

From my perspective

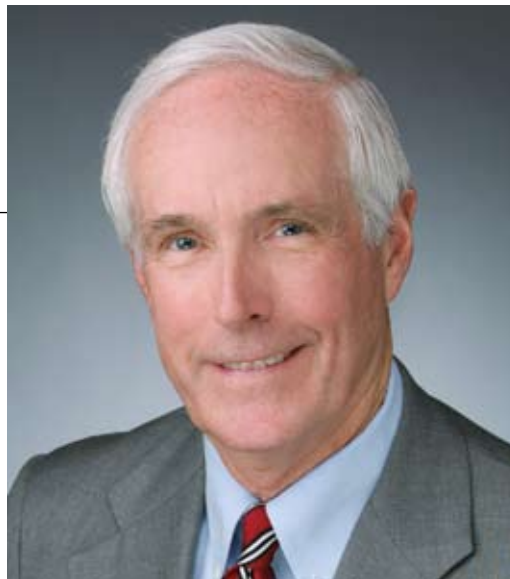
The practice of surgery just isn't what it used to be. This trend is affecting practice on many levels and will inevitably continue into the future. Surgeons who want to remain competitive in this new environment will need to possess a range of skills going far beyond the abilities traditionally needed to shine in the operating room. In large part, driving this evolution in the meaning of surgery are advances in technology.

As surgeons attempt to broaden their competence in new arenas, the health care professionals who have typically provided these services are seeking to stymie our progress. The American College of Surgeons intends to ensure that surgeons are capable of using new technology appropriately in the treatment of surgical disease and able to continue to contribute their unique understanding of acute conditions to patient-centered teams of medical professionals.

Technology

The endoscopic and laparoscopic revolution of the late 1980s broadly expanded the range of options available to medical practitioners to intervene in and manage acute and chronic diseases. Ongoing subsequent improvements in diagnostic and surgical technology have instigated a dramatic decline in the number of open operations performed in the U.S. Today, endoscopy is supplanting exploratory procedures previously done to diagnose cancer and other conditions of the bronchi, colon, rectum, urinary bladder, esophagus, stomach, larynx, nasopharynx, and pharynx. Furthermore, laparoscopic cholecystectomies and appendectomies are the norm, with more advanced video-assisted procedures—such as colectomy, nephrectomy, hysterectomy, and prostatectomy—rapidly becoming routine.

In more recent years, an even more expansive variety of instruments and techniques have been introduced to help surgeons deliver state-of-the-art care, including developments in robotic machinery, arthroscopic surgery, and natural orifice transluminal endoscopic surgery (NOTES). We also are making broader use of stents, catheters, balloons, and so on. Frequently, it is only after these alternatives have been exhausted or ruled out that an open surgical repair takes place. So, in the last 20 or so years, surgeons have found



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that they either must become competent providers of less invasive care or lose a significant portion of their patient base.

In addition, we are discovering uses for stereotactic-guided imaging that extend beyond screening and diagnosis and into interventional capacities as well. For example, imaging may be used to treat breast tissue via laser ablation, cryoablation, radiofrequency ablation, and placement of radiation catheters.

The American College of Surgeons offers a number of educational programs to help surgeons learn about and develop their skills in using these innovations. For example, during our 2007 Clinical Congress this month in New Orleans, LA, we plan to present a number of postgraduate courses and scientific sessions centered on laparoscopy, endoscopy, imaging, radiological interventions, and nonsurgical approaches to care. Some of the more cutting-edge topics that we will explore are as follows:

- NOTES
- Ablation for skin cancer
- Accelerated partial breast irradiation
- Breast imaging and ultrasound

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- Lymphatic mapping and sentinel node biopsy
 - Stereotactic breast biopsy
 - Image-guided diagnosis and treatment of the breast

This organization was founded largely for purposes of ensuring that surgeons stay informed about and competent in the delivery of cutting-edge surgical care. As the definition of surgery changes, the issues covered in our programs will evolve because eventually all of the surgical specialties will be challenged to remain up to date on the latest innovations in care.

A turf battle

Unfortunately, some members of the radiology community are seeking to assert control over all imaging techniques—particularly stereotactic breast biopsy—and thereby inhibit surgery’s ability to branch out into new vistas of quality patient care. More specifically, some of our radiology colleagues have asked that the U.S. Food and Drug Administration (FDA) regulate stereotactic breast biopsy under the Mammography Quality Standards Act (MQSA). The MQSA pertains to standards for cancer screening and diagnosis derived through the use of mammograms.

The College, the American Society of Breast Surgeons, the American Society of General Surgeons (ASGS), and the Society of Surgical Oncology have written to the FDA to explain that the provisions in the MQSA are inapplicable to stereotactic biopsy. If nothing else, we would appreciate the same opportunity that radiology was given to present our views to the agency’s National Mammography Quality Assurance Advisory Committee (NMQAAC). Subsequent to radiology’s testimony, the NMQAAC voted in favor of regulating stereotactic breast biopsy under the MQSA.

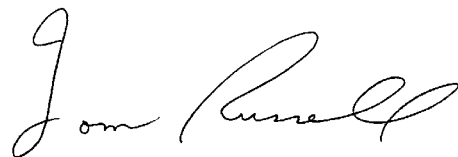
The surgical societies mentioned previously and the College are concerned that our radiology colleagues are using this issue as part of a broader effort to restrict the use of imaging to radiologists. If nothing else, they seem intent on making it much more difficult for nonradiologists to use imaging modalities. This activity really flies in the face of the future of medicine and surgery, which will likely be organized around cycles of care and disease management. Our ability to provide appropriate, safe, and effective care will hinge on

surgeons’ ability to perform imaging procedures and manipulate tissue. Technology is blurring the distinctions between the medical and surgical specialties, and it is myopic to claim that only one specialty is qualified to use certain imaging technology.

We are seeking wider support for our position on the breast imaging issue. During the recent meeting of the American Medical Association (AMA) House of Delegates (HOD), the ASGS introduced a resolution calling on the AMA to oppose the FDA’s proposed regulation of stereotactic breast biopsy. Instead, the proposal suggests that the AMA promote accreditation and certification as the preferred method for raising standards and improving the quality of image-guided care. The HOD opted to refer this resolution, which the College strongly supported, to the AMA Board of Trustees for a decision. On July 20, I wrote to Edward L. Langston, MD, chair of the AMA Board of Trustees, requesting that the board join our efforts to oppose FDA regulation of stereotactic breast biopsy.

Working differently, working together

These issues may be affecting breast surgery today, but it is safe to say that tomorrow or next year they will touch all of the surgical specialties. The delivery of quality patient care is going to be considerably different in the coming years. Divisiveness and specialty rivalry will only have debilitating effects on the profession’s ability to care for patients with acute illness. We must all work together to ensure that each and every member of the health care team can provide the state-of-the-art services our patients deserve.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@fac.org.