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EDITORIAL – BREAST ONCOLOGY

Presidential Address: The Road Ahead—Challenges and Opportunities

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I was blessed to have parents who nurtured, supported, and guided me toward my dream of becoming a physician. They instilled values of diligence, hard work, compassion, and humanism in their children. I had unconditional love (I was spoiled). I had two older sisters (Ellen and Fern), so as the youngest and the only son, I enjoyed a very favorable birth order. My sisters doted on me, and my parents kept me on track academically because my natural inclination was more toward sports and socializing.

My wife Gayle, the love of my life, and our children, Max and Ethan, are a blessing. They have provided the family fabric, love, dedication, and understanding that allows me to aggressively pursue my profession. They are my rock and sustenance.

I attended medical school and did my surgical residency at New York University School of Medicine from 1971 to 1980. Dr. Frank Cole Spencer (the Boss), a well-known cardiac surgeon, was the chief of surgery (Fig. 1). He was a demanding but fantastic mentor, an extraordinary surgeon, and a great educator. His M+M (mortality and morbidity) conferences were legendary for their drama, intensity, and impact. His mantra, deeply imbedded in his trainees, is that once you operate on a patient, you are responsible for that patient forever!

For me, Dr. Spencer's greatest asset was his skill as a master communicator. Observing his interaction with individual patients during a busy clinic was amazing. He understood his personal power, which he used to the benefit of his patients (a healer). During a brief visit, patients felt that he was always 100% present with unlimited time. I was thrilled that I was selected to be groomed by him to become a cardiac surgeon.

However, my path changed during residency when my sister Fern was diagnosed with Stage 4 breast cancer when she was 35 years old. She had three children and died 2 years later. She was living in Florida, and I was able to spend time with her by arranging elective surgical rotations. She pursued every conceivable traditional and alternative treatment method with vigor and determination. I learned a great deal from her about the patient perspective and witnessed first-hand professional insensitivity and the absence of a "healing" approach in many physician–patient interactions. I also became aware that some alternative methods (visualization, meditation, nutrition, massage, prayer) had real value even if they were "unproven" and would not "cure" patients. It opened my eyes to the importance of the quality, not just the quantity, of survivorship.

Subsequently, I completed a vascular surgery fellowship and established a general and vascular surgery practice in Kingston, New York in 1981. A decade later, a large percentage of my practice involved breast cancer patients.

In 1993, at the Society of Surgical Oncology (SSO) meeting in Boston, Dr. David Krag (Fig. 1) from the University of Vermont presented the first experience with sentinel node biopsy using a radioisotope. It was definitely an aha moment! David became a key research mentor and invited me to participate in the National Surgical Adjuvant Breast and Bowel Project (NSABP) B32 trial.[1] It was pretty remarkable to have my first academic publication as a coauthor in the *New England Journal of Medicine!*

In 1994, in honor of my sister Fern, my family established The Fern Feldman Anolick Breast Center (FFABC) at Benedictine Hospital in Kingston, New York (Fig. 2). I became the medical director without any real knowledge or experience! Breast centers were just coming of age in the United States.

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FIG. 1 Mentors

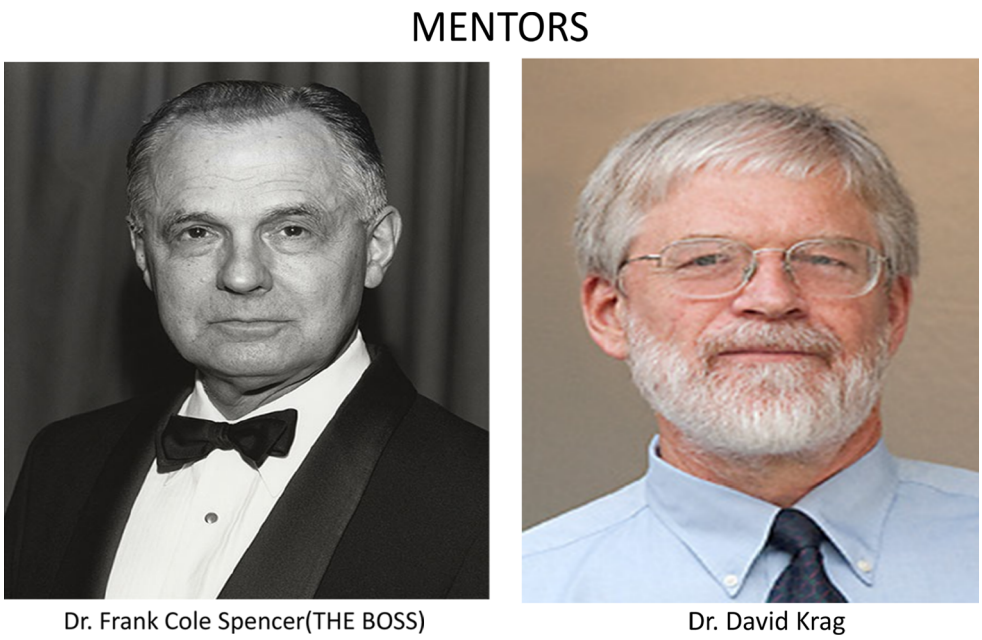

FIG. 2 Fern Feldman Anolick (1942–1979)

In my search for guidance, I met Dr. Melvin Silverstein. He promoted and developed the concept of a comprehensive multidisciplinary patient-centered approach, and his center in Van Nuys, California was a fantastic model.[2] I also had wonderful guidance from Dr. Michael Osborne, a world-class surgeon who directed the Strang Clinic in New York City.[3] A visit to his center was pivotal in the development of the FFABC, which continues to provide comprehensive care to woman in the Hudson Valley region of New York.

Dr. Bernie Seigel was an important influence on my approach to patient care. A Yale-trained surgeon, he coined the term "exceptional patients." These were patients actively involved in their care, embracing all potential healing methods. Dr. Seigel was an early proponent of support groups and stressed the importance of studying patients with stage 4 cancer who despite the slim odds survived! He authored many books including the best seller, *Love, Medicine, and Miracles,* in 1986.[4]

In 2000, my family and I decided to return to New York City. Dr. Alison Estabrook hired me to run the breast surgery program at Beth Israel Medical Center. Returning to academics after almost 20 years in community practice was quite daunting. Dr. Alison not only gave me this amazing opportunity but provided the mentorship I needed to succeed. As past president of the American Society of Breast Disease, she helped me understand the value of engagement with specialty societies.

VISIONARIES

I acknowledge four visionary breast surgeons who had an impact on me personally and our field as a whole. Sir Geoffrey Keynes from St. Bartholomew Hospital in the United Kingdom (Fig. 3) performed breast-conserving surgery with lumpectomy and interstitial radiation in 1932. His series of more than 1000 patients was published with excellent results, leading to the adoption of lumpectomy by Dr. George Crile at the Cleveland Clinic in 1965. Dr. Crile endured harsh criticism from his colleagues, as often is the case for pioneers who shift the paradigm. Sir Geoffrey really understood psycho-oncology. He stated: "It is impossible to escape the conclusion that radical surgery does occasionally do more harm than good;… there is the psychological aspect;… women know what is meant by surgical treatment of cancer of the breast, and I am sure they are often intimidated by the prospect. Surgeons bewail the fact that patients will not come for treatment soon enough. They are afraid of it, and frankly, I am not surprised that they should be. It is this feeling that deters them from seeking advise."[5] Sir Geoffrey also firmly stated 85 years ago: NEVER DISSECT THE AXILLA. He saw the future.

Professor Umberto Veronisi (Fig. 4) passed on last year. He and his team from Milan, Italy were always ahead of the curve. He pioneered the early adoption of breast conservation, sentinel node biopy, oncoplastic surgery, and intraoperative radiation. His colleagues are leading the SOUND trial,[6] which likely will eliminate sentinel node biopsy for many patients. He gave the keynote address to our Society in Chicago in 2013 and spoke about a paradigm shift: minimum effective treatment, NOT maximum tolerated treatment. He has advocated a patient-centered personalized approach to patient care for decades.

I met Dr. Susan Love (Fig. 3) in 1974 when I was doing a surgical subinternship at Beth Israel in Boston. She was an intern there, and it was immediately apparent that she was a rising star. Passionate, energetic, and blazing her own trail, she was an incredible role model who cemented my career choice in surgery. Dr. Love has hosted nine biannual meetings on the intraductal approach to breast cancer, and her research foundation has expanded our basic understanding of breast physiology and anatomy.[7] The Love Army of Woman has hundreds of thousands of woman who volunteer for clinical trial including tissue samples. Her breast book is a bible for patients, and through her own cancer diagnosis, she has expanded the conversation about reducing treatment-related collateral damage for our patients.

Dr. Eisuke Fukuma (Fig. 4) presented his work on endoscopic mastectomy at our annual meeting in Atlanta in

FIG. 3 Visionaries

FIG. 4 Visionaries

2003. I was intrigued by his approach and visited his center at Kameda Medical Center in Kamagowa, Japan a few months later. We have become great friends and colleagues over the years. He pioneered and understood the importance of nipple-sparing mastectomy for Japanese woman so they could have a normal appearance and participate in family events including communal bathing at the Onsen. He has trained many breast surgeons around the world in his methods to the benefit of thousands of patients.[8] He is on the faculty of our oncoplastic course at this meeting. Additionally, he has the largest experience in the world using cryotherapy for ablation of small tumors. Dr. Fukuma is a true visionary and patient advocate.

THE STATE OF OUR SOCIETY

Our Society is on an amazing trajectory, with membership approaching 3200 and a new record attendance for this annual meeting at 1750 attendees. We have surgeons attending from 51 countries. We have received more than 350 scientific abstracts. This success comes from the extraordinary leadership of my predecessors. My trajectory toward the leadership in our Society is due to Dr. Shawna Willey, our 12th president, who selected me as program chair in 2009. She taught me the American Society of Breast Surgeons (ASBrS) "ropes" and is a trusted advisor and valued friend. I have been fortunate to collaborate with our 16th president, Dr. Suzanne Klimberg, on research projects involving ablation and lymphedema prevention. She is an inspirational researcher who puts patients first. She has helped to guide my path in many ways.

Our Society is doing well financially, with capital reserves exceeding 5 million dollars. However, our success is due to our extraordinary human capital, which provides a rich culture of engagement and support. Our board of directors includes Steven Chen, Walton Taylor, Julie Morganthaler; Ricky Fine, Susan Boolbol, Mahmoud El-Tamer, Jill Deitz, Carrie Thoms, Nathalie Johnson, and Peter Blumencranz. This group well represents academic and private practice breast surgeons and mirrors our membership. We have more than 400 physician volunteers, 28 committees and working groups, and 14 representatives to other organizations (Fig. 5). The level of commitment and passion that all these individuals bring to our Society is truly remarkable. All are busy surgeons with active practices who freely give countless hours toward the benefit of our Society and our patients.

We are excited that our new website will be launched later this year. Our executive director, Jane Schuster, helps to keep our rapidly growing and evolving organization on top. Jane has worked for the Society since 1998 and as our historian, she was able to provide some Society highlights, which are listed in Table 1.

I highlight our Society's work in addressing an important quality measure: surgical margins for breast conservation. Dr. Jeffrey Landerscaper championed the Collaborative Attempt to Lower Lumpectomy Reoperation Rates (CALLER) project.[9] According to its mission statement, CALLER aims to "reduce the national reoperation rate in patients undergoing breast-conserving surgery for cancer without increasing mastectomy rates or adversely affecting cosmetic outcome, thereby improving value of care." Using

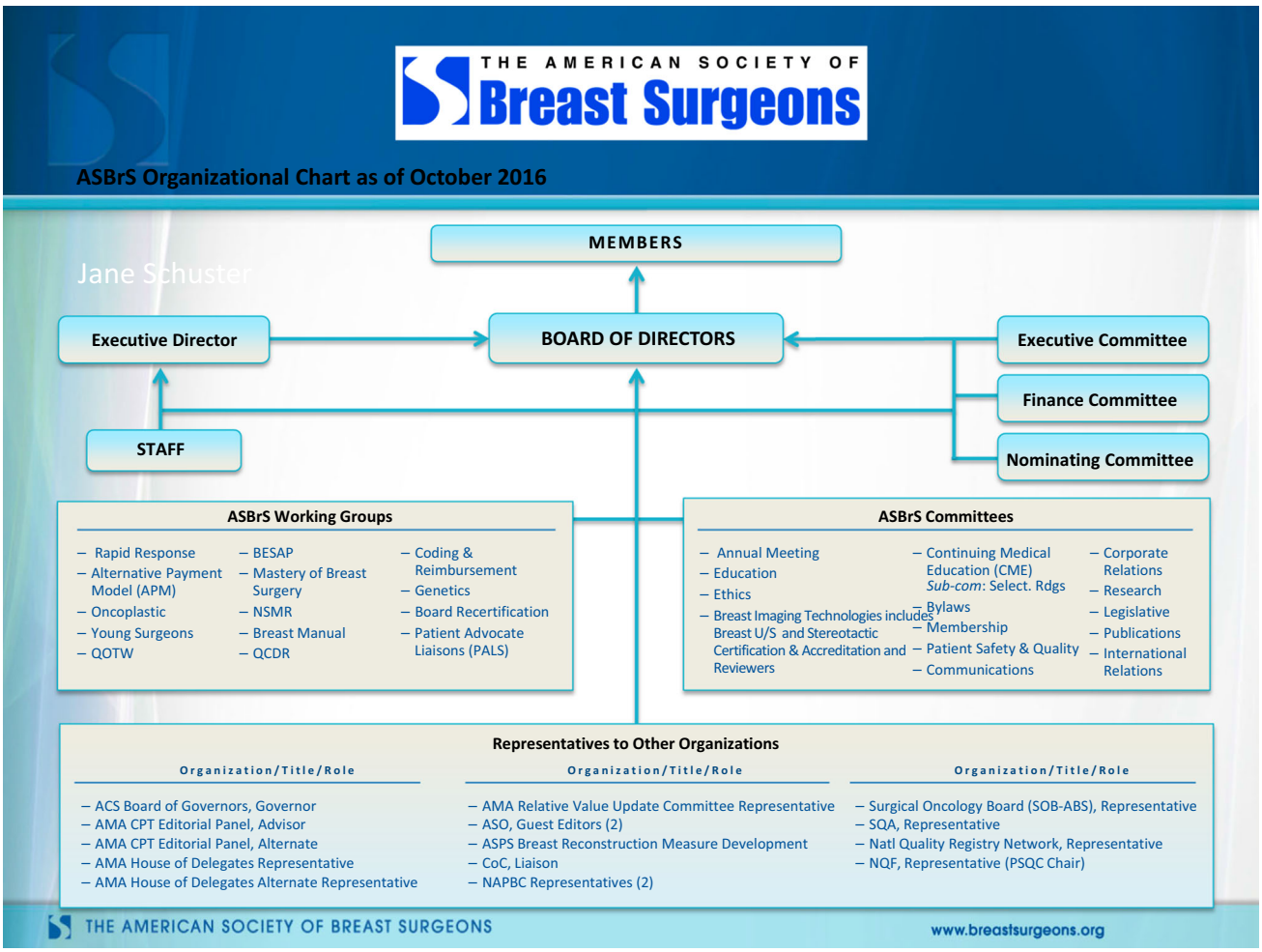

FIG. 5 ASBrS organizational chart as of October 2016

data from the Mastery, a large variation in reexcision rates was noted. The CALLER workshop defines a toolbox to include those methods that surgeons could use to reduce reexcision rates. We currently are tracking a volunteer breast surgery cohort using these tools and will report prospectively on the outcome. This is an outstanding example of an important quality improvement project.

CHALLENGES

With the changing health care environment, we commenced a strategic planning initiative in January 2016. A part of this process was to redefine our mission and vision statements:

Mission Statement

The American Society of Breast Surgeons is committed to improving the practice of breast surgery continually by serving as an advocate for those who seek excellence in the care of breast patients.

Vision Statement: LEAD—Leadership, Education, Advocacy, Dedication

We surveyed our membership to determine how to prioritize our resources toward developing a multiyear strategic plan. The 555 respondents reported the areas of greatest concern: decreasing payments, bundled payments, EMR and practice expenses, malpractice, burnout, information overload–keeping up, pay for performance, breast certification, lack of a specialty board, defining quality, difficult patients, time management, and less surgery. After multiple meetings and considerations, we have defined the following nine strategic initiatives:

1. Increase in online education programs
2. Creation of an education process regarding evolving reimbursement models

TABLE 1 American Society of Breast Surgeons timeline highlights

1995 Society is formed (with approximately 200 members)	2012 Breast manual launched
1999 Society issues its first official consensus statement on sentinel lymph node biopsy	2012 Selected readings launched
2000 First Annual Meeting in Charleston SC, Society moves to independent management	2013 Representation on ABS/SSO Advisory Council
2001 Seat on the American College of Surgeons Board of Governors	2014 Qualified Clinical Data Registry (QCDR) through the mastery program
2001 Breast ultrasound certification	2014 ACCME accreditation with commendation
2002 Breast fellowships (SSO and ASBD)	2014 BESAP 1 launched
2003 Mammosite registry	2015 First Arnold P. Gold Humanism Award
2004 Regional courses in breast ultrasound	2015 Nurse Bedi launched
2005 Komen Foundation grant awarded to support regional education program	2015 Seat on the AMA house of delegates
2005 Foundation formed	2015 www.breast360.org launched
2006 Membership grows to 2000 members	2015 Foundation recruits first executive director
2006 Joined the Commission on Cancer	2016 Focus on Strategic Planning for the future
2007 Stereotactic Breast certification	2016 Formation of the Young Surgeons working group, Genetics working group, International working group, and revitalization of the Oncoplastic working group
2008 Mastery of Breast Surgery program	2016 Collaborative ACS-ASBrS International Scholar program created
2009 Annals of Surgical Oncology as the Society's official journal	2016 CALLER Registry (collaborative attempt to lower lumpectomy re-operation rates) launched
2009 Representation on the Specialty and Service Society Caucus of the AMA House of Delegates	2016 Contralateral Prophylactic Mastectomy consensus panel
2009 Annual Health Policy Scholarship introduced in collaboration with ACS	2017 Co-sponsoring of first International Meeting—Dubai 2018
2011 Nipple Sparing Mastectomy Registry open	2017 Expert panel on lymphedema
2012 Accreditation by Council for Continuing Medical Education (CME)	

3. Development of a breast-specific patient-reported outcomes program
4. Rapid response for implementation of evidence-based clinical trial data
5. Development of key future quality and performance measures Qualified Clinical Data Registry (QCDR via Mastery), impact of Medicare Access and CHIP Reauthorization (MACRA) and Merit-Based Incentive Payment System
6. Participation in meetings at the national level regarding coding and reimbursement
7. Breast Surgery 2025: address future breast disease management
8. Practice Management Working Group
9. Support for ASBrS Foundation and Breast 360.

OPPORTUNITIES

We are pursuing aggressive timelines on all the aforementioned initiatives. I highlight the importance of supporting our Foundation and the Breast 360 website. Our past president, Deanna Attai, has advanced the partnership between our patient advocate liasons (PALS) and our society. Our foundation has been energized with a new structure and board of directors led by Beth Boyd and Ricky Fine. The patient experience and patient-reported outcomes are currently becoming well established as key quality measures, which increasingly will be linked to reimbursement. Breast 360 is a patient website to which more than 70 of our members have contributed content.

The physician champion, Carrie Thoms, has led the charge to create an amazing patient and Society resource. Launched in November 2015, it has 34,000 active users in 165 countries and has received the 2016 W3 Silver Award for Best Health Website. We anticipate additional philanthropic support for the Foundation, which will allow our Society to continue expanding patient-centered care for all patients and helping to address issues of disparities.

I am particularly proud of our relationship with the Arnold P. Gold Foundation. Its mission is to sustain the commitment of health care professionals to provide compassionate, collaborative, and scientifically excellent patient

care. Since 2015, we have presented the Gold Humanism award to three of our members: Drs. Brian Czernicki, Rogsbert Phillips-Reed, and Lisa Tolnitch. They exemplify extraordinary humanistic qualities and the power of an optimal patient-physician philosophy and relationship.

Surgical procedures for breast cancer will be less frequent in the future. Axillary dissection and sentinel node biopsy will be replaced by systemic therapy, radiation, and genomics. Much of ductal carcinoma in situ (DCIS) will be managed by active surveillance and topical or intraductal therapies. Primary tumor ablation with resulting autovaccination of antigens coupled with effective immunotherapy will be mainstream. Surgery after neoadjuvant chemotherapy when evidence shows a complete pathologic response will no longer be indicated.

All this is good news for our patients, but lots of work remains to be done. This puts the onus on us to make sure our surgical product is perfect. Surgical procedures must be carefully planned. Patients must be well prepared physically and emotionally. A healing environment must exist in the operating room including preemptive analgesia and an oncoplastic approach that includes minimal scars, with maintenance of a normal appearance. Just as ultrasound training has been fundamental to our members, oncoplastic expertise is a fundamental skill.

We are committed to ensuring that all our members have the opportunity for oncoplastic training. The patient experience is paramount, and we must be fully engaged and obtain the necessary skills including new diagnostics, communication, ablation and novel local therapies, intraoperative radiation, counseling, high-risk prevention, and genetics. We must increasingly understand that we can have a tremendous impact on our patients well beyond the use of a scalpel. Our words, attitude, and intention are powerful. We are important role models. We all can be healers and must embrace our personal power toward the benefit of our patients. The future will be bright, but we must be prepared and adapt to the changes ahead.

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