

0959-8049(95)00491-2

Towards a High Standard of Surgical Oncology Throughout Europe

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To retain their role in co-ordinating the multidisciplinary management of cancer, surgeons must adapt to new developments in oncology. In addition to technical skill in operative surgery, all surgeons treating cancer patients must add new information in tumour biology, chemotherapy and radiotherapy to their range of knowledge. Such a broad approach is needed nowadays in order to give a valid clinical opinion and is indispensable in the planning of operative strategies. Although considerable differences in cancer treatment exist within Europe, centres of excellence can be defined. The European Society of Surgical Oncology is planning, with the co-operation of national surgical oncology groups, to devise Guidelines for Good Practice in Surgical Oncology which will be acceptable throughout Europe. Identification of centres for training, registration and accreditation of trainees and a system of continuing education for established surgical oncologists will be proposed. The aims of these proposals are (i) to promote excellence in treatment, (ii) to facilitate an exchange of information, (iii) to encourage participation in clinical trials, (iv) to improve education of medical and para-medical personnel about oncology and (v) to point the way to research opportunities. In medical practice abundant evidence exists that (a) a high standard of clinical care promotes educational activity, (b) good education stimulates research and (c) research in turn activates improvements in service and care. Because of its complexity and the need to involve many disciplines in its management, the treatment of patients with cancer requires a high standard of professional training and competence. Moreover, because of rapid developments in cancer research and treatment, mechanisms for continuing medical education for oncologists are essential.

Eur J Cancer, Vol. 31A, Suppl. 6, pp. S22-S24, 1995

THE ROLE OF THE SURGICAL ONCOLOGIST

UP TO the early years of this century the patient and the surgeon were often the only participants in the active management of cancer, but now a sometimes bewildering variety of specialists and special interests play a part. In order to avoid confusion and difficulties with communication, it is necessary for one individual to guide the programme of care and to retain contact with the patient in the complex path of management. Because of the depth and scope of training and practice, the surgeon should be ideally placed to take responsibility for this central role. The surgeon treating cancer today must be prepared to assume this position. The cancer surgeon must be much more than a technical expert. He or she must, in addition:

- (i) be trained in the evolving understanding of tumour biology, mechanisms of spread of disease and other oncological principles;
- (ii) understand the principles, scope and limitations of different modalities of radiation therapy;
- (iii) be conversant with the theoretical and practical applications of cytotoxic chemotherapy;
- (iv) be prepared to study and evaluate evidence from clinical trials and thereby be in a position to propose new avenues

of research and study both in the clinical setting and in the laboratory;

- (v) be trained to be discriminating in the application of modern technology in the investigation and treatment of malignant disease; and
- (vi) be involved, as a member of a team, in each step of the decision-making process in planning the strategy of the patient's care [1, 2].

Where the surgeon treating cancer patients does not keep up to date with advances in oncology and adopts a purely technical role, suboptimal management is probable and outcome is likely to fall below acceptable norms. Evidence exists that cancer patients, treated by surgeons who, although technically skilful, have not been trained in surgical oncology, may suffer a higher rate of recurrence and have shorter survival than patients treated by trained surgical oncologists. In the treatment of malignant disease in the elderly this point is emphasised. Many older people with cancer are inadequately treated because of mistaken beliefs that high peri-operative mortality or serious morbidity with prolonged hospital stay are inevitable. Suboptimal surgery is often carried out in elderly patients who are sometimes thereby placed at an unnecessarily high risk of recurrence. Audits of surgical activity, including assessment and decisions about surgical procedures, operative techniques, postoperative care and rehabilitation programmes are needed throughout Europe.

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ACTIVITIES OF THE EUROPEAN SOCIETY OF SURGICAL ONCOLOGY

Because of varied medical systems within Europe, the delivery of surgical services to patients with cancer varies considerably (i) within hospitals, (ii) within regions and (iii) within countries. To define and identify high quality care and to make it accessible to all citizens is a challenge for all oncologists, training bodies and governments.

High quality care requires (i) good diagnostic and therapeutic facilities, (ii) good physical facilities, (iii) highly trained medical and paramedical personnel, (iv) a systematic organisation and (v) an in-built system of audit and verification. In treatment of patients, time and care are required to plan the surgical operation and to discuss it fully with the patient. The involvement of specialists in chemotherapy and radiotherapy, where appropriate, should be sought before the primary operation. Active programmes for rehabilitation and follow-up are needed to ensure a continuum of care.

The European Society of Surgical Oncology has established Task Forces or Working Parties, with the widest possible representation, to draw up guidelines for the management of patients with solid tumours. These Task Forces will deal with issues such as training of surgeons in the principles and techniques of surgical oncology and in the role and scope of surgery, radiotherapy and chemotherapy. They will address the problem of auditing personal and hospital practice with particular reference to operative technique, postoperative morbidity, recurrence rates and survival. They will make recommendations concerning the need for intramural and external meetings, the role of research and teaching in the practice of surgical oncology. They are likely to urge involvement in collaborative European studies where these are feasible.

The European School of Oncology, with the support of the Commission of the European Communities has launched a project aimed at building a European Database on current treatments in oncology. This project is called State-of-the-Art/Oncology in Europe (START) and aims at summarising standard treatments for human cancers. The protocols to be devised by the European Society of Surgical Oncology Task Forces could be integrated with the START project. It is expected the Good Practice Guidelines will be sufficiently detailed and authoritative to be valuable to all surgical oncologists and yet sufficiently flexible and lacking in rigidity to encourage participation in clinical trials under the auspices of the European Organization for Research and Treatment of Cancer (EORTC) or other respected national or international clinical research groups.

With the assistance and involvement of National Societies of

Surgical Oncology and National Training Organisations, many of which have already been involved in this process, the European Society of Surgical Oncology plans (i) to draw up Good Practice Guidelines and agreed protocols for different tumours, (ii) to identify centres of excellence for training in surgical oncology and (iii) to establish a register of surgical oncology trainees. These protocols will be submitted to the Federation of European Cancer Societies, to the Medical Faculties of Universities, the Union of European Medical Specialists (UEMS), the Union Internationale Contre le Cancer, Europe Against Cancer, the EORTC, EuroSurgery, the European Board of Surgery, the Royal Colleges of Surgeons and all European groups concerned with surgical oncological training and practice. They will be forwarded to the European Commission and to the Council of Europe for consideration.

It is also hoped to put mechanisms in place (a) for the assessment of trainers and trainees, (b) the accreditation of surgical oncologists and or (c) continuing medical education of all practitioners in this area of medicine. Because of insistence from within and outside the medical profession that medical practices be analysed, both in the interests of the patient and in the interest of the economy, support for these aims should be forthcoming. Each country in Europe has hospitals where patients with cancer are treated excellently. It is, however, almost certain that cancer treatment is not uniformly excellent in any country and that gaps in training and deficiencies in facilities and in expertise result in inappropriate and poor care. Recognising the sometimes "patchy" quality of treatment, some national professional groups have devised and agreed guidelines for the management of tumours and it should be a relatively simple matter of European professional collaboration to agree general protocols which would be acceptable and achievable.

Once guidelines have been established, each country should be in a position, through its oncology societies, universities and government health departments, to identify centres of excellence where the quality of cancer care is consistently high. Such centres should be recognised nationally and funded accordingly. The European Society of Surgical Oncology is in a position to promulgate information about these centres and to encourage international exchange of medical and nursing personnel among these centres. The Society has set up Fellowships of training for young surgeons and is seeking support from industry, national governments and the European Commission to expand this type of education. Establishment of a European training programme in surgical oncology could be agreed, a register of trainees maintained and a system of accreditation put in place. An arrangement for the continuing education of the trainers would also be required so that surgical oncologists could maintain standards and keep pace with developments. Such systems would obviously be in the interests of patients and would soon lead to an exchange of information and expertise. This development would, in turn, add to knowledge, promote educational opportunities and indicate new pathways of research.

TRAINING OF SURGICAL ONCOLOGISTS IN EUROPE

Deficiencies in the training of cancer specialists exist in every country. Some universities do not have any programme in oncology as part of the undergraduate medical curriculum. Some countries do not have dedicated training in surgical oncology for postgraduate surgical trainees. Even in countries which have established training systems in surgical oncology, anomalies exist. Medical oncologists and radiation oncologists have training programmes which rarely involve exposure to operative surgery

Table 1. Requirements for the surgeon treating patients with cancer

1. Technical competence
2. Knowledge
3. Understanding of different types of cancer therapy and care
4. Training in discriminating use of technology in cancer care
5. Judgement and skill to apply surgical options appropriately
6. Ability to work as key member of a multidisciplinary team
7. Involvement in follow-up and detection of recurrence
8. Commitment to systems of cancer prevention and early diagnosis
9. Participation in audit and in clinical trials where feasible
10. Ability to analyse cancer literature and to propose research projects
11. Training to provide a balanced opinion for patients with cancer
12. Concern and empathy for the individual patient

as part of cancer treatment and are thus excluded from an understanding of the role, goals and potential of operative surgery in cancer. It is hardly surprising, therefore, that medical oncologists and radiation oncologists both underestimate the value and overestimate the morbidity of cancer surgery. The situation in surgical oncology training is even more unsatisfactory. Surgical trainees have little opportunity to develop experience and knowledge of the principles and techniques of medical and radiation oncology, thus greatly diminishing the value of the surgeon's opinion in the management of complex problems. Worse still is the fact that such surgical oncological training that the surgeon receives often comes from trainers and educators whose own experience in surgical oncology is variable and often deficient. It must be recognised and accepted that, in the interests of patients, these systems must change.

Definition and recognition of centres of excellence should lead to exchange programmes of senior personnel and of trainees under the auspices of government Departments of Health ulti-

mately leading to an internationally acceptable European training programme in surgical oncology.

Such international co-operation would inevitably enhance the quality of care, improve medical and paramedical education about cancer and stimulate clinical and fundamental research [3, 4].

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