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Editorial

Reflections Upon Receiving Horary Membership to the Asociación Española de Cirujanos☆

Reflexiones tras ser nombrado miembro de honor de la Asociación Española de Cirujanos

Colleagues, what an unexpected honor to be invited to become an honorary member of your venerable Associacion Espanola de Cirujanos! I suspect that I was offered this honor because – 30 years ago – I saw an opportunity and had the good fortune to be in the right place at the right time to innovate in minimally invasive surgical technology and technique, to improve the quality of the surgical outcome, and to improve the patient experience of surgery. At first, it was hard to convince patients that one could remove their gallbladder without inflicting a great deal of pain and a six week recovery. Now, patients have come to expect that surgery, even major surgery, will create a minimal impact on increasingly busy professional and personal lives. Perhaps they will fit their Nissen fundoplication or cholecystectomy between a business trip to Japan and a much anticipated fishing trip!

It is a great institution that gives a young innovator the space to dream, to experiment, to fail, to dream differently, to experiment, and ultimately succeed. This was my good fortune at the University of Utah, 30 years ago. With the gift and the freedom to innovate comes a moral obligation to study and report the outcomes, good and bad, year in and year out. It is important that we share not only our successes, but we must also share our failures in the great hope that those that follow us will not have to make the same errors; that those who follow will not have to travel the dead end streets from which we were obliged to retreat in our journey toward the truth.

For the clinical scientist, our laboratories are the clinics, hospitals, and operating rooms. In these environs we find the greatest rewards, working with our patients to improve their health, invoking our surgical craft to improve the duration or quality of their lives. In these same environs, we suffer our greatest defeats, encountering the formidable forces of trauma, infection, cancer, and inflammation, as well as the limitations of our knowledge, judgment, technology, and skill. Let me illustrate these comments with several observations and stories from a 30 year career in surgery. The paradigm is esophageal surgery, but these stories can be translated to any branch of surgery.

Thirty years ago, 2 years out of general surgery residency and 1 year out of a fellowship in flexible endoscopy, it became clear that laparoscopic cholecystectomy was not only feasible, but represented the greatest advance in abdominal surgery in a century. The major risk, common bile duct injury, could be mitigated with a series of 5 steps that we reported in 1991, the steps that ultimately led to the concept of the ''critical view of safety''.[1]

In these ''early days'' of gastrointestinal laparoscopy, the space to innovate was wide open, and innovate we did, surgeons from around the world were freed from the yokes of convention and were given industry partners interested in providing the imaging and instruments to revolutionize surgery. Name a conventional procedure from appendectomy to pancreatectomy; it could all be done with a laparoscope and a series of small incisions! In the esophageal surgery space we started with fundoplication for gastroesophageal reflux disease (GERD), but then spread our wings to include paraesophageal hernia repair, Heller myotomy, diverticulectomy, Collis gastroplasty and ultimately to minimally invasive esophagectomy.

This rapid expansion of the minimally invasive repertoire led to a rapid growth in the practice of many surgeons, like myself, recently out of general surgical training, and now with clinics busier than the senior surgeons in our institutions. The patients were grateful and sought out laparoscopic surgeons. Journals published our articles on technique and the outcomes of the new techniques. Publications and clinical productivity led to promotion and leadership opportunities for many. The thirst for knowledge about this new surgery led to speaking

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invitations around the globe, leading to new colleagues, new ideas, and international research collaborations never before seen. And our surgical colleagues became international friends, meeting up to ski, fish, golf, or taste wine and wonderful international cuisine. What could be better?

But there were problems. A young German surgeon, Eric Muhe, the first to perform laparoscopic assisted cholecystectomy was denounced by his national surgical society and put under house arrest after a complication of laparoscopic cholecystectomy led to a patient death. Less dramatic, but no less important, many cautious conscientious surgeons incurred surgical complications unanticipated and morbid in their early experience with laparoscopic surgery.

Some shortsighted senior surgeons, whose practices were most affected by this 'minimally invasive revolution' descended to deride and shut down the ''young turks'' driving innovation. They wrote editorials. They urged hospital credentialing committees to remove privileges of those pushing the frontiers. They brought claims before state licensing boards directed at busy laparoscopic surgeons.

Despite the skepticism, there was no stopping this wave. The opportunity was not to become the advocate or the skeptic, but to hone one's minimally invasive surgical expertise with repetition and refinement of surgical technique and technology. Similarly, it was important to critically address the shortcomings of the technology and the techniques of minimally invasive surgery to ask questions that could be answered with well-designed studies, preferably randomized clinical trials.

When these principles were applied, programmatic success followed. Fellowships in minimally invasive surgery, to obtain exposure, competence, and mastery in MIS sprung up around the world. Initially funded by industry, these fellowships are now largely funded by the host institution or by the surgical practice benefiting from the additional help of the fellow, as the fellow simultaneously benefited from the experience of working at the elbow of the masters.

Ultimately, the success of minimally invasive surgery should be attributed to the many surgical fellows who were inspired to learn, to innovate, and to offer 'patient friendly' surgery in their university and community health systems. The fellows were the source of many questions that spawned well designed clinical research, advancing the field.

Finally, and most importantly, we must remember that MIS was successful because patients wanted in and were willing to put their faith in those of us innovating in this space. To our patients we owe the most supreme gratitude. Minimally invasive surgery, whether done with conventional instruments or a surgical robot is here for some time to come. Our children and grandchildren may figure out how to perform surgery without incisions, without anesthesia, and without pain. I am not sure I will live to see this development, but stay tuned!

Conflict of Interest

There is no conflict of interest.

REFERENCE

1. Hunter JG. Avoidance of bile duct injury during laparoscopic cholecystectomy. Am J Surg. 1991;162:71–6.

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