Together We are Stronger!

by Richard B. Reiling, MD, FACS

As a general surgeon with oncologic surgical training, I have often been asked by my patients—either before or after care—whether I thought they should be seen by an "oncologist." What they were asking, of course, was whether they should see a medical oncologist. And in many regards, my own surgical colleagues permitted this type of characterization to persist, i.e., that surgeons are not oncologists in the true sense.

Yes, it has been a struggle to bring all surgeons involved with cancer care to the multidisciplinary arena. Part of the explanation may be historical. For example, when I left medical school, there was only one treatment recommended for breast cancer. In those days, there were very few chemotherapeutic agents available for any cancers, and these were often given by the more knowledgeable surgeons of the time. When I first went into practice, my partners and I gave our own chemotherapy for breast and colon cancer. It was in that era that hematologists began to assume the role of medical oncologists since many of the drugs being used are toxic to the bone marrow. We surgeons should have picked up the banner of multidisciplinary care and played an integral role in establishing this approach through our cancer conferences. Instead, we delegated that task to the medical and radiation oncologists, and often relegated our own position to passive and less than enthusiastic participants.

Times have changed. We are in the era of "individualized" or "personalized care." No longer can we talk about breast cancer in a generic sense without recognizing that the disease is personal and rarely similar in any two patients. This fact needs to be recognized by surgeons in all specialties and, hopefully, is being taught in surgical residencies. Surgeons are often the first specialists to see most cancers. As a result, surgeons need to be cognizant of the full spectrum of care needed, and be ready to participate in a multidisciplinary approach.

I have often noticed that other physicians and cancer care professionals are amazed to find that a surgeon has been appointed medical director of our cancer center. I suppose this response is not unreasonable in view of the pattern of surgical involvement in cancer care in the latter half of the last century. But it is clear that surgery is a very important part of cancer care and the backbone of most cancer programs. And so, why shouldn't a surgeon serve as a medical director? Frankly, I reverse the question and ask: Why aren't surgeons *always* involved? Even knowing that it might offend some of my colleagues, I have no hesitation in indicating that any oncologic specialist who does not actively participate in a comprehensive multidisciplinary program—and this includes smaller, rural hospitals and clinics—should not be involved in the care of a cancer patient.

As only the second surgeon to serve as ACCC President, I hope to encourage and inspire my surgical colleagues to pick up the reigns of their cancer programs. I also hope and trust that those cancer programs that are struggling to develop multidisciplinary programs will get support from their surgeons. As we move forward in providing "personalized" multidisciplinary care to cancer patients, we hope for much more involvement of surgeons both locally and in our national organization. To borrow a slogan from the AMA—Together We are Stronger!

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