Endoscopic Skills: An Imperative for Surgeons

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The practice of endoscopy is an integral part of the diagnostic and treatment sequence for many diseases which confront the general surgeon. The advent of fiberoptic technology and the development of flexible endo-scopes have simplified some aspects of the diagnostic sequence, but at the same time have led to some practical difficulties within the community of practitioners. When the practice of endoscopy was limited to the oropharynx, the bronchial tree, the genitourinary tract and the anorec-tum, the surgical specialist was usually considered the 'endoscopist'. However, the availability of endoscopic devices which can be employed more conveniently and effectively than the prototypes has increased the use of endoscopic diagnosis by many groups of physicians. This generally propitious situation, unfortunately, has at the same time increased the competition between physician and surgeon endoscopists. While competition has some positive aspects, there are negative aspects which must be considered. If the participants in the competition lose sight of the traditional goals which inspire medical practice, the patients as well as the physicians suffer.

Controversial issues have marked the advent of endoscopic procedures in the same way they accompanied the introduction of other diagnostic and therapeutic techniques. These issues are between the physician and surgeon endoscopists, as well as between the community at large and the medical community. For example, some physicians mistakenly believe that surgeons should never perform endoscopic procedures, since the diagnosis of disease is the traditional role of the physician. Also, physicians may suspect that surgeons do not use rigorous criteria in selecting candidates for endoscopic intervention, despite the fact that there are legitimate differences of opinion in this area. At times, physician and surgeon endoscopists can be legitimately criticized for too frequent examinations or for allowing excessive fee schedules to persist. Lastly, if any group attempts to exclude another from the performance of an essential service for largely economic reasons, it deserves censure. Thus, it is clear that there are several practical issues which physicians and surgeons must address, each group respecting the other's prerogatives and traditions, and all mindful of the community of sick patients whom they attempt to serve at all times. There are several situations which literally and figuratively demand the insight of a surgeon; furthermore, it is important for the medical and surgical community to have clear perspectives about the rationales which motivate surgeon-endoscopists and about the traditional strengths of surgeons who perform endoscopic procedures.

In this reiteration of the fundamental beliefs of surgeons and surgical educators, we emphasize the view that the practice of endoscopic examinations is incorporated in and indistinguishable from good surgical practice. Taken as a whole, these beliefs motivate our daily activities, explain why embryonic surgeons must continue to be involved with all aspects of endoscopic devices, and are aptly described as an 'imperative'.

Intraoperative endoscopic examinations, often an important part of a complex therapeutic procedure, are one of the unique responsibilities of the modern surgeon. The procedure most commonly performed by the abdominal surgeon is choledochoscopy during operations in patients with gallstones or other conditions of the bile ducts. Another common indication in our medical center is to test for completeness of vagotomy when operations for chronic duodenal ulcer are performed; as in the first example, it is unreasonable to assume that other than a surgeon-endoscopist would have developed the necessary

2

Donahue/Yoshida/Nyhus

expertise or judgement to perform these procedures well. Other examples of intraoperative endoscopy include localization of colonic pathology and assistance in the performance or evaluation of stapled gastrointestinal anastomoses. The intraoperative procedures are not the only ones which are within the purview of the surgeon-endoscopist. Those individuals who have persistent digestive tract complaints following surgical procedures are also included in this group. Since the experienced surgeon is usually the individual who can best place the postoperative patient's complaints in perspective, any failure to include a surgeon's view in the evaluation of such patients is a serious omission. Lastly, the evolution of a number of endoscopic techniques for the management of traditional surgical problems demands the participation of surgeons if the lessons of the past are not to be forgotten. The use of the term imperative in this context is appropriate, since many of the conditions being treated are 'surgical' problems, which still require traditional surgical intervention if the endoscopic approach is unsuccessful. This latter situation is one in which a surgeon endoscopist is quite comfortable, and in which the physician endoscopist may be handicapped.

The topic of therapeutic endoscopy is particularly relevant in the present context, since surgeons have had a seminal role in the development of several specific techniques. Of course, gastroenterologic physicians have made invaluable contributions to the body of therapeutic endoscopic procedures, and there is no way to distinguish the efforts of these distinguished individuals from those of their colleagues. Paradoxically, we recognize that the clarity and specificity of endoscopic techniques have led to blurring of the usual role boundaries between physicians and surgeons; furthermore, this trend is likely to continue for the foreseeable future. At the same time, we believe that modern surgeons have a unique orientation to certain problems which must be recognized and encouraged. Surgeons with expertise in the treatment of digestive tract diseases are trained to be and aspire to be more than technicians who can operate upon 'surgical' conditions once they have been identified. Modern surgeons spend most of their training period (usually 6 years) learning about the indications, expectations, and complications related to surgical procedures. Of course, they learn the technical ramifications of the various surgical procedures, and how to individualize patient selection preoperatively. The well trained surgeon is the individual most able to evaluate a person's candidacy for elective surgical intervention, and most capable to respond to the concerns of a patient. In short, a vital participant in the

process of deciding upon a surgical procedure. Furthermore, surgeons, committed to the comprehensive care of patients' illness, often bearing the responsibility for life-threatening interventions, have an obligation to be completely familiar with the evidence suggesting the need for surgical intervention. It is sometimes not sufficient to read another individual's report, no matter how respected or experienced that individual might be; we must insist that surgeons be able to complete the entire diagnostic process independently when necessary. By maintaining the capability to make independent decisions, we will not lose sight of dynamic elements of the diagnostic process, and not be handicapped by outmoded approaches in an era of rapidly changing diagnostic technology. All of these considerations are part of the imperative alluded to, but it is not only in the preoperative situation that a surgeon-endoscopist possesses special perspectives.

The postoperative patient who suffers various complaints is often a special challenge to correct diagnosis. These individuals may suffer from a primary failure of the original treatment, a secondary complication of the first operative procedure, or from an unrelated condition. It is especially unfortunate if these patients do not have access to a mature and experienced surgeon who can often place the symptoms in the proper perspective with confidence and precision. Admittedly, some surgeons actively avoid exposure to the long-term surveillance of their patients, and by default allow less qualified individuals to manage postoperative problems. At other times, the referral 'merry-go-round' mandates that a patient who has had an operative procedure must be returned to a primary physician promptly. We try to imbue our trainees with the attitude that the proper care of the individual patient includes a commitment to the long-term analysis of the results of therapy; our relative success or failure in this regard no doubt reflects the spectrum of commitment of our faculty to this important dimension of patient care. The proper care of the postoperative patient is, then, an important part of the imperative.

One aspect of the postoperative clinic which deserves emphasis in this context is the fact that the long-term effects of an operation affect our subsequent use of that procedure. Also, the evolution of alternative procedures is directly related to perceived deficiencies in 'state of the art' surgical procedures. If, therefore, operations are evolutionary solutions to medical problems, we must evaluate their long-term effects and be ready to introduce refinements of various types when necessary. Recognizing the dynamic, evolving aspects of operative therapy, sur-

Endoscopic Skills: An Imperative for Surgeons

3

geons who utilize endoscopic views in studying postoperative patients are in accordance with the imperative mentioned previously.

For several years, the American Board of Surgery has included familiarity with endoscopic topics as an essential component of acceptable training programs. This requirement signifies the impact that the flexible fiberoptic endoscopes have had on all aspects of gastrointestinal and bronchopulmonary diseases, and emphasizes a long-present aspect of the better surgical training programs. Furthermore, the statement reinforces the view that optimal patient care may not be capable if an endoscopic view cannot be obtained. Furthermore, the leading American endoscopic societies have unanimously supported the concept that all highly qualified and appropriately trained practitioners should be able to practice their art. Therefore, it is obvious that communities in which the difficulties of competition and turf-disputes are paramount are not in accordance with the stated goals of the leaders in their respective groups. We suggest that physician- and surgeon-endoscopists have a responsibility to develop constructive solutions to

these problems and a responsibility to avoid unproductive and largely economic disputes; we have a duty to find more efficient, cheaper, and more effective means of treating the common digestive tract diseases, and must not use our energies perpetuating the false idols of the trade-guilds. All physicians and surgeons practicing today have lived in an era in which the use of endoscopes became an essential part of the approach for almost every aerodigestive disease. For the present, it seems obvious that wider application of diagnostic and therapeutic endoscopic skills is required in the community; for the future, there is obvious promise for further evolution of the capabilities of endoscopic procedures. If there are adequate numbers of competent surgeon-endoscopists, several of the important developments of past generations will be incorporated in the discoveries of the future, and the best traditions of surgical practice will be satisfied. Most importantly, part of the debt to our patients, who have taught us so much and been so tolerant of our limited knowledge, mandates that we remain involved with the imperative and not forget the lessons of the past.