American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

1. Provide the name of proposed area of focused practice:

Focused Practice Designation in Comprehensive Breast Surgery

2. Is this application a modification of an existing designation?

No

3. If multiple boards are interested in this Focused Practice Designation and wish to collaboratively submit an application, please view the addendum found at the end of this application. Each collaborating Boards should complete an addendum to describe specialty-specific modifications.

Complex General Surgical Oncology is a secondary certification of the American Board of Surgery. This application has been reviewed and commented upon by the CGSO board, a component board of the ABS.

4. State the purpose of the proposed area of focus practice and include a rationale for how this area of focused practice is different than a subspecialty, in two paragraphs or less.

The purpose of the proposed focused practice designation (FPD) in breast surgery is to improve the long-term health and quality of care delivered to patients with complex breast diseases including the management and treatment of patients with complex benign, high risk, and hereditary breast cancer risks/conditions, and breast cancer. This multidisciplinary care is best delivered by surgeons who have additional surgical expertise and dedicate a significant percentage of their practice to the longitudinal comprehensive care of these patients. A FPD in breast surgery will provide the American Board of Surgery with the opportunity to establish standards and assessments for this specific area within the field of general surgery and complex general surgical oncology. Surgeons seeking a comprehensive breast surgery FPD must provide access to and critical education for patients with complex benign breast conditions and must also be able to counsel patients on prevention, screening, genetic assessment, early detection and treatment of breast cancer. They must demonstrate proficiency in leading multidisciplinary teams in complex breast care. The goal of the FPD is to improve overall disparities in breast care.
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The evidence that the practice of general surgery recognizes the need for specialty breast surgeons includes the following:

1. The American Society of Breast Surgeons (ASBrS) was established in 1995 and is a professional organization that specializes in education for breast surgeons. The ASBrS has 3,135 members from the United States and multiple countries around the globe. The ASBrS sponsors an annual CME meeting that is attended by over 1,600 breast surgeons and multidisciplinary providers. The ASBrS provides continuing education through its annual conference, online offerings, and hands-on courses throughout the year led by national leaders.

2. The Society of Surgical Oncology (SSO) was established in 1940 (originally as the James Ewing Society) and is a professional organization specializing in the education for surgeons devoted to the scientific advancement of oncologic care and cancer surgery. The SSO has 3,086 members of which 1,555 are identified as breast surgeons. Approximately one third of the annual SSO meeting is dedicated to education focused on breast cancer surgery and multidisciplinary management.

3. Establishment of breast surgery fellowships with clear and comprehensive curricula addressing benign and malignant breast conditions that is agreed upon between the ASBrS and the SSO with a dedicated match and oversight provided by the SSO.

4. Abundance of guideline/position statements and choosing wisely recommendations by the ASBrS, the American Society of Clinical Oncology (ASCO), and the SSO related to the screening, diagnosis, and treatment of breast diseases.

5. Recognition by the American College of Surgeons of the importance for comprehensive multidisciplinary breast care with minimum standards of quality and practice through the standardized National Accreditation of Programs in Breast Cancer (NAPBC) accreditation process. Programs that receive NAPBC accreditation must demonstrate delivery of evidence-based care and adhere to strict quality standards.

6. Creation and maintenance of a dedicated Breast Education Self-Assessment Program (BESAP) through the ASBrS for breast specific self-assessment opportunities for practicing breast surgeons. A portion of BESAP is also used by the breast fellowships as a pre and post breast surgery fellowship knowledge assessment.
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7. Creation of breast specific quality reporting tools, including the ASBrS-sponsored Mastery of Breast Surgery and the National Quality Measures for Breast Centers (NQMBC) via the National Consortium of Breast Centers (NCBC), available to track personal and programmatic outcomes and benchmark these outcomes with breast surgeons or breast programs worldwide.

8. Nationally available additional educational opportunities for general surgery residents and practicing general surgeons to gain specialized training and expertise in breast surgery techniques (incision placement, cavity closure and basic tissue rearrangement, image guided biopsy, ablative therapies).

9. Large number of CME events hosted by individual institutions, other societies (American College of Surgeons and ASCO) and professional CME organizations (Physicians’ Education Resource) dedicated to breast education.

10. There are many textbooks devoted to management of benign breast disease, breast surgical oncology, breast pathology, breast imaging and breast surgical procedures.

5. Focused practice typically falls under one of these areas. Please describe which of the following this application addressed:

a. Evolving area of practice -

This FPD represents an evolving area of multidisciplinary clinical practice with continuous evolution of the nuances of complex benign and malignant diseases of the breast. The management of breast disease has changed significantly since the initial publication of landmark clinical trials establishing breast conservation therapy as an alternative to mastectomy for patients with early stage breast cancer. Major advances in understanding breast cancer biology and the availability of targeted and novel therapies require surgeons who manage breast patients to have an in-depth understanding of this rapidly moving field. In addition, the fields of breast cancer risk assessment, prevention, and hereditary breast cancer have rapidly expanded and breast surgeons must integrate this information into evidence-based recommendations for patients. Access to genetic counselors may be limited. Therefore, surgeons who care for breast patients should be aware of genetic testing options available to patients, indications for testing, and management of patients with hereditary breast cancer. They should be familiar with treatment and screening options for women who may not have a genetic mutation but are at increased risk of developing breast cancer based on family history and risk models. Benign breast disease comprises a significant portion of breast care. Surgeons taking care
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of complex breast patients should be able to address high risk lesions, such as atypia, determining when surgical excision is warranted as well as complex benign lesions that may require surgical intervention (i.e.: recurrent abscesses). Finally, surgical decision-making after completion of neoadjuvant therapy requires a full understanding of tumor biology, response to therapy, and sensitivity and specificity of imaging modalities in this clinical setting. As new therapies for breast cancer are introduced into clinical practice, the surgical management will continue to evolve.

The surgeon should participate in a multidisciplinary team that includes radiology, medical oncology, pathology, reconstructive surgery and radiation oncology when indicated. A FPD would require the surgeon to maintain a comprehensive understanding of the entire spectrum of breast care. A breast FPD would also provide patients, hospital credentialing committees, peers and other stakeholders an easily identifiable way to identify surgeons who have intentionally acquired and maintained a minimum standard of proficiencies in the ongoing evolution of breast surgery and management of benign and malignant breast conditions.

b. **Area of practice limited in scope or size**

A breast FPD for surgeons specializing in breast care and surgery would recognize the specific complexities of caring for the subset of patients with benign and malignant disorders of the breast. Specialization in this limited subset of challenging patients would allow the surgeon to focus improvement on the multidisciplinary setting to establish high quality, efficient, and coordinated care for the patient. Understanding the amount and complexity of rapidly evolving evidence-based medicine over multiple specialties is critical to achieving good outcomes in the treatment of benign but common breast diagnoses as well as improve breast cancer prevention and treatment.

c. **Specialized procedures**

Breast and axillary surgery are integral components of general surgery and complex general surgical oncology training. However, several breast and axillary procedures are highly specialized and complex including: selective major duct excisions for nipple discharge, therapeutic breast conserving surgery with cosmetically acceptable results, nipple-sparing mastectomy, flat mastectomies with removal of excess adiposity as indicated, axillary staging following neoadjuvant systemic therapy, and management of local and regional recurrence.
Breast conserving surgery with cosmetically acceptable results: Breast conserving surgery has evolved from large resections with wide margins to smaller resections based on tumor size and location. Surgical outcomes should be tailored resections through cosmetically favorable natural skin incisions maintaining the natural contour of the breast mound. Appropriate lumpectomy margin standards should be based on the biology of the cancer and type. Closure of the breast parenchyma and skin is important in achieving cosmetically acceptable outcomes. Surgical planning for breast conserving surgery involves utilization of imaging to access and correlate with cancer removal. Working in collaboration with breast radiologists to assess appropriateness of breast conservation, optimal localization methods, and ability to monitor the breast for local recurrence post-therapy may enhance outcomes.

Large volume resections require unique surgical expertise in local tissue rearrangement, skin resection, nipple repositioning, and contralateral symmetry procedures. Breast surgeons should have the required surgical skills to offer complex oncoplastic procedures, practice in a multidisciplinary environment with close collaboration with reconstructive surgeons to collectively offer complex breast conserving approaches, or have the ability to refer to an appropriate reconstructive surgeon.

Nipple-sparing mastectomy: Mastectomy options have expanded from traditional simple mastectomy and skin-sparing mastectomy to nipple-sparing mastectomies (NSM) when oncologically appropriate. NSM requires expertise in patient selection and surgical techniques to maximize resection of breast tissue while preserving adequate skin thickness and blood supply for healing. Operative risks for NSM are higher than simple or skin-sparing mastectomy due to technical challenges of developing the skin flaps via remote incisions.

Axillary staging: Surgical procedures to stage the axilla have become increasingly complex. Sentinel node biopsy has displaced routine axillary node dissection for primary staging in node-negative and low volume node-positive breast cancer. As a result, the number of routine axillary lymph node dissections has significantly declined. Axillary lymph node dissection (ALND) is still required in patients presenting with advanced axillary disease, persistent positive nodes following completion of neoadjuvant systemic therapy, inflammatory breast cancer and for axillary recurrence. Increasingly, axillary node dissections are performed after prior axillary sentinel node staging (redo axillary surgery) or prior axillary radiation therapy. Restaging the axilla after neoadjuvant therapy with targeted axillary dissection and resection of previously biopsied and positive nodes requires significant expertise in axillary surgery and a multidisciplinary environment with radiology and pathology expertise to help guide axillary management.
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Currently, only small numbers of any axillary surgery are required in training. Specifically, general surgery residency training mandates residents complete only five axillary procedures (SLNB or ALND). Among residents completing general surgery residency in the 2018-2019 academic year, the average number of sentinel node biopsies performed/logged for breast cancer was 4.2, and for melanoma was 3.7. Graduating residents averaged only 2.5 major lymphadenectomies over 5 years of training. Breast surgery fellowships mandate 10 ALNDs to be completed during the one year training program. CGSO fellowships do not specifically classify the number of axillary procedures needed.

Management of Benign and High-Risk Proliferative Breast Lesions: Surgeons seeking FPD in breast surgery should have expertise in the evaluation and management of benign breast conditions (i.e. breast pain, nipple discharge, cysts, fibroadenoma, granulomatous mastitis, etc.) as well as high risk proliferative changes (i.e. atypical ductal hyperplasia, atypical lobular hyperplasia, radial scar, intraductal papilloma with and without atypia, and lobular carcinoma in situ). Management of high-risk proliferative lesions has continued to evolve over time requiring up-to-date knowledge of rates of upstaging with surgical excision and recommendations for surveillance if surgery is not performed. Collaboration with radiology and pathology to understand radiologic and pathologic concordance is a critical step in managing these patients. Further, comprehensive risk assessment incorporating family history, biopsy history, and other patient factors utilizing available risk-assessment models is essential for tailoring recommendations for annual screening. Expertise in breast cancer prevention including lifestyle modifications and use of appropriate anti-estrogen therapies is essential for educating patients about their personal risk and helping to manage that risk.

6. Document the professional and scientific status of this area of focused practice by addressing (a) through (d) below:

   a. Please describe how the existence of a body of scientific medical knowledge underlying the proposed area of focused practice is, in large part, distinct from, or more detailed than that of other areas in which certification or focused practice are offered:

   The surgical practice of breast surgery has evolved and modernized. The explosion of randomized clinical trials, high quality meta-analyses, and large clinical series coupled with refinements in minimally invasive and cosmetically superior techniques over the past 3 decades have revolutionized breast care. Collectively, these changes have mandated breast surgeons understand and critically synthesize large quantities of multidisciplinary data in
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order to deliver the highest quality, individualized patient care to patients with complex breast disease and breast cancer. Not only must breast surgeons provide access to and critical education for prevention, screening, genetic assessment, early detection and treatment but they must understand how to treat complex recurrent benign breast conditions.

Substantial scientific medical knowledge exists specific to breast diseases. There have been numerous ACCME accredited meetings and/or workshops sponsored by the SSO, ASBrS, American College of Surgeons, large national and international institutions, and educationally based CME companies. These symposia, hands-on lab courses, and other educational opportunities have provided consistent opportunities for surgeons to gain additional training in breast surgery techniques, breast ultrasound and biopsy, and patient management. The ASBrS annual meeting is dedicated to educating breast surgeons and general surgeons performing breast surgery for all indications. About one third of the annual SSO meeting is dedicated to breast education. In addition, the American College of Surgeons, ASCO, and San Antonio Breast Cancer Symposium all provide significant educational breast content. Each provides a platform for peer-reviewed scientific papers/videos and scientific posters, invited speakers and discussants and draws attendees from around the world.

There are numerous textbooks and journals dedicated to all aspects of multidisciplinary breast care both benign and malignant. The *Annals of Surgical Oncology* is the official journal of both the SSO and the ASBrS. The journal is currently in its 26th year and has an impact factor (IF) of 3.85 underscoring the quality of research published. Approximately 19% of articles published in the *Annals of Surgical Oncology* are focused on breast. In addition, a large number of breast manuscripts are published in the *Journal of Clinical Oncology* (IF:26.3), *Breast Cancer Research and Treatment* (IF:6.14), *The Annals of Surgery* (IF:9.2), JAMA, *JAMA Surgery*, the *New England Journal of Medicine*, *Science*, and many others. Although the total number of peer-reviewed publications on breast surgery and multidisciplinary breast care are impossible to estimate, there is no doubt that it is many thousands. The extensive science, prospective randomized clinical trials and resulting progression of evidence-based practice changes in breast surgery might be considered as the blueprint for practice advances in many other diseases.

The ongoing need for high quality and fruitful multidisciplinary relationships between surgeons and other integrated health specialists is a notable difference between breast surgery and other areas where certification is currently available, in which practitioners typically do not have knowledge or extensive experience in advanced risk reduction strategies, chemoprevention, or oncoplastic surgery. While those diplomates with a CGSO
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certification would have these experiences and skill sets, CGSO training requires extensive training in all cancers (not just breast) which may not appeal to many choosing to focus the majority of their practice in breast surgery.

b. **Explain how this proposed area of focused practice addresses a distinct and well-defined patient population and care need:**

The sheer volume of breast specific literature, large number of breast surgery fellowship training programs, breast dedicated ACCME accredited conferences, and volume of breast cancers annually within the United States attests to the fact that breast surgery and breast patients are a distinct and critical population of patients. Millions of women experience benign breast conditions that warrant surgical discussion and/or management. Breast health impacts all women over age 40 and many women younger than 40 through recommended cancer screening. Further, breast cancer affects 10-12% of women over their lifetime or, approximately 250,000 women in the US annually. The patient population is well defined. Furthermore, adoption of screening mammography and advances in systemic targeted therapies has collectively resulted in reduced breast cancer mortality. As a result, the NCI estimates nearly 4 million breast cancer survivors will be alive in the US by 2024. Clearly, this is a distinct and well defined patient population with unique prevention, treatment, and survivorship care needs.

c. **Please provide information about the group of diplomates concentrating their practice in the area of focused practice, if known:**

i. **The projected number of such diplomates in total and annually (along with the source(s) of the data):**

The American Society of Breast Surgeons (ASBrS) has 2,610 active surgeon members. We would estimate that >75% of those active members would be eligible for focused designation. The annual rate of new members is 60-100. The majority of these are fellows completing a breast fellowship of which all would be eligible for focused designation.

The number of general surgeons concentrating their practice in breast surgery is less well understood. The total number of board certified general surgeons is approximately 32,000. Up to 5% of surgeons may wish to participate in this FPD, for a total of up to 1,600 surgeons at the initial outset of the FPD. Annually, a total of about 50 new applications from this cohort is expected.
ii. The annual rate of change of such diplomates in the recent past and projected annual rate of change in the near future (along with the source(s) of the data):

The annual rate of change is estimated from yearly growth of the American Society of Breast Surgeons (ASBrS) membership which grows by 60-100 members annually. This rate is anticipated to be consistent yearly. Most of this growth is derived from completion of SSO/ASBrS approved breast fellowships. There has been a dramatic rise in the number of breast fellowship programs and applicants for available breast fellowships over the past 15 years. (See #16 for current list)

iii. The current geographic distribution of this group of diplomates, its projected spread in the next five (5) years, and an explanation of how you arrived at this projection:

The American Society of Breast Surgeons (ASBrS) membership is geographically distributed as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Members</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>681</td>
<td>27%</td>
</tr>
<tr>
<td>Midwest</td>
<td>537</td>
<td>21%</td>
</tr>
<tr>
<td>Rocky Mountain</td>
<td>91</td>
<td>4%</td>
</tr>
<tr>
<td>Southeast</td>
<td>630</td>
<td>25%</td>
</tr>
<tr>
<td>Southwest</td>
<td>232</td>
<td>9%</td>
</tr>
<tr>
<td>Pacific</td>
<td>337</td>
<td>14%</td>
</tr>
</tbody>
</table>

We would consider this representative of our expectations of distribution of diplomates seeking a focused designation. The geographic distribution is expected to remain similar over the next five years.

d. Please identify the existing national societies that have a significant interest in the area of focused practice:
   i. Indicate the existing national societies' size and scope, along with the source(s) of the data:
1. The American Society of Breast Surgeons (ASBrS) was established in 1995 and is a professional organization that specializes in education for breast surgeons. The ASBrS has 3,135 members (as of 8/29/2019) from the United States and multiple international countries. The ASBrS sponsors an annual CME meeting that is attended by over 1600 breast surgeons and multidisciplinary providers. The ASBrS provides continuing education through its annual conference and through hands-on course throughout the year led by national leaders.

2. The Society of Surgical Oncology (SSO) was established in 1940 (originally as the James Ewing Society) and is a professional organization specializing in the education for surgeons devoted to the scientific advancement of oncologic care and surgery. The SSO has 3,086 members of which 1,555 are identified as breast surgeons. Approximately one third of the annual SSO meeting is dedicated to breast surgery education.

These data were obtained through the administrative staff of both organizations.

3. The American College of Surgeons was established in 1913 and is a professional organization specializing in the education and fellowship of all surgeons including general surgeons. It is estimated the American College of Surgeons has approximately 82,000 members.

ii. Indicate the distribution of academic degrees held by their members, along with the source(s) of the data:
iii. Indicate the relationship of the national societies’ membership with the proposed focused practice designation:

Significant overlap in membership between the SSO and ASBrS societies exists and as a result, the education goals of the two societies overlap in many ways as well. Both organizations draw a large number of breast surgeons. While the SSO may have a higher percentage of surgeons identifying as being based in
traditional academic practice, the ASBrS has a large number of community and hospital employed breast surgeons who are very facile with advanced breast surgery skills like surgeon directed ultrasound, biopsy, or genetic testing. Nevertheless, surgeons in both organizations, as well as many within the American College of Surgeons have self-identified as breast surgeons regardless of their place of practice but based primarily on their training, continuous learning patterns, patient and procedural mix, and unique skill sets separating them from traditional general surgeons in an otherwise broad-based practice.

Consequently, the SSO and the ASBrS have a well-established, long and collegial relationship. This relationship is probably best demonstrated in their collective development, oversight, and governance of the 63 breast surgery fellowship programs. Together, the two societies have worked to develop a multidisciplinary curriculum and surgery case minimums though the administration of the fellowships and match are performed through the SSO, the ASBrS participates in the programmatic changes and curriculum reviews by appointing ASBrS members to the SSO Training Committee. In addition, both the ASBrS and the SSO designate members to perform site visits to the individual fellowships resulting in joint reviews of the programs.

Nearly all members of the SSO and the ASBrS are also members of the ACS. Most general surgeons are members of the ACS.

7. **Please describe how the cognitive knowledge, clinical and interpersonal skills, professional attitudes, and practical experience of the diplomates in this area of focused practice will be distinct from diplomates in other specialties, subspecialties, and areas of focused practice in terms of:**

   a. **Clinical competence:**

   Surgeons with a focused practice in breast surgery will enter this designation through a breast surgery fellowship, CGSO fellowship, or through the practice pathway. The practice pathway specifically highlights individuals who have acquired additional knowledge and surgical expertise through continuing medical education programs and dedicate a significant percentage of their clinical practice to the comprehensive care of breast patients.

   Because the treatment of breast diseases is constantly evolving and has become so complex, the surgeon who chooses to pursue this FPD should be proficient in interpreting clinical trial data, participate in available clinical trials, practice in a multidisciplinary setting, review and interpret breast imaging, screen high risk patients, perform genetic
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assessments, and manage and counsel patients regarding benign, complex, recurrent breast conditions. He or she must also be able to perform a range of procedures such as major and selective duct excisions, excisional biopsies, lumpectomies, skin and nipple-sparing mastectomies, sentinel node biopsies, axillary dissections and provide cosmetically acceptable outcomes. The surgeon should participate in a multidisciplinary team and must have access to or ability to refer to necessary resources including but not limited to plastic surgery, radiation oncology, medical oncology, breast imaging, and pathology as indicated.

b. Scope of practice:
The scope of practice would include both complex benign and malignant breast diseases. However, some surgeons may choose to primarily see cancer patients depending on the practice environment. Regardless of the majority focus, individuals must also be proficient in screening, prevention, treatment, and the genetic assessment of patients. Breast surgery is often performed outside of traditional academic centers and most general surgeons will have to perform the full breadth of breast surgery. In order to provide optimal treatment for the general population, the surgeon who will pursue this FPD must feel comfortable with the multidisciplinary treatment of both complex benign and malignant breast disease. Breast surgeons and general surgeons with a concentration in breast surgery have a much broader and more complete understanding of breast diseases and procedures, multidisciplinary treatments, redo procedures, and management of complications.

c. Body of knowledge and skills:
Because of the rapidly evolving knowledge and treatment of breast diseases, both benign and malignant, a focused breast surgery practice requires the surgeon to be able to assess and interpret landmark and new clinical trial data and be able to apply it to their patients. The optimal treatment of breast patients also requires a multidisciplinary approach to patient care. The surgeon serves as the leader of the group with the majority of patients entering the health care system through the surgical consult. The surgeon must serve as liaison for the team, including medical oncology, radiation oncology, plastic surgery, pathology, genetic counseling, and radiology. The surgeon must be able to assimilate large amounts of data, navigate controversies, and provide medical strategies/treatment for breast cancer prevention and high risk screening. It is imperative that the breast surgeon is proficient in the multitude of radiology tools available for assessment and competency in reading and interpreting those tests. The surgeon must be able to identify indications for neoadjuvant versus adjuvant therapy, including both chemotherapy and endocrine therapy. Understanding the indications for radiation therapy for both the patient undergoing breast conserving surgery and mastectomy are also of utmost importance. The oncologic breast surgeon must also recognize eligibility for reconstructive surgery and the types of
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techniques that are ideal for each individual patient. Finally, the surgeon must be able to determine when surgery would not benefit the patient and be familiar with the non-operative alternatives.

With respect to surgical technique, the surgeon must be proficient in total, skin and nipple-sparing mastectomy, segmental mastectomy, excisional biopsy, sentinel node mapping and biopsy, and axillary dissection. The surgeon may also incorporate image guided biopsy. They may choose to have the skill set to perform oncoplastic surgery as deemed necessary by their individual practice or they should have a relationship with a plastic surgeon and the ability to refer to them in order to provide them with improved cosmesis.

8 - Is there any additional information you would like to provide to help the committee understand why this area is worthy of a Focused Practice designation?

9. For (a) through (e) below, please project the need for and the effect of the proposed new focused practice on the existing patterns of certification or other areas of focused practice. Please indicate how you arrived at your response:

   a. Please indicate whether there is overlap between this area of focused practice and existing subspecialty certification or other areas of focused practice: There is likely overlap between this area of Focused Practice and the CGSO subspecialty certificate. It does not overlap with other existing FPDs.

   b. Please outline plans for evaluation of the impact of the proposed area of focused practice on your own programs of specialty and subspecialty certification and any other areas of focused practice:

An FPD in breast surgery may impact practicing general surgeons who do breast surgery, as well as the patients they serve. The FPD may impact general surgeons who perform limited breast surgery. It is important to note that straightforward breast care can be taken care of by general surgeons and does not require an FPD recognized surgeons. However, performing a small volume (<35 cases annually) would not qualify as FPD and patients should have this information when selecting a surgeon.

FPD in breast surgery is not expected to impact practicing OB/Gyn or GYN Oncology physicians as their existing training requirements in the US are not sufficient to perform breast surgery. To seek an FPD in breast surgery, these physicians are encouraged to complete an approved breast oncology surgery fellowship.
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Regarding impact on practicing breast surgeons, surveys of practicing general surgeons can be developed and monitored for trends. Further, the ASBrS and SSO memberships can be surveyed to determine the impact of a breast FPD on their practices and satisfaction with the process. Monitoring the percentage of physicians (general surgeons, CGSO certified surgeons, and fellowship trained breast surgeons) who apply for FPD and re-certify in FPD is another way to measure the impact and value of FPD. The committee recognizes the value and impact may be different for each diplomate depending on prior training. A future measure of impact may be to monitor and assess whether FPD is used by hospital credentialing committees and/or eligibility for breast surgery employment. However, the latter is not expected to be the case as surgeons holding certificates from the ABS are qualified to perform breast surgery. This FPD is specifically designed for those whose concentration is in breast surgery.

c. Please outline plans for evaluation of the impact of the proposed area of focused practice on other Member Boards’ programs of specialty and subspecialty certification and any other areas of focused practice:

Boards that may be impacted by breast FPD would include ABS, CGSO, perhaps ABOG Gyn/Onc. However, the breast FPD is meant to be inclusive of diplomates of the ABS, CGSO, and ABOG Gyn/Onc. The expectation is that diplomates will maintain certification within their respective board which would be a requirement for maintenance of breast FPD. Due to the fact that the ABOG has no minimum requirement for any breast cases, individuals certified by this board will need to complete a breast fellowship in order to obtain the requisite experience to participate in this FPD. The impact of the implementation of the FPD can be evaluated by monitoring the number of ABOG certified surgeons accepted into breast fellowships.

The impact of this FPD can be similarly evaluated for surgeons certified by the ABPS, who also have no minimum required number of breast cases directly related to breast pathology, which is generally considered outside the scope of plastic surgery.

d. The impact of the proposed area of focused practice on practice, both existing and long-term, specifically:

i. Access to care (please include your rationale)
Focused practice in Breast will have a positive impact on public identification of appropriately trained and experienced providers for the purpose of optimizing access to medical care and reducing disparities in access and disparities in outcome for these patients.
ii. Quality and coordination of care (please include your rationale)

The quality and coordination of care for these patients would be improved because of the demands of multidisciplinary care, documentation of quality metrics through existing databases, and the continuous professional development requirements required to maintain initial and continuous certification.

iii. Benefits to the public (please include your rationale)

As outlined above, the initiation of this FPD will allow for more focused and multidisciplinary care of the breast patient. With the tracking of outcomes, there will be an increased focus on streamlining processes and delivery of coordinated, high quality care by a multidisciplinary team.

e. Please explain the effects, if known, of the proposed area of focused practice on:

   i. Immediate costs and their relationship to the probable benefits (please indicate your methodology):

The additional financial cost of the FPD for the candidate would only be an initial examination fee for the written examination that will be developed by a breast committee within the ABS. The candidate will need to maintain his or her Continuous Certification and board certification and will pay the normal required fees as they would without the FPD. CME requirements would remain the same with an increased requirement for a breast focus. Case logs with diagnoses and procedure codes would be submitted at no extra cost and the requirement for participation in a quality initiative remains the same.

The benefits of the FPD designation are significant for the candidate. There has been a movement towards sub-specialization of surgical care and patients are recognizing this expertise. However, the need for the general surgeon remains, particularly in non-metropolitan areas. There are general surgeons who have specific interests in disease sites and have tailored their practice, CME focus, and adoption of new technology and standards to reflect this. The treatment of breast disease is one such area. The benefit of this designation for these surgeons reflects their commitment to staying current with the treatment of diseases in this area and for patients to see recognition of this commitment. With this designation, they could attract higher patient volumes and patients could benefit from someone who specializes in this field who may not be fellowship trained but is well versed in the latest treatments.

ii. Long-term costs and their relationship to the probable benefits (please indicate your methodology):
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The long-term costs would be the same as they would be for the candidate to maintain board certification.

The long-term probable benefit is that insurance reimbursement may require specific patient case volumes for payment. This FPD would be a guarantee of these volumes. For example, the state of New York has volume requirements for Medicaid patients who are being treated for breast cancer. From the New York State Department of Health website:

“Research shows that five-year survival increases for women who have their breast cancer surgery performed at high-volume facilities and by high-volume surgeons. Therefore, it is the policy of New York State Department of Health (the Department) that Medicaid members receive mastectomy and lumpectomy procedures associated with a breast cancer diagnosis, at high-volume facilities defined as averaging 30 or more all-payer surgeries annually over a three-year period. Low-volume facilities will not be reimbursed for breast cancer surgeries provided to Medicaid members.

Each year, the Department reviews the list of low-volume facilities and releases an updated list effective April 1st. The Department has completed its annual review of all-payer breast cancer surgical volumes for 2015 through 2017 using the Statewide Planning and Research Cooperative System (SPARCS) database. Eighty-four low-volume hospitals and ambulatory surgery centers throughout New York State were identified. These facilities have been notified of the restriction effective April 1, 2019. The policy does not restrict a facility’s ability to provide diagnostic or excisional biopsies and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for Medicaid members. For mastectomy and lumpectomy procedures related to breast cancer, Medicaid members should be directed to high-volume providers in their area.”


While this is one state with this requirement, as insurance companies seek quality metrics, more agencies may move towards this requirement and the FPD may be beneficial for the candidate in this aspect.

f. Please explain the effects if this area of focused practice is not approved:

If this designation is not approved, the surgeons whose practice is comprised of a large proportion of breast cases and who are dedicated to staying current with breast care guidelines and technologies will not receive the acknowledgement of their efforts. More importantly, patients will not be provided transparent information to allow them to choose between these surgeons and those who perform very few breast cases a year. Ultimately, patient quality of care may suffer resulting in poor outcomes and perpetuated disparities.
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It is possible that insurance companies will begin to realize this and require case minimums to prove experience for reimbursement. By approving this FPD, we are acknowledging the commitment to quality breast care ahead of the insurance companies determining policy.

10. Please outline the eligibility criteria required of the candidate in the proposed area of focused practice as it pertains to the following:

10a. What specialty or subspecialty certificate(s) will the diplomate be required to hold in order to be eligible for this area of focused practice?

Diplomates must have a primary certification in General Surgery from the American Board of Surgery (ABS) and/or a certificate from the Complex General Surgical Oncology Board. Diplomates must maintain and fulfill the requirements of the ABS Continuous Certification Program (http://www.absurgery.org/default.jsp?exam-moc).

Therefore, any candidate for the Breast FPD will be required to have primary certification in General Surgery from the American Board of Surgery and maintain and fulfill the requirements of the ABS continuous certification program. Those holding a subspecialty CGSO certificate will also be eligible. For those holding that certificate, maintenance of their primary General Surgery certificate will not be required.

Although those holding a specialty certificate from the American Board of Obstetrics and Gynecology may be interested in pursuing a FPD in breast surgery, these candidates must demonstrate completion of an SSO/ASBrS sponsored breast surgery fellowship. Current guidelines and case requirements for obstetrics and gynecology (OB-GYN) residency training do not mandate completion of any breast surgery cases during training. Further, only a small number of basic breast principles are included in the overall goals and objectives expected to be covered in an OB-GYN residency or gynecologic oncology fellowship. These requirements alone are not considered sufficient to warrant eligibility for FPD in breast.

Similarly, those physicians holding a plastic surgery specialty certificate may also be interested in pursuing an FPD in breast surgery. These candidates who have completed a traditional plastic surgery fellowship after at least 5 years of general surgery residency and are ABS board certified with an active certificate in good standing may seek FPD in breast surgery via the practice pathway. Although, physicians holding plastic surgery specialty certificates attained through the completion of an accelerated (3 general surgery and 3 plastic surgery post graduate years) or integrated (0/6 post graduate years) plastic surgery training program may be interested in pursuing an FPD in breast surgery, these candidates must also demonstrate completion of an SSO/ASBrS sponsored breast surgery fellowship.
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

Current guidelines and case requirements for integrated plastic surgery residencies do not mandate completion of any specific breast surgery oncology cases (instead minimum case requirements stratify only the completion of a minimum number of any cancer case) nor do they require education on other benign breast health conditions like nipple discharge, fibrocystic disease, hereditary breast cancer risks, or high risk breast lesions. Further, these candidates are not eligible for certification by the ABS. Therefore, these requirements alone are not considered sufficient to warrant eligibility for FPD in breast surgery.

Common program requirements for the SSO/ASBrS breast surgery fellowships allow for candidates completing general surgery or OB-GYN residencies or gynecologic oncology or plastic surgery fellowships to apply for breast surgery fellowship. At present, 18 breast fellowship programs will accept/have accepted OB-GYN graduates and 6 will accept plastic surgery graduates. To date, 12 OB-GYN/gynecologic oncology trainees and 1 plastic surgery fellow have been trained in breast fellowships.

10b. **Clinical practice (both in terms of time and patient volume) in the area of focused practice beyond initial training**

For initial breast FPD application, candidates may seek approval through three pathway options.

1. **Practice pathway**—candidates seeking approval through the practice pathway must:
   a. Document care for 45 unique breast patients annually or an annualized average of at least 45 breast patients per year over the previous consecutive 3 years. Of the 45 breast patient experiences,
      i. The surgeon must complete a minimum of 25 breast surgical cases annually of which at least 15 must have a cancer diagnosis. Benign conditions (i.e. discordant biopsy, recurrent subareolar abscess, nipple discharge, enlarging fibroadenoma, excision of atypical ductal hyperplasia, surgical management of genetic predisposition to breast cancer) may constitute the remaining 10 surgical procedures. Indications/diagnosis and surgical procedure should be recorded by ICD 10 and CPT codes.

      1. The 15 cancer cases must include at least 5 axillary procedures, and a mix of both breast conserving and mastectomy procedures with no fewer than 3 cases in an individual category (mastectomy, lumpectomy, axillary) averaged annually.
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

2. Only one surgical procedure per patient can be counted towards the index minimum 75 surgical cases over 3 years (i.e., a modified radical mastectomy can count as either a mastectomy or axillary dissection, a bilateral mastectomy with sentinel node biopsy can count as either a single breast or sentinel node case, a bilateral prophylactic mastectomy can count for a single benign mastectomy).

ii. If desired by the surgeon, the remaining 20 of 45 annual experiences may be fulfilled through non-operative patient management for: genetics counseling discussion, calculation and counseling on risk reduction and management of high-risk status, non-operative management of breast abscess, management of granulomatous mastitis, management of breast pain, nipple discharge evaluation and work up, cyst aspiration/management, management of fibroadenoma, or management of breast disease in pregnancy.

iii. Thus at 3 years, the applicant demonstrates 135 breast patient experiences with at least 75 surgical procedures (minimum 45 cancer care surgeries), and 60 non operative encounters.

b. Alternatively, surgeons performing more surgical procedures for malignant diagnoses may use these to offset the number of benign non-operative encounters if they choose (i.e. could potentially have up to 135 cancer procedures to fulfill FPD criteria depending on one’s practice)

c. Complete a minimum of 3 years in clinical practice

2. SSO/ASBrS breast surgical oncology fellowship pathway—candidates seeking approval through the breast surgery fellowship pathway must:
   a. satisfy criteria as listed in 1a or b as stated above in the practice pathway with the below modification
      i. May count up to 25 surgical cases from fellowship towards the initial 3 year surgical case requirement.
   b. Demonstrate an independent clinical practice with a focus in breast surgery. They may include the length of their fellowship towards their focused practice clinical practice requirement (i.e. may apply after 2 years of independent clinical practice).

3. CGSO fellowship pathway—candidates seeking approval through the CGSO fellowship pathway must:
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

a. Satisfy criteria as listed in 1a or b as stated above in the practice pathway with the below modification
   i. May count up to 25 surgical cases from fellowship towards the 3 year surgical case requirement

b. Demonstrate an independent clinical practice with a focus in breast surgery. They may include the length of their fellowship towards their focused practice clinical practice requirement (i.e. may apply after 1 year of independent clinical practice).

10c. Additional qualifications (if any):
For initial application, candidates must also:

1. Complete the ABS breast-specific continuous certification module if continuous certification is due prior to FPD application.

2. Demonstrate ongoing participation in breast-specific education as evidenced by completing a minimum number of breast-specific AMA PRA Category 1™ Credit in the prior 3 years. Those entering via the:
   a. Practice pathway must log 38 breast-specific CME credits (this constitutes 50% of 75 AMA PRA Category 1™ Credit assuming current continuous certification requires 125 CME in 5 years).
   b. Fellowship pathway (breast or CGSO) must log 25 breast-specific AMA PRA Category 1™ Credit.

3. Participate in a quality registry that is either institutionally designated or individually reported. Acceptable quality programs include:
   a. NCI designated Comprehensive Cancer Center.
   b. American College of Surgeons Commission on Cancer certification.
   c. American College of Surgeons NAPBC accredited center.
   d. National Quality Measures for Breast Centers (NQMBC) via the National Consortium of Breast Centers (NCBC) either as a Certified Quality Breast Center or Certified Quality Breast Center of Excellence. Candidates may also individually participate in the Surgeon Program of the NQMBC if institutional limitations preclude participation as a center.
   e. Mastery of Breast Surgery via the ASBrS which allows for individual reporting and tracking of outcomes as well as benchmarking to national standards.

11. With regard to Board-based assessment for candidates prior to awarding this area of focused practice, which assessment methods will be required (check all that apply):
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

a. Examinations
   a. Written: YES
   b. Oral/practical: NO
   c. Other: NO
b. Participation in a registry: YES
c. Submission and review of case logs: YES
d. Review of patient charts: NO
e. Other: demonstrate participation in and attendance at a weekly or biweekly multidisciplinary tumor board, demonstration of commitment to education in breast care.

Describe the rationale behind the methods required in the assessment process.

A. Written exam: Candidates for a focused practice designation in breast will be required to pass a written examination that will be developed by a breast committee within the ABS. The examination will be administered at a secure testing center. Existing breast self-assessment (BESAP) can serve as the foundation for the written FPD exam. The test will be subjected to standard psychometric evaluation by the ABS psychometricians. This test will be designed to ensure a minimum level of breast specific medical knowledge.

B. Registry: FPD applicants will be expected to benchmark their outcomes through individual participation in a quality registry (NQMBC or Mastery of Breast Surgery via the ASBrS) or through institutional participation in a national quality program (NAPBC, CoC, NQMBC, NCI Cancer Center of Excellence). The aforementioned quality resources emphasize similar measures defining high quality, multidisciplinary breast care and defining operative principles relevant to both benign and malignant conditions (i.e., diagnosis by needle biopsy, localization techniques, orienting surgical specimens, value of specimen x-ray, sentinel node biopsy as standard axillary assessment, radiation therapy after breast conservation, use of antiestrogen therapy, rate of breast conservation surgery, etc.). The overlap in the metrics between these registries and programs establish minimum standards of practice for high volume breast focused surgeons. Although these registries and programs vary in how they define the minimal compliance rate, they all allow for benchmarking individual outcomes or program outcomes to other surgeons/programs nationally. This benchmarking allows for active and often real time opportunity for quality improvement. Further, participation in these mechanisms will ensure not only delivery of high quality of care but will also ensure a minimum standard of coordinated care among the multidisciplinary specialties critical for managing patients with high risk but benign conditions and cancer.
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

(radiology, surgery, medical oncology, radiation oncology). Active involvement in quality metrics aims to eliminate or at least minimize disparities in breast care.

C. Case logs: Although diplomates applying for FPD in breast will not be expected to have completed subspecialty training, it is expected that they demonstrate breast surgery to be a significant portion of their practice. Initial application should include review of submitted case logs to ensure applicants demonstrate experience with a variety of breast surgical diagnoses and procedures including lumpectomy for benign conditions, lumpectomy for breast conservation, mastectomy (conventional, skin sparing, nipple sparing), sentinel node biopsy, and axillary dissection. Applicants should log some cases in each broad surgical case category with no fewer than 3 cases per category (i.e. not all can be breast conservation, must have experience with axillary dissection, etc.) and provide the diagnosis/indication for surgery. Criteria for specific cases according to pathway are listed in 5b above.

D. Other/multidisciplinary team: It is clear that the highest quality of care for breast patients occurs in the multidisciplinary setting. This can be difficult to document granularly in a practice setting outside of training or fellowship. However, documentation of the diplomate’s attendance and participation in weekly or biweekly institutional multidisciplinary tumor boards will be used as a surrogate marker for multidisciplinary care for applicants. Participation in virtual tumor boards with participating local or regional hospitals where patient care will be managed is acceptable.

E. Other/breast-specific CME: A significant challenge in breast care is the assimilation of high volumes of published multidisciplinary data and the ability to understand the impact of surgical decisions on future benign and high risk counseling and surveillance follow as well as the impact of surgical decisions on both medical oncology and radiation oncology cancer treatment decisions. For this reason, diplomates should demonstrate participation in a minimum number of breast-specific CMEs as outlined in 5c above.

12. Please outline the Maintenance of Certification (MOC) program planned for this area of focused practice:

All diplomates must be board certified by the American Board of Surgery or have an acceptable companion specialty board certificate. They must also maintain and fulfill the requirements of the ABS Continuous Certification Program including 125 AMA PRA Category 1™ Credit every 5 years of which at least 60 are breast-focused. Participation includes taking the continuous certification examination every two years with 20 general surgery questions and 20 breast related questions for those attaining FPD via the practice
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

or breast fellowship pathways. For those approved for FPD via the CGSO pathway at least one of the two MOC examinations (assuming 2 continuous certification cycles in 5 years) over a 5 year MOC cycle must include the ABS breast module.

Case logs should be submitted at the time of re-certification every five years. Case logs may be randomly audited for accuracy. Focused Practice Designees will be expected to maintain the minimum 45 annual breast patient experience case clinical volume averaged annually over 5 years.

Diplomates are also required to demonstrate ongoing participation in an approved quality program as outlined above (see 5c).

13. Please indicate how the proposed area of focused practice will be evaluated periodically (e.g. every five years) to assure that the area of focused practice remains viable:
Because the field of breast diseases is rapidly changing, the breast FPD would be evaluated every five years. Diplomates must submit documentation of sustained performance of average annual practice volumes as outlined above (see item #7). The criteria used to define FPD should be continually evaluated by the proposed breast subcommittee of the ABS who also aids in creation and execution of the initial written exam for FPD. This group can also assist in monitoring adherence or auditing FPD recipients as needed.

14 - Provide an anticipated timeline for when your Board will assess candidates and when your Board will begin issuing this designation.
Approval process: 2023-24
Initial written exam for candidates: 2025
Initial designation awarded: 2025
Renewal every five years thereafter

15. Please list key stakeholder groups from which the ABMS may wish to solicit commentary on the proposed area of focused practice:
Complex General Surgical Oncology (CGSO) subspecialty board
Society of Surgical Oncology (SSO)
American Society of Breast Surgeons (ASBrS)
American College of Obstetrics and Gynecology (ACOG)
American College of Surgeons including the National Accreditation of Programs in Breast Cancer (NAPBC) and the Commission on Cancer
American Society of Clinical Oncology (ASCO)
American Society for Radiation Oncology (ASTRO)
American College of Radiology (ACR)
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American College of Surgeons (ACS)

TO BE COMPLETED FOR AREAS OF FOCUSED PRACTICE FOR WHICH FORMALIZED TRAINING IS CURRENTLY AVAILABLE TO MEET SOME OF THE REQUIREMENTS FOR CLINICAL EXPERIENCE AND PATIENT VOLUME:

16. Please provide the following information for those training programs that have a primary educational effort devoted to the proposed area of focused practice, along with their geographic locations and the source(s) of the data:

   a. Please list the names of training programs in the proposed area of focused practice:

<table>
<thead>
<tr>
<th>Breast Surgical Oncology Fellowship Programs</th>
<th>Complex General Surgical Oncology (CGSO) Fellowship Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegheny General Hospital – Pittsburgh, PA</td>
<td>Cedars-Sinai Medical Center Fellowship in Complex Surgical Oncology – Los Angeles, CA</td>
</tr>
<tr>
<td>Anne Arundel Medical Center – Annapolis, MD</td>
<td>City of Hope National Medical Center – Duarte, CA</td>
</tr>
<tr>
<td>Baylor Scott &amp; White Health – Dallas, TX</td>
<td>Massachusetts General/Brigham/Dana-Farber CancerCare – Boston, MA</td>
</tr>
<tr>
<td>BreastCare Center, Beth Israel Deaconess Medical Center – Boston, MA</td>
<td>Duke University Medical Center – Durham, NC</td>
</tr>
<tr>
<td>Mount Sinai West and Mount Sinai Chelsea – New York, NY</td>
<td>Fox Chase Cancer Center – Philadelphia, PA</td>
</tr>
<tr>
<td>The Breast Health Center Program in Women’s Oncology/Women and Infants Hospital – Providence, RI</td>
<td>H. Lee Moffitt Cancer Center and Research Institute at the University of South Florida – Tampa, FL</td>
</tr>
<tr>
<td>The Bryn Mawr Hospital – Bryn Mawr, PA</td>
<td>Icahn School of Medicine at Mount Sinai – New York, NY</td>
</tr>
<tr>
<td>Carolinas Medical Center – Charlotte, NC</td>
<td>Jackson Memorial Hospital/ University of Miami – Miami, FL</td>
</tr>
<tr>
<td>Cedars-Sinai Medical Center – Los Angeles, CA</td>
<td>St. John’s Cancer Institute – Santa Monica, CA</td>
</tr>
<tr>
<td>Christiana Care Health System – Newark, DE</td>
<td>Johns Hopkins Hospital and Sidney Kimmel Cancer Center – Baltimore, MD</td>
</tr>
<tr>
<td>City of Hope – Duarte, CA</td>
<td>Loma Linda University Health – Loma Linda, CA</td>
</tr>
<tr>
<td>Cleveland Clinic Akron General – Akron, OH</td>
<td>*McGill University Surgical Oncology Fellowship Program – Montreal, Quebec, Canada</td>
</tr>
<tr>
<td>The Cleveland Clinic Foundation – Cleveland, OH</td>
<td>Medical College of Wisconsin – Milwaukee, WI</td>
</tr>
<tr>
<td>Columbia-Presbyterian Medical Center – New York, NY</td>
<td>Memorial Sloan-Kettering Cancer Center – New York, NY</td>
</tr>
<tr>
<td>Duke University Medical Center – Durham, NC</td>
<td>Ohio State University Wexner Medical Center – Columbus, OH</td>
</tr>
<tr>
<td>Emory University School of Medicine – Atlanta, GA</td>
<td>Roger Williams Medical Center and Cancer Center – Providence, RI</td>
</tr>
<tr>
<td>Fox Chase Cancer Center – Philadelphia, PA</td>
<td>Roswell Park Cancer Institute – Buffalo, NY</td>
</tr>
<tr>
<td>Georgetown University Hospital Breast Oncology Fellowship Program – Washington, DC</td>
<td>Rutgers Robert Wood Johnson Medical School/Rutgers Cancer Institute of New Jersey – New Brunswick, NJ</td>
</tr>
<tr>
<td>H. Lee Moffitt Cancer Center and Research Institute – Tampa, FL</td>
<td>*University of British Columbia – Vancouver, Canada</td>
</tr>
<tr>
<td>Indiana University School of Medicine Breast Fellowship – Indiana</td>
<td>*University of Calgary – Calgary, Alberta, Canada</td>
</tr>
<tr>
<td>Jackson Memorial Hospital/ University of Miami – Miami, FL</td>
<td>University of Chicago– Chicago, IL</td>
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<tr>
<td>Johns Hopkins Hospital – Baltimore, MD</td>
<td>University of Louisville James Graham Brown Cancer Center – Louisville, KY</td>
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<tr>
<td>Institution</td>
<td>University</td>
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<tr>
<td>Maimonides Medical Center – Brooklyn, NY</td>
<td>University of New Mexico – Albuquerque, NM</td>
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<tr>
<td>Massachusetts General Hospital, Dana-Farber Cancer Institute and Brigham and Women’s Hospital – Boston, MA</td>
<td>University of North Carolina Chapel Hill – Chapel Hill, NC</td>
</tr>
<tr>
<td>Mayo Clinic – Rochester, MN</td>
<td>*University of Ottawa – Ottawa, Canada</td>
</tr>
<tr>
<td>Memorial Sloan-Kettering Cancer Center – New York, NY</td>
<td>University of Pittsburgh Medical Center– Pittsburgh, PA</td>
</tr>
<tr>
<td>Mount Sinai Medical Center – Dubin Breast Center Breast Surgery Fellowship – New York, NY</td>
<td>University of Texas MD Anderson Cancer Center – Houston, TX</td>
</tr>
<tr>
<td>New York University Langone Medical Center – New York, NY</td>
<td>University of TN Health Science Center &amp; West Cancer Center – Memphis, Tennessee</td>
</tr>
<tr>
<td>Northwestern University Feinberg School of Medicine – Chicago, IL</td>
<td>*University of Toronto – Toronto, Ontario, Canada</td>
</tr>
<tr>
<td>OhioHealth Grant Medical Center – Columbus, OH</td>
<td>University of Wisconsin School of Medicine and Public Health – Madison, WI</td>
</tr>
<tr>
<td>Roswell Park Cancer Institute – Buffalo, NY</td>
<td>Virginia Commonwealth University Medical Center – Richmond, VA</td>
</tr>
<tr>
<td>Rutgers Cancer Institute of New Jersey – New Brunswick, NJ</td>
<td>Wake Forest University– Winston-Salem, NC</td>
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<tr>
<td>Stanford University School of Medicine – Stanford, California</td>
<td>Advocate Aurora Health – Milwaukee, WI</td>
</tr>
<tr>
<td>Texas Tech University Health Science Center (TTUHSC) – Lubbock, TX</td>
<td>Allegheny Health Network – Pittsburgh, PA</td>
</tr>
<tr>
<td>UCLA Breast Fellowship Program – Los Angeles, CA</td>
<td>Stanford University – Stanford, CA</td>
</tr>
<tr>
<td>University of Alabama at Birmingham (UAB) Health System– Birmingham, AL</td>
<td>University of California – Irvine – Orange, CA</td>
</tr>
</tbody>
</table>
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| University of California at San Francisco Breast Care Center – San Francisco, CA | Zucker School of Medicine at Hofstra/Northwell – New Hyde Park, NY |
| University of Iowa – Iowa City, IA | Emory University – Atlanta, GA |
| University of Kansas – Kansas City, KS | |
| University of Michigan – Ann Arbor, MI | |
| University of Pennsylvania Breast Cancer Fellowship – Philadelphia, PA | |
| UPMC Hillman Cancer Center and Magee-Womens Hospital of UPMC – Pittsburgh, PA | |
| University of Southern California (USC), Keck School of Medicine (Norris Cancer and University Hospitals) and Hoag Memorial Hospital – Los Angeles, CA | |
| University of Texas MD Anderson Cancer Center – Houston, TX | |
| University of Texas Southwestern Center for Breast Care – Dallas, TX | |
| University of Toronto – Toronto, Canada | |
| Vanderbilt University Medical Center – Nashville, TN | |
| Washington University School of Medicine – St. Louis, MO | |
| West Cancer Center – Memphis, Tennessee | |
| William Beaumont Hospital, Comprehensive Breast Care Program – Royal Oak, MI | |
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

<table>
<thead>
<tr>
<th>Institution</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Winthrop P. Rockefeller Cancer Institute at University of Arkansas for Medical Sciences – Little Rock, AR</td>
<td></td>
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<tr>
<td>Yale Interdisciplinary Breast Fellowship – New Haven, CT</td>
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<tr>
<td>UMMS – Baystate Health – Springfield, MA</td>
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<tr>
<td>Henry Ford Hospital – Detroit, MI</td>
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<tr>
<td>Advocate Christ Medical Center – Oak Lawn, IL</td>
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<tr>
<td>Montefiore Medical Center – Bronx, NY</td>
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<tr>
<td>Northshore University Health System – Evanston, IL</td>
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<tr>
<td>University of Rochester – Rochester, NY</td>
<td></td>
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<tr>
<td>Montefiore Medical Center – Bronx, NY</td>
<td></td>
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<tr>
<td>Cooper University – MD Anderson Cancer Center at Cooper – Camden, NJ</td>
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<tr>
<td>Inova Schar Cancer Institute – Fairfax, VA</td>
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<tr>
<td>The Ohio University Wexner Medical Center – Columbus, OH</td>
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<tr>
<td>Saint John’s Cancer Center Institute – Santa Monica, CA</td>
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</tbody>
</table>

b. **Please indicate the total number of trainee positions available currently (along with any source(s) of data):**

As of May 2022:
Breast Surgical Oncology Fellowship Positions Available: 86
CGSO Fellowship Positions Available: 73

Source: SSO Internal Records
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

c. Provide the number of trainees completing the training annually (along with the source(s) of the data):

![Graduating Breast Surgical Oncology Fellows per academic year](chart1)

![Graduating CGSO Surgical Oncology Fellows per year Number of Graduating Fellows](chart2)

Source: SSO Internal Records

d. Organization(s) providing accreditation or oversight for the training programs (please submit evidence that they have the willingness, capability, and resources to conduct the review of these programs):
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

The SSO and the ASBrS jointly provide oversight for approval and management of the Breast Surgical Oncology Fellowship programs. The SSO Training Committee is charged with “Coordination of the overall educational activities of the SSO as it pertains to fellowship training programs, management of all aspects of the breast oncology fellowship training programs for the SSO, and maintenance of a leadership role with the complex general surgical oncology training programs (ACGME).” The SSO Training Committee is comprised of 22 members which includes an official ASBrS representative. This committee and ASBrS representatives also serve as the on-site review committee that conducts site visits and reviews all intra-cycle documentation submitted by any approved Breast Surgical Oncology Fellowship program or prospective programs.

Furthermore, the SSO has a Breast Surgical Oncology Fellowship Program Director subcommittee that is comprised of Program Directors of all approved programs. This group meets twice per year and serves as a communication forum for the Breast Surgical Oncology Fellowship training programs. Additionally, they help to provide educational opportunities to the current fellows (e.g. quarterly Breast Fellows webinars on a variety of topics, develop the educational outline for the hands-on Fellows Institute and didactic Fellows Institute II), assist with the oversight of the yearly match calendars, and identify opportunities for improvement within the programs, and more.

The Training Committee meets quarterly to review current and prospective Breast Surgical Oncology Fellowship programs and additional information pertaining to those programs including a regular review of the Curriculum and Minimum Training Requirements, Breast Fellowship and Breast Fellow policies, the Breast Surgical Oncology matching program, and other relevant items.

As of late 2022, the SSO will launch a web-based centralized database that will be the main repository for all Breast Surgical Oncology fellowship program documents, historical data, applications, and reviews. This database will also allow programs to submit all intra-cycle documentation online through the system, eliminating the need for paper or email submission and tracking.

SSO currently has 1.50 FTE staff to handle all aspects of the management of the Breast Surgical Oncology fellowship programs.

17. How much additional clinical experience is required beyond training?
The applicant for a breast FPD must attain board certification by the American Board of Surgery and must have completed a minimum of three years of practice after a general
American Board of Surgery Application for Focused Practice Designation in Comprehensive Breast Surgery

surgery residency, two years in practice after a breast surgery fellowship, or one year after CGSO fellowship (additional criteria are listed in sections 5a–c and 6 above).

NOTE: WHEN SUBMITTING THE APPLICATION, PLEASE INCLUDE THE FOLLOWING ITEMS:

- Copy of proposed application form for candidates for this area of focused practice.
- A written statement indicating concurrence or specific grounds for objection for each Primary and Conjoint Boards having expressed related interests in the same field.
- Written comments on the proposed area of focused practice from at least one (1) public stakeholder group
- An example of how the diplomates will be recognized for the area of focused practice.
Proposed ABS application or potential applicants

ABS Application for Designation of Focused Practice in Comprehensive Breast Surgery

SECTION 1: PERSONAL DATA

Please enter your name.

NAME: First, Middle, Last, and Medical Degree

Date of Birth:

☐ Home Address:

Home Telephone:

Email Address:

☐ Business Address:

Business Telephone:

Fax:

Medical School Graduation Year:

Individual National Provider Number:

AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) BOARD CERTIFICATION:

List below all your ABMS primary and subspecialty certifications.

<table>
<thead>
<tr>
<th>Specialty/Subspecialty</th>
<th>Board that Issued Certificate</th>
<th>Certification Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

☐ I attest that I am Board certified by the American Board of Surgery
SECTION 2: MEDICAL LICENSURE

Please provide the following information regarding your license(s) to practice medicine. If you answer “No” to the question on compliance with the enclosed Policy on Medical Licensure, please use a separate sheet to explain.

<table>
<thead>
<tr>
<th>List all states, territories, or provinces in which you hold a medical license</th>
<th>License Number</th>
<th>Expiration Date (mm/dd/yy)</th>
<th>Is this license in compliance with the ABS Policy on Medical Licensure?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>YES</td>
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<td></td>
<td>YES</td>
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<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

SECTION 3: SELECTION OF APPLICATION PATHWAY

Please select one application pathway.

- [ ] Training-Plus-Practice Pathway
- [ ] Practice Pathway

Complete Section 3A

Complete Section 3B

SECTION 3A: Breast Surgery TRAINING-PLUS-PRACTICE PATHWAY

Complete this section if you selected the Training-plus-Practice Pathway.

TRAINING REQUIREMENT: You must have successfully completed at least 12 months of acceptable fellowship training in Breast Surgery

Select Fellowship Pathway:

- [ ] SSO/ASBrS breast surgical oncology fellowship pathway
- [ ] CGSO fellowship pathway

Name and Institution of the Fellowship Training Program:

Name of Fellowship director and contact information:

Address: [ ] City/State:

Month/Day/Year of training:
Note: ABS will independently verify with your fellowship program director that you successfully completed all program requirements and that the program is acceptable.

PRACTICE REQUIREMENT within the Training-Plus-Practice Pathway

Enter information about your Breast Surgery practice below. ABS will independently verify the practice(s) you list in this application.

1. Duration of your Breast Surgery practice.
To report your practice of Breast Surgery, identify at least three years (36 months) when you practiced Breast Surgery.

The two years do not need to be contiguous.
My two or more years of Breast Surgery practice are not contiguous.

<table>
<thead>
<tr>
<th>The start date:</th>
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Practice Address:
City/State/Zip:

Phone: Email: Fax:

SECTION 3B: Breast Surgery PRACTICE-ONLY PATHWAY

Complete this section if you selected the Breast Surgery Practice-only Pathway.

PRACTICE REQUIREMENT

Enter information about your Breast Surgery practice below. ABS will independently verify the practice(s) you list in this application.

1. Duration of your Breast Surgery practice.
To report your practice of Breast Surgery, identify at least three years (36 months) when you practiced Breast Surgery.
The two years do not need to be contiguous. My three or more years of Breast Surgery practice are not contiguous.

The start date:
Month/Day/Year

The end date:
Month/Day/Year

Technical competence in performing Breast Surgery

☐ I attest that I have technical competence in performing Breast Surgery

SECTION 4. Clinical practice knowledge and expertise

I attest that I have satisfactory expertise in the following:

☐ A total of 45 unique Breast cases are required over 3 years (Practice Pathway).

1. The surgeon must complete a minimum of 25 breast surgical cases annually of which at least 15 must have a cancer diagnosis. Benign conditions (i.e., discordant biopsy, recurrent subareolar abscess, nipple discharge, enlarging fibroadenoma, excision of atypical ductal hyperplasia, surgical management of genetic predisposition to breast cancer) may constitute the remaining 10 surgical procedures. Indications/diagnosis and surgical procedure should be recorded by ICD 10 and CPT codes.
   a. The 15 cancer cases must include at least 5 axillary procedures, and a mix of both breast conserving and mastectomy procedures with no fewer than 3 cases in an individual category (mastectomy, lumpectomy, axillary) averaged annually.
   b. Only one surgical procedure per patient can be counted towards the index minimum 75 surgical cases over 3 years (i.e. a modified radical mastectomy can count as either a mastectomy or axillary dissection, a bilateral mastectomy with sentinel node biopsy can count as either a single breast or sentinel node case, a bilateral prophylactic mastectomy can count for a single benign mastectomy).

2. If desired by the surgeon, the remaining 20 of 45 annual experiences may be fulfilled through non-operative patient management for: genetics counseling discussion, calculation and counseling on risk reduction and management of high-risk status, non-operative management of breast abscess, management of granulomatous mastitis, management of breast pain, nipple discharge evaluation and work up, cyst aspiration/management, management of fibroadenoma, or management of breast disease in pregnancy.
3. Thus at 3 years, the applicant demonstrates 135 breast patient experiences with at least 75 surgical procedures (minimum 45 cancer care surgeries), and 60 non operative encounters.

4. Alternatively, surgeons performing more surgical procedures for malignant diagnoses may use these to offset the number of benign non-operative encounters if they choose (i.e. could potentially have up to 135 cancer procedures to fulfill FPD criteria depending on one’s practice)
   a. Complete a minimum of 3 years in clinical practice

For initial application, candidates must also:

1. Complete the ABS breast-specific continuous certification module if continuous certification is due prior to FPD application.

2. Demonstrate ongoing participation in breast-specific education as evidenced by completing a minimum number of breast-specific *AMA PRA Category 1<sup>TM</sup> Credit* in the prior 3 years. Those entering via the:
   a. Practice pathway must log 38 breast-specific CME credits (this constitutes 50% of 75 AMA PRA Category 1<sup>TM</sup> Credit assuming current continuous certification requires 125 CME (or on average 25 CME annually) in 5 years).
   b. Fellowship pathway (breast or CGSO) must log 25 breast-specific *AMA PRA Category 1<sup>TM</sup> Credit*.

3. Maintain membership in a minimum of one national society with emphasis on continuing education in breast cancer and breast disease (SSO, ASBrS, NCoBC).

4. Participate in some type of quality registry that is either institutionally designated or individually reported. Acceptable quality programs include:
   a. NCI designated Comprehensive Cancer Center.
   b. American College of Surgeons Commission on Cancer certification.
   c. American College of Surgeons NAPBC accredited center.
   d. National Quality Measures for Breast Centers (NQMBC) via the National Consortium of Breast Centers (NCBC) either as a Certified Quality Breast Center or Certified Quality Breast Center of Excellence. Candidates may also individually participate in the Surgeon Program of the NQMBC if institutional limitations preclude participation as a center.
   e. Mastery of Breast Surgery via the ASBrS which allows for individual reporting and tracking of outcomes as well as benchmarking to national standards.
- A total of 45 unique Breast cases are required over 3 years (fellowship training)

  a. SSO/ASBrS breast surgical oncology fellowship pathway:
     i. satisfy criteria as listed in 1a or b as stated above in the practice pathway with
        the below modification
        1. May count up to 25 surgical cases from fellowship towards the initial 3
           year surgical case requirement.
     ii. Demonstrate an independent clinical practice with a focus in breast surgery.
         They may include the length of their fellowship towards their focused practice
         clinical practice requirement (ie may apply after 2 years of independent clinical
         practice).

  b. CGSO fellowship pathway
     i. Satisfy criteria as listed in 1a or b as stated above in the practice pathway with
        the below modification
        1. May count up to 25 surgical cases from fellowship towards the 3 year
           surgical case requirement
     ii. Demonstrate an independent clinical practice with a focus in breast surgery.
         They may include the length of their fellowship towards their focused practice
         clinical practice requirement (ie may apply after 1 year of independent clinical
         practice).
August 23, 2022

Jo Buyske, MD
President and Chief Executive Officer
American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103 USA

Dear Dr. Buyske,

The American Society of Breast Surgeons strongly supports the application for a Focused Practice Designation in Breast Surgery. The practice of Breast Surgery and the management of patients with Breast Cancer has and continues to evolve rapidly. This evolution is resulting in higher survival rates with lower morbidity and improved clinical as well as psychosocial outcomes. Improvement has come with the advent of multidisciplinary care, newer surgical developments such as Oncoplastics or nipple sparing techniques, in addition to incorporation of neo adjuvant chemo or endocrine therapy approaches. Despite the advent of such specialized care, we are seeing disparate outcomes and, in some regions, wider gaps in care. This can be multifactorial, but we know that patients receiving care by surgeons that focus on breast are far more likely to receive this higher-level multidisciplinary care and see improved outcomes.

In addition, surgeons leading teams in their communities and interested in heading Breast Centers or Cancer Programs would benefit if they are able to have a Focused Practice Designation recognizing their extra level of commitment to the management of Breast cancer and breast diseases. We hope that the recognition of Breast as a Focused Practice will also encourage surgeons that are performing occasional breast surgery to stay current with newer techniques and level up. An additional benefit of the Focused Practice Designation is for our patients. It will allow patients to choose a surgeon that is committed to breast care be they general surgeon, breast fellowship or Surgical oncology fellowship trained. For general surgeons with breast expertise, it will allow them to stand firm in competitive markets. We believe the move to FPD will ideally improve the quality of Breast care and subsequent outcomes for patients nationwide. We wholeheartedly support this application.

Sincerely,

Nathalie Johnson, MD, DHL, FACS
President, American Society of Breast Surgeons

CC Anne Campbell Larkin, MD, FACS
Vice Chair, Complex General Surgical Oncology Board
Councilor, American Board of Surgery
April 18, 2023

Jo Buyske, MD
President and Chief Executive Officer
American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103

Dear Dr. Buyske,

I am writing on behalf of The Arkansas Cancer Coalition (ACC), Arkansas’ statewide comprehensive cancer control partnership and a network of cancer control members and organizations united around reducing the human suffering and economic burden from cancer for the citizens. Moreover, our mission is always to ensure that men and women have access to specialists that make an extremely critical difference in their care.

According to the National Breast Cancer Foundation, Inc., one in eight women will develop breast cancer. Breast cancer is the most common cancer in women and the second leading cause of cancer death in women in the United States.

Our team strongly supports the American Board of Surgery’s intent to file an application for focused practice in Breast Surgery. The purpose of the proposed focused practice designation (FPD) in breast surgery is to improve the long-term health and quality of care delivered to patients with breast diseases including the management and treatment of patients with benign, high risk, and hereditary breast cancer risks/conditions, and cancer. This high quality multidisciplinary care is best delivered by surgeons who have additional surgical expertise and dedicate a significant percentage of their practice to the comprehensive care of these patients.

The evidence that the practice of general surgery recognizes the need for specialty breast surgeons includes the establishment of more breast surgery fellowships with clear curricula and oversight, the creation and maintenance of a dedicated Breast Education Self-Assessment Program, nationally available educational opportunities and CME institution led events. Moreover, it’s important to recognize general surgeons whose expertise is breast disease.

We submit this letter of support to a cause that not only shapes the way we care for patients but also a cause that affects the lives of countless men and women.

Sincerely,

Trena Mitchell
Executive Director
Arkansas Cancer Coalition
Dear Dr. Buyske,

I am writing on behalf of Pink Revolution, which is a breast cancer patient advocacy group in Central Massachusetts. The role of Pink Revolution is to provide support, education and resources for patients diagnosed with breast cancer.

Pink Revolution has been informed of the Board's intent to file an application for focused practice in Breast Surgery. I have had the opportunity to review the goals and anticipated outcomes of this designation, and on behalf of the organization, I strongly support it.

Breast cancer patients across the country and here in New England will truly benefit from this designation in terms of empowering them to make decisions based on a full breadth of knowledge about what a surgeon does and where they concentrate their efforts. It will give patients a sense of confidence that their surgeon performs a lot of breast cases, takes care of many different kinds of breast patients, is required to stay on top of the latest literature, and has access to a team of caregivers around them. During a time of great anxiety and fear, patients will be able to rest assured knowing that their surgeon has done what it takes to receive such a designation. My group sees this first hand as we place certified volunteers in our local breast center on team day with a breakfast cart. Patients get a warm embrace and few items that they might need. One of the things we tell them is that they are in the right place as their doctors are specialists in their field. The relief on their face is palpable.

As a long time cancer advocate I honestly don’t understand why a designation hasn’t been given to surgeons who train and specialize in a specific field that they have given so much to.

Respectfully,

Audrey Kurlan-Marcy

Audrey Kurlan-Marcy
Cofounder, PINK Revolution
508-873-3600
Dear Dr. Buyske,

I am writing on behalf of Sisters by Choice, an organization that provides countless mammograms and breast exams to uninsured, unemployed, and homeless women each year and provides free educational seminars, workshops, and health fair screenings to promote breast cancer awareness.

Additionally, our vision is to continue providing innovative programs to educate the public about breast cancer, to support men and women diagnosed with breast cancer and their families and to collaborate with our breast health advocacy groups to help eradicate the disease.

My team and I support the application and its purpose for focused practice in Breast Surgery. We understand the purpose of the proposed focused practice designation (FPD) in breast surgery is to improve the long-term health and quality of care delivered to patients with breast diseases including the management and treatment of patients with benign, high risk, and hereditary breast cancer risks/conditions, and cancer.

A breast FPD for surgeons specializing in breast care and surgery would recognize the specific complexities of caring for the subset of patients with benign and malignant disorders of the breast. Specialization in this limited subset of challenging patients would allow the surgeon to focus improvement on the multi-disciplinary setting to establish high quality, efficient, and coordinated care for the patient.

Further, understanding the amount and complexity of rapidly evolving evidence based medicine over multiple specialties is critical to achieving good outcomes in the treatment of benign but common breast diagnoses as well as improve breast cancer prevention and treatment.

Countless breast patients across the country and here in Georgia will benefit significantly from this designation.

It is for these reasons and more that I submit this Letter of Support.

Sincerely,

Dr. Rogsbert Phillips-Reed, M.D., FACS
Sisters by Choice Founder and CEO
August 25, 2022

Jo Buyske, MD
President and Chief Executive Officer
American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103

Dear Dr. Buyske,

On behalf of the Society of Surgical Oncology (SSO), I am pleased to support an application for the Focused Practice Designation (FPD) in Breast Surgery.

The FPD in Breast Surgery will ultimately improve the care for patients with breast disease, including the management of benign and malignant breast conditions. By attaining this designation, and maintaining it by means of continuing education, surgeons caring for breast patients can enhance and validate their comprehensive care of these patients. In addition, surgeons with this designation will champion a multidisciplinary team approach with the goal of delivering high quality, patient-centered breast care.

These goals are in line with our mission and values of the SSO around comprehensive surgical oncology care. We have collaborated with our colleagues at the American Society for Breast Surgeons (ASBrS) to bring this effort forward and are fully supportive of this FPD.

Sincerely,

Sandra L. Wong, MD, MS, FSSO
President, Society of Surgical Oncology

Cc:  

Anne Larkin, MD, FACS, Vice Chair, Complex General Surgical Oncology Board and Councilor, American Board of Surgery
Sarah McLaughlin, MD, FSSO, SSO/ASBrS Breast FPD Taskforce Chair
Anna Polyak, RN, JD, CEO, Society of Surgical Oncology
This Board hereby recognizes that

Jane Doe, M.D.

has demonstrated the necessary clinical experience and has fulfilled all requirements of this Board for a Focused Practice Designation in

COMPREHENSIVE BREAST SURGERY

within the specialty of

SURGERY

Diplomate No. 123456

This designation is valid as long as primary certification is maintained.

Issued May 1, 2019