

2010 SSO Presidential Address: Subspecialty Certificate in Advanced Surgical Oncology

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The directors of the American Board of Surgery unanimously approved the proposal for a subspecialty certificate in advanced surgical oncology at their meeting in Philadelphia in June 2009. What events preceded this approval? What other hurdles need to be surmounted before certification in surgical oncology becomes a reality?

HISTORY OF THE AMERICAN BOARD OF SURGERY

To put things in perspective, let me briefly summarize the history of the American Board of Surgery (ABS). It was exactly 100 years ago, in 1910, that Dr. Abraham Flexner, supported by funds from the Carnegie Foundation, recorded the state of affairs of medical training in the USA at the beginning of the century: the quality of medical schools was extremely variable, with some of them based on scientific principles and others completely devoid of proper training, resulting in practitioners of vastly different education and quality. By the same token, there were no standards for training in medicine and surgery or any standards to verify and validate the quality of the individual trainee at the end of specialty training. The field of medicine was in disarray and needed standardization of educational quality and certification of individual competence.

The idea of certification by a specialty board was first adopted by the ophthalmology organizations, which formed a specialty board, the American Board for Ophthalmic

Examinations, which was incorporated in 1917. By 1933, the name was changed to the American Board of Ophthalmology. The otolaryngologists formed the American Board of Otolaryngology, which was incorporated in 1924. The American Board of Surgery, a private, nonprofit, autonomous organization, was incorporated in 1937.

Today the American Board of Surgery is 1 of the 24 boards of the American Board of Medical Specialties (ABMS), and its principal objective is to evaluate the education, training, and knowledge of broadly qualified and responsible surgeons and to issue certificates to all candidates meeting the board's requirements and satisfactorily completing its prescribed examinations. The ABS considers certification to be voluntary and limits its responsibilities to fulfilling the purposes stated above and not to designate privileges, credentialing or special recognition in the practice of surgery or its subspecialties. In doing so, the ABS serves the public, by guaranteeing that certified surgeons are highly qualified, and it serves the diplomates, by conferring on them recognition of their special skills, training, and knowledge.

The founding organizations of the American Board of Surgery were the American College of Surgeons (ACS), the Surgical Section of the American Medical Association (AMA), and the American Surgical Association (ASA), each providing three representatives, plus four regional surgical societies, the New England Surgical Society, the Pacific Coast Surgical Association, the Southern Surgical Association, and the Western Surgical Association, each providing one representative. With the increase in workload created by the growing number of surgeons seeking certification and the process of recertification started in the early 1980s, the ABS has added to the number of directors over the years by inviting representation from other surgical societies: currently 22 national and regional surgical organizations and 3 surgical boards provide 32 directors

TABLE 1 Nominating organizations to the American Board of Surgery

Founding organizations
American College of Surgeons (ACS)
American Medical Association (AMA)
American Surgical Association (ASA)
New England Surgical Society (NESS)
Pacific Coast Surgical Association (PCSA)
Southern Surgical Association (SSA)
Western Surgical Association (WSA)
Regional surgical organizations
Central Surgical Association (CSA)
Southeastern Surgical Congress (SESC)
Southwestern Surgical Congress (SWSC)
Academic/research organizations
Association for Academic Surgery (AAS)
Society of University Surgeons (SUS)
Specialty surgical organizations
American Association for the Surgery of Trauma (AAST)
American Pediatric Surgical Association (APSA)
American Society of Transplant Surgeons (ASTS)
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)
Society for Surgery of the Alimentary Tract (SSAT)
Society of Surgical Oncology (SSO)
Society for Vascular Surgery (SVS)
Program director associations
Association of Pediatric Surgery Training Program Directors (APSTPD)
Association of Program Directors in Surgery (APDS)
Other ABMS surgical boards
American Board of Colon and Rectal Surgery (ABCRS)
American Board of Plastic Surgery (ABPS)
American Board of Thoracic Surgery (ABTS)

(Table 1). In 2005, the ABS decided to add three at-large directors, selected from a list of nominations from the surgical community, to provide greater diversity, bringing the total number of directors to 35 (Table 2). Nine of the 35 current directors are members of the Society of Surgical Oncology (SSO).

The SSO requested to nominate a member to the ABS in the early 1980s. The request was approved by the ABS in June 1983. Dr. Charles M. Balch was our first representative (1986–1992), followed by Dr. John M. Daly (1992–1998) and Dr. Timothy J. Eberlein (1998–2004). Our current representative is Dr. Ronald J. Weigel; his term expires in June and he will be replaced by Dr. Douglas S. Tyler. Besides these four representatives, many members of our society have served as directors of the American Board of Surgery, and ten have served as chairs of the board of directors, undeniably the highest honor a director can achieve:

Dr. William P. Longmire, Jr. (1961–1962), Dr. Claude H. Organ, Jr. (1984–1986), Dr. Samuel A. Wells, Jr. (1988–1989), Dr. Edward M. Copeland, III (1990–1991), Dr. Andrew L. Warshaw (1992–1993), Dr. Jay L. Grosfeld (1996–1997), Dr. Glenn D. Steele, Jr. (1999–2000), Dr. Barbara L. Bass (2004–2005), Dr. Courtney M. Townsend, Jr. (2006–2007), and the current chair of the board, Dr. Steven Stain (2009–2010). Three of these directors have also served as presidents of our society.

FIRST ATTEMPT AT CERTIFICATION: THE 1980S

The idea that training in surgical oncology has differentiated itself sufficiently from the training of general surgery to be recognized with a subspecialty certificate is not new. In the early 1980s, the SSO moved forward to approve training programs in surgical oncology and made plans for a written “certifying” examination. A working committee, chaired by past-president Charles Balch, was appointed in February 1984 to develop questions for a surgical oncology examination. The committee also met with the National Board of Medical Examiners in December 1984 to submit a proposal to administer the examination. At a SSO Executive Council meeting in January 1985 it was agreed that the first “certifying” examination would take place in 1986, and that admission would be limited to those surgeons who had graduated from SSO-approved programs since 1980. It was further agreed that a second examination would take place in 1988 with admission extended to all members of the Society of Surgical Oncology.

These decisions stimulated the ABS to investigate the possibility of some type of certificate in surgical oncology. After preliminary informal talks between members of the ABS and the SSO, the SSO Executive Council voted in May 1985 to enter into a dialogue with the American Board of Surgery and with the Residency Review Committee in Surgery toward the establishment of a certificate of “added qualifications in Surgical Oncology.”

To evaluate the merits of a certificate in surgical oncology, the American Board of Surgery created an Ad Hoc Committee on Surgical Oncology in 1986. Chaired by the late C. James Carrico, the committee included eight additional members: Drs. Bradley Aust, Charles Balch, Murray Brennan, Edward Copeland, Bernard Jaffe, R. Scott Jones, LaSalle Leffall, and Paul Weeks. In a show of good faith, the SSO elected to suspend its efforts toward the development of an examination leading to certification and to put on hold approval of new training programs in a vote taken at a meeting of the Executive Council in May 1986.

The ABS committee met three times between October 1986 and April 1987 and submitted an interim report and recommendations to Dr. Arthur J. Donovan, chairman of

TABLE 2 Directors of the American Board of Surgery (2009–2010)

Stanley W. Ashley, MD—Boston, MA (AAS)	
Karen R. Borman, MD—Orlando, FL (ACS)	
L.D. Britt, MD—Norfolk, VA (ASA)	
Joseph B. Cofer, MD—Chattanooga, TN (SESC)	
Thomas H. Cogbill, MD—La Crosse, WI (at-large)	
E. Christopher Ellison, MD—Columbus, OH (ACS)	
Stephen R.T. Evans, MD—Washington, DC (AMA)	SSO member
B. Mark Evers, MD—Lexington, KY (SUS)	SSO member
John B. Hanks, MD—Charlottesville, VA (SSA)	
Douglas W. Hanto, MD—Boston, MA (ASTS)	
Ronald B. Hirschl, MD—Ann Arbor, MI (APSA)	
Lenworth M. Jacobs Jr., MBBS—Hartford, CT (NESS)	
Nathalie M. Johnson, MD—Portland, OR (at-large)	SSO member
V. Suzanne Klimberg, MD—Little Rock, AR (ASA)	SSO member
David M. Mahvi, MD—Chicago, IL (SSAT)	SSO member
Jeffrey B. Matthews, MD—Chicago, IL (SUS)	
J. Wayne Meredith, MD—Winston-Salem, NC (AAST)	
Fabrizio Michelassi, MD—New York, NY (CSA)	SSO member
Joseph L. Mills, MD—Tucson, AZ (SVS)	
Leigh A. Neumayer, MD—Salt Lake City, UT (ACS)	
John R. Potts III, MD—Houston, TX (SWSC)	
John J. Ricotta, MD—Washington, DC (APDVS)	
William P. Schechter, MD—San Francisco, CA (PCSA)	
Bruce D. Schirmer, MD—Charlottesville, VA (SAGES)	
Anthony J. Senagore, MD—Grand Rapids, MI (ABCRS)	
Kenneth W. Sharp, MD—Nashville, TN (ACS)	
Steven C. Stain, MD—Albany, NY (WSA)	SSO member
Richard C. Thirlby, MD—Seattle, WA (ASA)	
Thomas F. Tracy Jr., MD—Providence, RI (APSTPD)	
R. James Valentine, MD—Dallas, TX (APDS)	
Nicholas B. Vedder, MD—Seattle, WA (ABPS)	
Selwyn M. Vickers, MD—Minneapolis, MN (ASA)	SSO member
J. Patrick Walker, MD—Crockett, TX (at-large)	
Ronald J. Weigel, MD—Iowa City, IA (SSO)	SSO member
Cameron D. Wright, MD—Boston, MA (ABTS)	

the board of the ABS between 1986 and 1988. In the report, the committee mentioned that there were eight SSO-approved surgical oncology training programs and went on to recommend establishing a certification process for added qualifications in surgical oncology.

The committee discussed a number of related issues. Several of these deserve brief comment:

A. The committee agreed that such a certificate was not intended to be a license which would exclude general surgeons from the treatment of primary tumors. The committee felt that this was best accomplished by eliminating the option of “grandfathering” past trainees through an examination. Instead the committee recommended that this certificate be available only to individuals after completion of an Accreditation Council for Graduate Medical

Education (ACGME)-approved training program in surgical oncology. We should take a minute to recognize the wisdom of this recommendation to avoid fragmentation of surgery and to stress the unique value of an ACGME-approved training.

B. The committee agreed that requirements for the certificate should include 2 years of training to cover core knowledge and to enhance clinical expertise in surgical oncology.

As far as the core knowledge, the committee recommended inclusion of:

1. Tumor biology and host response
2. Natural history of tumors
3. Pathology

4. Principles of multimodality therapy

As far as clinical expertise, the committee recommended inclusion of:

1. Management of unusual and infrequent malignancies
2. Surgical management of recurrent and complex malignancies
3. Application of multimodality therapy
4. Principles of surgical reconstruction

The committee further specified that the trainee should be well founded in all these areas and initiate investigation in one or more.

The report of the ad hoc committee was discussed at the directors meeting in Philadelphia on June 23, 1987. At the end of the discussion a motion was approved:

- That the directors of the American Board of Surgery agree, in principle, to establish an examination process leading to certification of added qualifications in surgical oncology.
- That the preparation for this certification include head and neck oncology as a major component.
- That the requirements for such certification be constructed to enhance, rather than detract from, the exposure of general surgery residents to the principles and practice of the treatment of primary tumors.

The ad hoc committee also developed guidelines for the training programs in surgical oncology. These were very specific to the kind of training in cancer care, research, and education that trainees should receive during a 2-year fellowship; they defined a minimum number of advanced surgical oncology operative cases that each fellow should have prior to graduating from the training program; they also included institutional leadership in oncology as a required skill for the trained surgical oncologist. These guidelines were prepared in time for the subsequent meeting of the American Board of Surgery directors in January 1988.

The momentum generated by the Ad Hoc Committee on Surgical Oncology for board recognition of the specialty created concerns about the possible fragmentation of surgery as a discipline. Pediatric surgery had become a component board in 1972, and vascular surgery 10 years later in 1982; in 1984 the ABMS granted authorization to the ABS to award certificates of added qualifications in surgical critical care and in 1986 in hand surgery. Fragmentation of the profession of surgery was the topic at the American Board of Surgery retreat in January 1989, and a decision was made to form an ad hoc committee and charge it with bringing recommendations back to the American Board of Surgery regarding a policy for determining under what circumstances certificates of added or special

qualifications should be granted. The committee, composed of three members of the American Board of Surgery (Drs. Carrico, Tompkins, and Sheldon) and three members of the Residency Review Committee (Drs. Austen, Silen, and Wells), met on April 12 and May 30, 1989. After much deliberation, it was felt by the members of the committee that further granting of certificates of added qualifications would greatly fragment surgery and would lead to its dissolution. There was much discussion about surgical oncology as a mature discipline deserving board recognition: in the end, it was felt that a certificate of added qualifications in surgical oncology would be a step which would lead to the granting of several other certificates of added qualifications (gastrointestinal surgery, trauma, endocrine), since there would be no justification to refuse the proposals of various specialty groups. Although the ad hoc committee voted against additional certificates of added or special qualifications, effectively ending the SSO quest for one in surgical oncology, the ABS decided to recognize surgical oncology as a primary component of general surgery and started including questions and clinical scenarios in surgical oncology in its examination process.

For its part, the SSO reinstated the approval process for new training programs, developed a match process, and for a while administered a written examination for trainees similar to the ABS qualifying exam. It should be noticed at this point that the leaders of our society, although disappointed by the decision of the ABS, demonstrated great maturity and foresight in deciding to avoid resuming the efforts at developing a "certifying" examination for graduates of SSO-approved fellowships and for SSO members. This decision was reached at a SSO Executive Council meeting in October 1989. It would take 20 years for the "mature and collegial" behavior of the SSO vis-à-vis general surgery to be rewarded by the unanimous vote of the directors of the ABS in favor of pursuing a subspecialty certificate in advanced surgical oncology.

THE DEFINING PERIOD: THE 1990S

The movement toward a certificate of added qualifications in surgical oncology had come to a sudden halt, yet the vision was still there and the work continued. Through the commitment and perseverance of the SSO leadership, the professional and scientific status of surgical oncology was consolidated and refined over the subsequent 15 years. Specifically, the following aspects of the application for subspecialty certification were strengthened and enhanced: (1) the identification of a body of scientific medical knowledge defining surgical oncology distinct from or more detailed than the scientific medical knowledge defining general surgery, (2) the existence of a group

of physicians concentrating their practice in surgical oncology, and (3) the existence of a national society with principal interest in surgical oncology. Let us review how this development was accomplished.

The Existence of a Body of Scientific Medical Knowledge Underlying Surgical Oncology in Large Part Distinct from or More Detailed Than the Medical Knowledge Underlying General Surgery

Currently there are 19 SSO-approved surgical oncology training programs, offering a total of 51 positions per year; 16 programs are in the USA and 3 are in Canada (Table 3). This represents a significant increase since the mid 1980s, when there were only nine training programs, graduating 22–30 trainees every year (Table 4).

All these programs are based on the training requirements established by the Ad Hoc Committee on Surgical Oncology of the late 1980s. The differences in goals of training and curricula between current general surgery and surgical oncology training programs have become clear and they speak to the existence of a body of scientific medical knowledge in surgical oncology which is additive to, and in many areas distinct from, that of general surgery.

The training requirements in surgical oncology are designed to develop a practitioner with skills additional to those of a general surgeon. Indeed, the curriculum is expected:

TABLE 3 SSO-accredited programs and positions available

In the USA	
Boston University/Roger Williams Hospital	(1)
City of Hope	(3)
Dana Farber	(1)
Fox Chase Cancer Center	(3)
H. Lee Moffitt Cancer Center	(2)
Johns Hopkins Hospital	(1)
John Wayne Cancer Institute	(4)
Memorial Sloan–Kettering Cancer Center	(7)
M.D. Anderson Cancer Center	(7)
Ohio State University	(2)
Roswell Park Cancer Institute	(4)
University of Chicago	(2)
University of Louisville	(1)
University of Miami	(1)
University of Pittsburgh	(5)
Virginia Commonwealth University	(1)
In Canada	
McGill University	(1)
University of Toronto	(2)
University of Calgary	(1)

TABLE 4 Surgical oncology training programs and positions available

Year	Number of training programs	Number of available slots/year
1986	8	23
2001	13	38
2002	12	36
2003	14	38
2004	15	41
2005	15	46
2006	18	46
2007	17	47
2008	19	51
2009	19	51

- To impart knowledge and qualifications in the diagnosis, surgical treatment, and multidisciplinary care required by patients with rare, unusual, complex or recurrent cancers, inclusive of palliative procedures and management of chronic pain
- To develop trainees to become educators in cancer prevention, diagnosis, treatment, and rehabilitation
- To develop trainees to assume a productive role in cancer research through conduct of basic science, translational, epidemiological, and/or outcome research, and through active enrollment of patients in clinical trials
- To develop trainees to assume a leadership role in cancer centers or in the community regarding cancer education, prevention, screening, and treatment and to become involved in legislative initiatives in favor of cancer patients

In addition, trainees of SSO-approved surgical oncology training programs acquire additional expertise in the performance of complex procedures, as defined by the General Surgery Residency Patient Care Curriculum Outline 2008–2009 (SCORE) project. Table 5 provides recent data for complex oncologic procedures from the academic year 2007–2008, listed by SCORE category, performed by graduating general surgery residents compared with graduating trainees of SSO-approved surgical oncology programs. These data show that SSO-approved surgical oncology training focuses on advanced surgical oncologic procedures and is additive to the experience obtained during the general surgery training program.

At the same time, current SSO-approved surgical oncology training programs do not detract from the experience of the graduates of general surgery training programs in institutions where they coexist. Only 8 of the 19 SSO-approved programs are in US departments of

TABLE 5 Number of complex oncologic procedures performed by general surgery chief residents and trainees of SSO-approved surgical oncology training programs

Procedure	General surgery chief residents Mean \pm SD	Trainees in SSO-approved surgical oncology training programs Mean \pm SD
Category 1: abdomen—general, operations/procedures, complex		
Retroperitoneal lymph node dissection-open	0.6 \pm 2	1.98 \pm 3.05
Category 4: abdomen—liver, operations/procedures, complex		
Segmentectomy/lobectomy-open	3.9 \pm 4	16.82 \pm 12.68
Category 5: abdomen—pancreas, operations/procedures, complex		
Pancreaticoduodenectomy	4.0 \pm 4	45.2 \pm 57.28
Total pancreatectomy	0.2 \pm 1	1.8 \pm 1.79
Distal pancreatectomy	2.3 \pm 2	13 \pm 12.29
Category 7: alimentary tract—esophagus, operations/procedures, complex		
Esophagectomy, total	1.1 \pm 2	1.53 \pm 3.78
Esophagogastrectomy	0.9 \pm 1	2.84 \pm 3.86
Category 8: alimentary tract—stomach, operations/procedures		
Partial gastrectomy	4.3 \pm 3	6.6 \pm 5.64
Total gastrectomy	1.0 \pm 1	3.2 \pm 2.59
Category 11: alimentary tract—anorectal, operations/procedures, complex		
Abdominoperineal resection	3.1 \pm 3	6.87 \pm 6.37
Category 13: breast, operations/procedures, complex		
Stereotactic breast biopsy	1.5 \pm 4	5.6 \pm 10.43
Category 14: endocrine, operations/procedures, complex		
Adrenalectomy-open and laparoscopic	1.9 \pm 2	2.81 \pm 3
Category 15: skin and soft tissue, operations/procedures, complex		
Major lymphadenectomy	4.1 \pm 4	19.23 \pm 14.09
Major resection for soft tissue sarcoma	2.7 \pm 3	15.13 \pm 15.99
Category 27: head and neck, operations/procedures, complex		
Modified radical neck dissection	1.4 \pm 2	6.12 \pm 6.37

SD standard deviation

surgery with a concomitant general surgery training program. The number of major surgical oncology procedures from the 34 general surgery residents graduating from these eight programs shows that there is no difference in operative experience obtained in general surgery training programs with or without a coexisting surgical oncology training program. Indeed, when performance of pancreatoduodenectomies is considered, general surgery residents graduating from programs coexisting with a surgical oncology fellowship performed a mean of seven Whipple procedures versus three for the other programs (Table 6). This “halo” effect has been reported already: past-president Ted Copeland mentioned it in his presidential address a decade ago.¹

These results are interesting but not surprising when one considers that the SSO has been historically very careful to grant certification only to programs in institutions with high volume of oncologic cases, allowing for healthy coexistence, and possible synergy, of the general surgery

and surgical oncology training programs. If one were to take this observation further, it should be possible for interested residents of general surgery training programs coexisting with surgical oncology training programs to receive an enhanced experience in operative oncology. This might be done by more specific sharing of experience among fellows and residents, by selected oncologic rotations during the senior years of the residency, or by using fellows in their second year of training in the role of junior attendings. While some of this would require changes in Residency Review Committee (RRC) requirements, it could lead to modifying the relationship between a fellowship and a residency program. The fellowship program would enhance and enrich the general surgery residency training, and the residency program could better prepare the candidate for a subspecialty training program. The end result could be a more focused and enhanced general surgery training, a better prepared candidate for a surgical oncology fellowship, a potential shortening of the length of

TABLE 6 Median number of major surgical oncology procedures from 34 general surgery residents graduating from the eight programs coexisting with surgical oncology training programs (SOTP) and from 885 general surgery residents graduating from programs without a coexisting surgical oncology training program (Other)

OP CODE	DESC	SOTP Chief_mean	Other Chief_mean	SO Fel Chief_sum
				38
1540	RADICAL MASTECTOMY	0	0	0
2010	ESOPHAGECTOMY	1	1	45
2020	ESOPHAGO-GASTRECTOMY	0	1	16
2220	GASTRIC RESECT, PARTIAL-OPEN	2	2	66
2225	GASTRIC RESECT, PARTIAL-LAPAROSCOPIC	1	2	44
2230	GASTRIC RESECT, TOTAL	1	1	19
2630	COLECTOMY, PARTIAL-OPEN	16	16	543
2650	ABDOMINO-PERINEAL RESECTION	3	2	113
3210	LOBECTOMY OR SEGMENTECTOMY	4	3	136
3620	PANC RESECTION, DISTAL	3	2	114
3630	PANC RESECTION, WHIPPLE	7	3	230
3640	PANC RESECTION, TOTAL	0	0	9
5030	ADRENALECTOMY	2	1	76

the combined training, and board eligibility in both surgery and advanced surgical oncology. I am convinced that this is possible, and I am delighted to say that a few days ago a special committee on residency training with participation of directors of the American Board of Surgery, Residency Review Committee, and other major stakeholders had the first of four meetings looking at better integration of general surgery residency training and further subspecialty training.

The Existence of a Group of Physicians Concentrating Their Practice in Surgical Oncology

The practice profiles of surgeons who have completed a surgical oncology fellowship differ from those of other general surgeons, and as one would expect, tend to concentrate on treatment of cancer. This is supported by analyzing the scope of practice of general surgeons who have completed an SSO-approved surgical oncology training program with those who have not at the time of their first recertification for surgery.

Table 7 lists the differences in oncologic and nononcologic cases in the group of surgeons who first recertified in the years between 2005 and 2007. Several differences are apparent. Despite 2–3 years less in practice prior to recertification, the practices of graduates from surgical oncology training programs include more oncologic and fewer nononcologic cases. Statistically significant differences are present for all procedures except colon surgery, probably a reflection of a large number of benign colon conditions (diverticulitis, volvulus, inflammatory bowel disease, etc.), which is the province of the general surgeon. However, in consideration that the number of general surgeons is more than 30-fold greater than the number of

TABLE 7 Practice patterns of general surgeons with and without subsequent SSO-approved surgical oncology training (2005–2007 first recertification cohort)

Procedure	Completed SSO-approved surgical oncology training program		p-Value
	Yes (n = 93) Mean	No (n = 2938) Mean	
Cholecystectomy	24.3	56.1	0.008
Hernia repair (all)	22	59	0.002
Colon (all)	17.6	20.1	0.275
Pancreas (all)	9.5	1.6	0.005
Breast (all)	98.8	55.8	0.0001
Major lymphadenectomy	7.3	2.6	0.04
Major excision skin neoplasm	12.5	2.6	0.002
Sentinel lymph node biopsy for melanoma	11.1	1.2	0.006
Radical excision for soft tissue tumors	11.5	1.8	0.001

surgeons with additional surgical oncology training (93 versus 2,938 in our sample), it is apparent that up to 95% of oncologic cases are being performed by graduates of general surgery residency training programs without additional training in surgical oncology.

The Existence of a National Society with Its Principal Interest in Surgical Oncology

Our society, the Society for Surgical Oncology (SSO), is the principal specialty organization for surgical oncologists. It was founded in 1975 from the Ewing Society, which had been in existence for many decades. The SSO now counts

more than 2,300 members, 90% of whom are surgeons, with the remainder made up of basic scientists (PhD) and other health care personnel (nurses, tumor registrars, etc.).

In 1994, the Society of Surgical Oncology recognized the need for a journal devoted to communicating newly acquired knowledge related to the diagnosis and treatment of oncologic diseases and established the *Annals of Surgical Oncology*. The driving force behind the conception of the journal was our past-president Charles Balch, aided by presidents who preceded and followed him. Dr. Balch continues to be the editor-in-chief, flanked by Mark S. Roh as executive editor and Deborah Whippen from the editorial office. Over the intervening 15 years, this journal has become the premier scientific publication for presentation of new information in surgical oncology, and it is now the official journal for both the Society of Surgical Oncology and the American Society of Breast Surgeons. Today, keeping pace with modern times, the complete journal, including all articles dating back to 1994, is available in a searchable web version, and new manuscripts are posted on the web version as soon as they are accepted, to facilitate prompt distribution of new knowledge. *Annals of Surgical Oncology*, which is owned by our society, has a circulation of more than 3,000 and an impact factor of 3.917, ranking 6th out of 139 journals in the field of surgery.²

THE SURGICAL ONCOLOGY ADVISORY COUNCIL

In recognition of surgical oncology as a mature subspecialty discipline, the American Board (ABS) established the Surgical Oncology Advisory Council (SOAC) in 1998 with the charge to report to the board of the ABS on matters of interest to surgical oncology, such as training, maintenance of certification and potential certification procedures, and to provide a formal communication channel to the surgical oncology community regarding matters related to certification and recertification.

SOAC is composed of both ABS directors with expertise and scope of practice in surgical oncology and members proposed by organizations representative of the specialty. The initial chair of SOAC was Dr. Glenn D. Steele, Jr. (1998–1999). He was followed by Drs. Timothy Eberlein (1999–2004), Marshall M. Urist (2004–2005), and Carlos A. Pellegrini (2005–2009). Currently, the membership of the Surgical Oncology Advisory Council consists of six ABS directors (Drs. B. Mark Evers, Nathalie M. Johnson, V. Suzanne Klimberg, Fabrizio Michelassi, Selwyn Vickers, and Ronald J. Weigel), three SSO representatives (Drs. Jeffrey F. Moley, Raphael E. Pollock, and Mitchell C. Posner), one representative from the American Association of Endocrine Surgeons (Dr. Richard A. Prinz), one

representative from the American Society of Breast Surgeons (Dr. Rache M. Simmons), and the ABS executive director, Dr. Frank R. Lewis, Jr., MD (ex officio). I succeeded Dr. Carlos Pellegrini as the chair of SOAC in June 2009.

As a group, SOAC provides the ABS with additional expertise regarding our specialty, and is acknowledged as the voice of surgical oncology within the ABS. SOAC has also functioned very aptly as a link between the ABS and our specialty society. In effect, SOAC has become the operative information channel between the ABS and the SSO.

CURRENT APPLICATION

With the strength and depth acquired by our training programs and our specialty over the past 15 years, the discipline of surgical oncology appeared to be mature for subspecialty status additional to and distinct from surgery. The 2006 SSO strategic plan developed under the guidance of past-president Raphael Pollock listed many objectives to be obtained as part of the education and training goals. One of the listed objectives tasked the leadership of the SSO to work with SOAC and the American Board of Surgery to initiate an application for a subspecialty certificate in advanced surgical oncology.

The advisability of pursuing a certificate was first vetted with the directors of the surgical oncology training programs, realizing that they represent the group which will be most affected by the limitations brought by ACGME oversight. A questionnaire was circulated in January 2007, asking whether the directors were supportive of pursuing a subspecialty certificate in surgical oncology and investigating the consequences of such a certificate. The questionnaire generated overwhelming support for pursuing such a certificate.

With the support of the surgical oncology training program directors, the Executive Council of the SSO established an ABS Advisory Task Force at its March 2007 meeting. Chaired by Dr. James E. Goodnight, Jr, the committee saw Drs. David R. Byrd, Ronald P. DeMatteo, Douglas L. Fraker, Peter W.T. Pisters, Mitchell C. Posner, and Ronald J. Weigel as the other members. This group was charged to investigate the appropriateness and the timing of a request for a certificate. In its report to the Executive Council in October 2007, the task force felt that ACGME oversight would ensure a level of objectivity and external credibility in regard to the quality and uniformity of our training programs; the ABS certification process would create a formalized, highly structured examination which would lend the successful candidate objective measures of competence, and that a subspecialty certificate

would improve the quality of applicants attracted to our training programs. In the end this would translate into a benefit to the public and in an improved public image for surgical oncology. The task force report concluded by giving full support to such an initiative and stated that the "Surgical Oncology subspecialty certification should be the highest goal of the SSO leadership."

The request for a certificate in surgical oncology was then transmitted to the Surgical Oncology Advisory Council. At that time, SOAC was chaired by Dr. Carlos Pellegrini and saw Drs. Suzanne Klimberg, our current Treasurer, Dr. Ronald Weigel, our current representative to the American Board of Surgery, Dr. Nathalie Johnson, and me as directors of the American Board of Surgery; Dr. Raphael Pollock and Dr. John Daly, both past-presidents of the SSO, were additional members. SOAC, under the skillful guidance of Dr. Pellegrini, became the group responsible for the preparation of a document to submit to the entire board of the ABS and for gathering support for the initiative. The presence of Drs. Suzanne Klimberg, Ronald Weigel, and myself in the leadership of the SSO, the Surgical Oncology Advisory Council, and the American Board of Surgery made the preparation of the proposal as seamless as a complex process can be.

One of the issues to decide early on revolved around "grandfathering," which refers to the practice of issuing certificates following a successful examination to trainees who have completed their training prior to the establishment of a certificate. As can be imagined, the decision in favor or against "grandfathering" had considerable implications. SOAC felt that the decision needed to be made by the SSO. Hence, the issue of "grandfathering" was discussed at the Executive Council meeting of the SSO in March 2009 in Chicago. At the end of the discussion, a unanimous vote was taken against pursuing the option of "grandfathering." Only graduates of ACGME-accredited surgical oncology programs would be eligible for certification. This decision, which may be viewed as quite restrictive by some, was made in recognition of the wisdom of a similar decision 22 years earlier and of the report of the task force, which indicated that the advantages to the public and the discipline of surgical oncology would come only through applying the highest criteria of quality.

In retrospect, this decision was crucial and opened the door to a unanimous vote by the directors of the American Board of Surgery in favor of a subspecialty certificate in advanced surgical oncology at their meeting in Philadelphia in June 2009. The name of the certificate was specifically chosen to reflect the "advanced" cognitive, research, practice, and leadership skills that differentiate the product of a surgical oncology training program from the general surgeon with an oncology practice.

NEXT STEPS

Over the summer, the certificate proposal was sent to the Accreditation Council for Graduate Medical Education (ACGME) for review. The application was discussed at the ACGME board at its February meeting. I am pleased to report that the ACGME board of directors has approved that the ACGME accredit fellowships in surgical oncology and has delegated the authority to do so to the RRC for surgery. Soon the RRC-S will start the process of writing the program requirements. In preparation for this step, the RRC-S has asked our society to nominate one of our members for representation on the RRC-S subcommittee which will write the program requirements. The Executive Council has appointed Dr. Russell Berman, chair of the Training Committee, to represent the SSO.

The certificate proposal was also sent to the American Board of Medical Specialties (ABMS). The ABMS forwarded our application to the Committee on Certification Sub-certification and Recertification (COCERT), which formally discussed the application at its meeting at the end of February. COCERT was supportive of the subspecialty certificate in surgical oncology and brought up a number of questions which will need to be answered by SOAC and the ABS prior to COCERT's next meeting in September. The ABS is currently waiting for the detailed COCERT report to study, understand, and address the questions raised.

In the future, candidates who have completed an ACGME-approved surgical oncology training program will be able to be evaluated for the subspecialty certificate in advanced surgical oncology by means of a written cognitive examination followed by an oral examination aimed at assessing judgment and decision-making. The Surgical Oncology Advisory Board (SOAC) of the ABS will have the responsibility for developing these examinations. This development will occur via a multitiered process where multiple-choice items and standardized clinical problems that a surgical oncologist should be able to manage are contributed by a panel of consultants and then evaluated by the SOAC for inclusion or exclusion in the qualifying examination (written) and certifying examination (oral).

Successful passage of both the qualifying examination and certifying examination will be required to achieve subspecialty certification in advanced surgical oncology. All certificates will be time limited, and all diplomates holding such certificates will need to comply with an ABMS-approved maintenance of certification (MOC) program to maintain such certification. This program will be structured to meet the same standards and requirements as those for diplomates in surgery.

CONCLUSIONS

It is fair to say that the goal is in sight, yet it is prudent to remind ourselves that we have not crossed the finish line yet. As I hope I have been able to convey to you, this has been an effort by many over a quarter of a century. Our thanks go to all those that I have mentioned and to the many who have done work behind the scenes.

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