

Foreword



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Consulting Editor

When it was first agreed that I would serve as Consulting Editor to the *Surgical Clinics of North America* it was with the agreement between the publishers and me that we would try to explore topics that had true relevance to the general surgeon. Although at the time that seemed like a straightforward objective, it has proved to me to be a more elusive concept than I might have originally thought. The topic of breast care is particularly illustrative of how difficult it can be to characterize what it is that a general surgeon should know and what a general surgeon should do.

One of the first difficulties to address is; what is the difference between limiting one's practice and developing a specialty practice. I would think that most surgeons know of surgeons who limit their practice to certain problems and then claim to be specialists. One might argue that a surgeon who limits her or his scope of practice is able to maintain a focus of development that would allow for development of extraordinary knowledge in that area. Others may argue that additionally focused formal fellowship specialty training is mandatory to be considered a specialist. We as a discipline have not addressed this dilemma well and perhaps we cannot. The American Board of Surgery is clear and specific about its inclusion of the diagnostic and operative management of patients who have breast problems being within the scope of a fully trained general surgeon. There are also fellowship-trained breast surgeons, either by specific additional training in breast surgery or as part of a surgical oncology fellowship, who feel that the training provided by standard residency training is inadequate to be considered fully qualified in the management of patients who have breast disorders.

Technically both may be right or wrong. It is unclear to me who would be the final arbiter of such a disagreement.

Another point of contention that was made very clear to me at a recent systemwide meeting in the large multispecialty clinic in which I work was the concept of “Captain of the Ship.” It was proposed at that meeting that we discuss limitations on the process of performing and choosing biopsy options and timing. One of the arguments that was put forth was that a general surgeon should be consulted before every biopsy, no matter how performed. This would effectively eliminate the ability for a physician to directly request a biopsy performed by someone other than a surgeon. This rings as a battle cry to some of you reading this and some will squirm as they imagine their clinic space filled with patients requiring urgent consultation before stereotactic biopsy of benign disease.

Like many of the readers of this series I was trained to believe that general surgeons can do just about everything better, faster, cheaper, and with fewer problems than any other specialty. Although my ego would like me to believe that is true, I am not sure that my intellect will allow me to accept it as a blanket statement anymore (not that it ever should have). Although we as surgeons may envision ourselves as Captains of Ships, I don’t believe it is written anywhere that we actually are. Also, our ability to force anyone else to believe that is pretty limited. If we are to convince anyone of our value to the patient who has breast problems we shall have to do so by providing superior service to our patients and referring physicians and providers.

The comprehensive care of the patient who has complex breast problems is for the most part multidisciplinary at this time. It is the extremely rare surgeon who solely prescribes chemotherapy or delivers radiation therapy. It would seem to me that given the complexities of skill sets, from diagnostic imaging to extirpation and adjuvant therapy, most general surgeons involved in this kind of care are more likely to become valuable team members in a service line than sole providers. And because that is the case the expectation that we will *always* be the Captain of the Ship is probably unlikely to be a philosophy shared by our other valued team members. Perhaps we should rethink our positions in some situations to optimally care for the patient.

A last point refers to breast care related to other disorders. Breast care, and specifically breast cancer, is an extraordinarily well-funded health care concern. It is most likely funded disproportionately to other similarly devastating health care problems. There certainly many reasons for this—public awareness through the media, celebrity backing of funding events, and public perception relative to actual data, to name a few. In a national or international strategy (or lack thereof) to address health care research and funding, the process of open competition for what seems to be limited global funding may either be brilliant market pressure strategy or complete abdication of establishing priority by central powers; most likely the answer lies in between.

As in many situations, the answers to the questions posed above are certainly not absolute. Any considered response to these challenges requires a sound understanding of the underlying subject matter. Dr. Newman and her colleagues have assembled an excellent collection of articles so that the considered reader can be well versed in the issues as they present from the surgeon's viewpoint. At the minimum a thorough understanding of these topics will make one a better team member; perhaps it will better qualify one for a leadership position.

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