatively healthy postmenopausal women offer primary prevention of coronary heart disease? Do the epidemiologic data show that estrogen causes a small increase in breast cancer risk or do they reflect the effect of HT on pre-existing tumors? A few studies are working on answering the first question. Designing a study to answer the second—that's a challenge!

MAF: Some people may not know about your other books, on such topics as senior slow-pitch softball, the early American Indian physician Carlos Montezuma, and the Deschutes River railroad war. What's next?
LS: There is always something. Currently, I'm working on a biography of Gregory Pincus, whom many would consider "the father of the pill." I don't agree with this designation, and my book explains why. ■

Reference

1. Heiss G, Wallace R, Anderson GL, et al; WHI Investigators. Health risks and benefits 3 years after stopping randomized treatment with estrogen and progestin. *JAMA*. 2008;299:1036-1045.