Micrographic Surgery

To the Editor:

I read with interest Dr. Robins' editorial, "Mohs Micrographic Surgery"[1] in the March, 1993 issue of the *Journal.* It supports the certification examination offered by the American Board of Mohs Micrographic Surgery (ABMMS). I commend those who designed and passed the examination for their pursuit of excellence in cutaneous oncology. Although I completed fellowship training in, and practice and teach Mohs surgery, I do not believe the Mohs technique merits specialty certification.

Dermatologic surgery and surgical cutaneous oncology are integral and essential parts of dermatology. The title and contents of the *Journal* illustrate that dermatologists perform many highly complex and sophisticated surgical procedures. In evaluating the appropriateness of specialty certification, it is important to consider that Mohs surgery is one method of frozen section-controlled excisional surgery, which is one technique in surgical cutaneous oncology. Mohs surgery is an effective, elegant and complex procedure, but, in and of itself, it does not encompass a sufficiently large and distinct body of knowledge to merit specialty board certification. Dermatologic surgery or surgical cutaneous oncology may evolve into a distinct subspecialty, but certification in a single technique is not warranted. Mohs surgery retains a specialized role primarily because opportunities to learn it have been severely limited and controlled.

The Mohs technique is ideally suited to the practice of dermatology, because the foundational knowledge of surgery and dermatopathology needed to learn it is an inherent part of dermatology training. That is why large numbers of dermatologists wish to incorporate Mohs surgery into their practices. Tromovitch, et al[2] in 1987 found that 40% of 2570 dermatologic surgeons surveyed planned to practice Mohs surgery within 5 years, by 1992. Dr. Robbins notes that Mohs surgery fellowship training incorporates the study of ". . . surgery, wound healing, dermatopathology, pharmacology, anesthesia, and plastic and reconstructive surgery." These subjects are part of the required dermatology residency training curriculum and are required knowledge for all surgically oriented dermatologists. Dr. Robins recognizes that Mohs surgery can be competently learned without fellowship training, stating that, "in addition to the physicians who have completed 1-year teaching programs, there are a number of physicians who were self taught and who have completed hundreds of cases on their own with skill and dexterity."[1] There are many more than "a number" of such dermatologists. Founded in 1990, the American Society for Mohs Surgery (ASMS) already represents over 110 such dermatologists who mastered Mohs surgery in residency or through preceptorships. The goal of the ASMS is to create an educational environment where all interested dermatologists can successfully learn Mohs surgery. This should be the goal of dermatology residency programs, the American Academy of Dermatology (AAD), the American Society for Dermatologic Surgery (ASDS), and this journal.

Many contend that a postresidency fellowship is the correct method of learning Mohs surgery and that training in other ways diminishes the quality and reputation of the technique, to the detriment of patient care. I do not agree. The tenet that Mohs surgery requires fellowship training worthy of specialty certification is arbitrary and inaccurate. Limiting its teaching to postresidency fellows restricts clinical expertise in treating advanced and aggressive skin cancers to an ever decreasing proportion of dermatologists, to the detriment of the remainder; this retards the evolution of dermatology as a surgical specialty. Certainly fellowship training in any technique increases one's abilities, but there is no reasonable justification for not teaching Mohs surgery to all interested dermatologists. This is precisely what is done in dermatopathology, which is taught freely and extensively in residency, at AAD and ASDS meetings, and elsewhere.

Dermatologists who have developed, mastered, and refined surgical techniques have consistently and unselfishly taught them to their peers. As a result, there are enormous opportunities for all dermatologists to learn a remarkable and increasing variety of advanced therapeutic and cosmetic surgical techniques at annual meetings of the AAD, the ASDS, and at many other meetings, courses, seminars, and preceptorships. Many of these surgical techniques are highly complex, require considerable knowledge, judgment, skill, and dexterity, and would result in significant patient morbidity if not competently performed. Only training in Mohs surgery has been excluded from this process.

Many practitioners of Mohs surgery are among dermatology's most experienced and capable surgery teachers, and are responsible for the surgical training of dermatology residents. Yet, according to a survey conducted in 1991 by the American Board of Dermatology, only 34 of 101 United States residency training programs provided technical instruction in Mohs surgery (American Board of Dermatology, Personal communication, May, 1993). At the 1992 Annual Meeting of the AAD, 96% of the instructors in the Basic Cutaneous Surgery Course, 35% in the Advanced Cutaneous Surgery Courses, 88% in the Intermediate Surgery Course, and 90% in the Laboratory Workshop In Flap Surgery were fellowship trained in Mohs surgery (1992 Program, 51st Annual Meeting, American Academy of Dermatology and Membership Directory, American College of Mohs Micrographic Surgery and Cutaneous Oncology). The AAD and these instructors clearly recognize that dermatologists possess the knowledge, skill, and judgment to competently learn and ethically practice the techniques they are teaching. Yet they chose to teach no sessions in Mohs surgery. It is illogical to teach comprehensively dermatologists to master skin flap and graft repairs without fellowship training, yet maintain that they are not capable of learning the most efficient, effective, and, when indicated, the most economical technique for first obtaining clear surgical margins.

Dermatology must consider a major paradigm shift in its view of Mohs surgery training. Those supporting fellowship training and specialty certification believe that there are signifi-

cant quality-of-care, judgment and utilization considerations that preclude teaching Mohs surgery in other ways. These concerns ring hollow in the present educational environment where Mohs surgeons actively teach so many other complex surgical techniques, yet Mohs surgery is not taught. Quality-of-care, judgment, and utilization concerns apply to all surgical techniques that dermatologists perform. The best guarantee of competency is quality teaching. Some argue that Mohs surgery is too difficult to learn competently without fellowship training. That dermatologists have already done so, even given the present dearth of learning opportunities, belies this argument. Some maintain that there is insufficient space in the residency curriculum to teach Mohs surgery and that dermatology residents lack the skills to learn it. They need only look to one of the few residency training programs that have successfully incorporated Mohs surgery into their curricula.

Dr. Robins states that ". . . many referring physicians have and continue to express concern regarding the competency of the Mohs surgeons to whom they refer patients. These referring physicians would like to be assured that the Mohs surgeon is competent, surgically skilled, and adept at patient care." Dermatologic surgeons are competent, surgically skilled, and adept at patient care and many simply want the same educational support in mastering Mohs surgery that is provided in all other areas, so that, rather than refer, they can competently treat their patients using the Mohs technique.

Mohs surgery is a technique, not a specialty, and there is thus no need for board certification. The current teaching of Mohs surgery as a unique specialty is incorrect, divisive, and inhibits dermatology's evolution as a surgical specialty. Teachers of Mohs surgery have contributed greatly to dermatology's surgical evolution and can contribute even more profoundly by simply teaching Mohs surgery, the most effective technique for removing certain skin cancers, to their peers in the same open, generous, and expert fashion that they teach so many other surgical procedures. Let us begin to foster an educational environment in which all dermatologists can learn the complete spectrum of surgical cutaneous oncology and not continue an arrangement in which a very few may receive comprehensive training and the rest have limited or no opportunity. This single, simple, and long overdue change in our educational focus would greatly enhance dermatology's evolution and standing as a surgical specialty.

HOWARD K. STEINMAN, MD
President
American Society for Mohs Surgery

References

1. Robins P. Mohs micrographic surgery [editorial]. J Dermatol Surg Oncol 1993;19:71.
2. Tromovitch TA, Stegman SJ, and Glogau RG. A survey of dermatologic surgery procedures. J Dermatol Surg Oncol 1987;13:763-66.

Response

To the Editor:

I wish to thank Dr. Steinman for his letter and I would like to respond to his concerns. I think Dr. Steinman's concerns regarding Mohs micrographic surgery and board certification completely ignore the basic points for certification. The name of the board is "Mohs Micrographic Surgery and Cutaneous Oncology." Mohs micrographic surgery is a technique, but the specialty of Mohs Micrographic Surgery and Cutaneous Oncology encompasses a vast body of knowledge in which the technique of Mohs micrographic surgery is only one part. Cutaneous oncology is a highly complex field in which the physicians deal with a variety of tumors from the most common to the unusual not only clinically but pathologically. The Mohs Surgeon (Cutaneous Oncologist) is frequently called upon as a reference source for the treatment of complicated and difficult tumors, some with extensive and life threatening consequences. These include squamous cell carcinomas with parotid involvement, perineural invasion by tumor, metastasis, and complex situations in which the general dermatologist and other physicians may not be familiar.

No one suggests that a dermatologist cannot adequately remove a nodular basal cell carcinoma with sophistication. In fact, dermatologists in general do an excellent job of handling the vast majority of tumors. Unfortunately, tumors get away from every practitioner and in these situations expert care is called upon. From Merkel cell tumors, to dermatofibrosarcoma protuberans, to malignant melanoma, and to extensive squamous and basal cell carcinomas, there is no single group as qualified as the Mohs micrographic surgeon to participate in the management and care of these patients. To be proficient in anatomy, anesthesia, the technique of Mohs micrographic surgery, wound care, reconstructive surgical techniques, tumor oncology, pathology, therapeutic radiology, and expertise in the technical aspects of the laboratory, specialty training is necessary. They must also be competent in the management of complications in extensive surgical wounds, and of course in basic and advanced life support.

Many years ago hundreds of dermatologists were trained for only 2 weeks in the technique of Mohs micrographic surgery. These people tried to practice this specialty and of course almost without exception could not and discontinued the practice entirely. Unfortunately, at our meetings we suffered through watching some of their reconstructions, their inadequacies, and poor technique. Why anyone would want to go back to those days is beyond me.

With the advent of 1-year training, programs that were instituted by Dr. Perry Robins, the quality of Mohs micrographic surgery soared. The body of knowledge has increased and the true specialist in cutaneous oncology emerged. At this time, the technique became widely accepted and Mohs micrographic surgeons were sought out by every major university. The next logical step was board certification to distinguish those individuals who were the true specialists in cutaneous oncology from those that had been inadequately trained such as the individuals of yesteryear. The only purpose of certification is to deter-