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EDITORIAL

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Training in minimal access gynaecological surgery

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Abstract Training in minimal access surgery is the source of much discussion in European endoscopy circles. The apprenticeship model of training, long a hallmark of the British medical system, is being replaced by modular training. The European working time directive, reduction in junior doctors' hours, and the need to cover emergency duties are largely driving this change.

Keywords Training · Europe · Minimal access

Training in minimal access surgery is the source of much discussion in European endoscopy circles. The apprenticeship model of training, long a hallmark of the British medical system, is being replaced by modular training. The European working time directive, reduction in junior doctors' hours, and the need to cover emergency duties are largely driving this change. Inevitably, doctors in training are thus rotated through a bewildering number of special interests, clinics, and operating lists, spending little time with a specific consultant with a particular interest. To overcome this situation, the principle of protected teaching time and special training in small groups, whether didactic learning or practical skills, has been developed. Clinical skills labs are being built or modified from defunct anatomy and nurse training areas so that students can practice techniques on models or animal tissue. All specialist registrars (the English specialist training grade 1) now also rotate through a series of hospitals, and training takes place in different hospitals within a region.

The European system is very different, and many doctors never leave the unit in which they work, where there is one department and many specialists—none of whom, however, have ultimate patient responsibility and who themselves rotate through polyclinic, obstetric, or surgical periods on a quarterly or yearly basis. Subspecialisation can occur, but it usually takes place late in training or during the time spent as a specialist. Preferment is at the whim of the department head in a very pyramidal system. Unlike in the United Kingdom, these specialists never have ultimate clinical responsibility, which rests with the Chef de Department or Hauptarzt. How, then, does one offer training that is ultimately practical instruction to aspiring minimal access surgeons?

This question was recently addressed at the European Society for Gynaecological Endoscopy (ESGE) conference in Luxembourg [1] and was the source of much discussion between specialist societies and the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK. At the ESGE conference, various trainers were asked to present talks on the core areas of training that they would cover. As they were speaking to other trainers, however, most of the talks rapidly became complex discussions on the areas of controversy within particular fields rather than exploring the core knowledge that trainees require.

The management of ectopic pregnancy is an example. The European view is that salpingotomy with preservation of the fallopian tube is the preferred method of treatment whenever possible, whereas the RCOG advice is salpingectomy unless the other fallopian tube is damaged [2]. For both treatment methods, the evidence base is far from clear and is based on low-grade evidence. It is likely that different, if unpublished, departmental guidelines exist throughout Europe.

In the UK, routine laparoscopic management of ectopic pregnancy is far from the norm, and one study showed that only 37% of trainees in one English region had ever undertaken laparoscopic surgery for an ectopic pregnancy or had been offered training [3]. Medical management remains the exception rather than the rule. Similar controversies exist within all aspects of minimal access surgery, from the appropriate method of trocar

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insertion (open vs. closed) to the management of adnexal masses and the treatment of early endometriosis.

Modular training is unlikely to address any of these issues but may help with simple practical training. However, it is a major leap of imagination to believe that the ability to unwrap a boiled sweet in a simulator box using laparoscopic instruments or to suture bits of foam rubber in an idealised setting is a good way to learn how to repair ruptured bowel in a puddle of blood. But I suppose one has to start somewhere....

Alternatively, where national regulation allows, "wet" laboratories are set up using what is euphemistically called "the porcine model" (pigs that are subsequently sacrificed). These labs, although not ideal, do allow practice in a more true-to-life situation and are certainly a better model than offal from the local slaughterhouse. The use of a live model probably allows for the development of suitable practical skills. Commercial institutions whose main function is the need to sell their equipment run most of these laboratories, and unless they succeed in sales, they are not commercially viable. Thus, training will always be subject to possible commercial subjugation. There is, however, no doubt that we owe an enormous debt to the instrument makers and our other commercial partners.

But does every doctor in training need to learn these techniques on models rather than under direct supervision in the operating theatre? Most of us did our first laparoscopy under direct supervision, as indeed our first caesarean section, ventouse, or other operative delivery. There is currently no substitute for undertaking surgery under supervision, as close as necessary according to the surgeon's experience, on real patients with real problems: assessing those problems carefully and undertaking the appropriate and well-planned surgery to try to deal with these problems. This does not, of course, mean just turning up to an operating list; it involves careful history-taking, clinical assessment, and examination, as well as obtaining the patient's informed consent. It involves observing how a variety of clinicians deal with different problems, assessing the aggressive and timid approaches to surgery, and looking at the audit of results, where these exist. Most units, though, lack any defined way of assessing the efficacy of their surgeries.

Is the picture really this grim? Are surgeons to be trained on boiled sweets, offal, and expiring pigs before undertaking badly planned surgery on patients they have never encountered off the operating table? Will surgical results remain unmeasured and unaudited unless some surgical crisis intervenes? The answer is possibly "yes" unless we offer proper supervised training to those with aptitude, and that training includes assessment, subsequent surgery, and audit of results. With the coming together of the European endoscopic societies, the launch of a new journal, and enthusiasm, we potentially have the capacity to produce a generation of appropriately skilled and trained surgeons. What is required is the will to do this, and we should look to the relevant specialist societies, both national and international, to develop a well-thought-out, practical, and cohesive training programme. From this foundation, properly controlled and audited studies can be developed to look at the areas of controversy within our subspeciality, such as the place of laparoscopic surgery in pelvic floor repair, the management of advanced endometriosis, and the role of laparoscopy in oncology.

Let us turn away from confusion, controversy, and conflict and look to cohesion through training and well-planned international trials and audit.

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