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EDITORIAL

Perspectives on this issue of the IJS

Surgery is forever changing and will continue to do so. Of the operations which were common when I was a trainee, many are no longer performed, just as those performed by the great surgeons of the past are rarely seen today. Medical treatment has replaced surgery for peptic ulceration, coronary artery stenting is taking over coronary artery bypass grafting, and other methods for treating haemorrhoids means that only the neglected ones need to come to surgery. Operations are far less invasive and it is highly likely they will become even less so in this century. The radical operations to “cut out cancer” such as radical mastectomy and saucer plate very wide local excision for malignant melanoma, have thankfully been replaced. Minimally invasive laparoscopic and thoracoscopic surgery is becoming the norm and may yet be replaced by natural orifice surgery.

Surgeons too have changed, becoming more and more specialised. My father’s operating list would read: gastrectomy, mastectomy, tonsillectomy, removal of bone for osteomyelitis, hysterectomy and then haemorrhoidectomy, with emergencies such as appendicectomy and pleurodesis added on at the end. My own list when I started as a General Surgeon was also very different: thyroidectomy, open cholecystectomy, highly selective vagotomy, varicose vein surgery, femoro-popliteal bypass, wide local excision and split skin graft for malignant melanoma, superficial parotidectomy, hernia operations and trans-thoracic sympathectomy, commonly appearing alongside anterior resection, excision of palmar fascia for Dupuytren’s, orchidopexy and block dissections. In the last few years I have confined my surgery, in the main, to upper GI, skin malignancies and soft tissue tumour work. Is the super specialised surgeon more or less likely to obtain the highest of recognitions, a Nobel Prize? Perhaps the paper looking back “In recognition of the surgical healing strategy” (pp. 129–133) might show us the way.

In 2000 I was invited by the Association of Surgeons in Training to give a plenary lecture on “Surgery in 2025” following my publication of the “Operating Room of The Future” for the UK Department of Health and the Department of Trade and Industry. I advised these aspiring surgeons to enter one of the following specialties: Trauma, Plastic and Aesthetic Surgery, Joint Replacement Surgery, Transplantation, and what one could term Reparative

(Geriatric) Surgery. Cancer, I am convinced will in time be cured by other means – genetics and immunotherapy. Urology, Cardiac Surgery and Otolaryngology will mostly disappear and become medical specialties. This is reflected in the types of articles that will be published this year although, sadly, surgery for solid cancers is still the only treatment.

The bulk of this second issue still deals with main line surgical problems. We are still a craft specialty and therefore it is not surprising to read papers on vascular prostheses comparing new ones to vein grafts (pp. 109–113), or new drugs in the prevention of deep vein thromboses in cancer patients (pp. 114–119). On the cancer front, the vexed question of follow-up for colo-rectal cancer is addressed and patient power is explored asking for patients’ views on sentinel lymph node biopsies in breast cancer (pp. 76–80). Trauma and clinical judgement is still a part of our daily routine so it is not surprising to include articles on appendicitis (pp. 95–98), hand lacerations (pp. 105–108) and blood transfusion (pp. 89–94). Finally, radiology is vital to surgeons, both for anatomy and diagnoses so the paper on the role of PET scans in the early detection of loosening of total knee replacements will be of great interest to all orthopaedic surgeons (pp. 99–104).

Not only surgery but also surgical training has changed dramatically. Gone are the years of apprenticeship; gone the “see one, do one, teach one” fortunately for the patient. There will be increasing use of simulation and virtual reality training. These have excellent attributes but nothing is the same as dealing with patients – the hands-on approach. IPPI’s will be a huge step forward in bridging the gap between simulation and reality.¹ However, the training of a surgeon is not the same as an airline pilot where a simulator and a plane are identical. No dummy or virtual reality machine can replace the responses of patients although, as stated, Integrated Procedural Performance Instrument’s (IPPI’s) will be helpful. Also no virtual reality machine can be equal to a real operation. The article on “How to teach the Teacher to teach the TUR-B” (pp. 81–85) is therefore as important now as it was in the past.

What of the future for surgical journals? Publication for the sole purpose of enhancing a trainee’s portfolio has

always been the case but will it continue? Undoubtedly it will for the next few years of transition of Modernising Medical Careers, which is occurring in the United Kingdom. However, once run-through training is a fact of life research will not play an important part to enter training programmes, and once on a training programme the trainee will be able to continue without doing research providing he/she passes the competencies laid down.

Post-graduate education with the rush in the United Kingdom to implement Modernising Medical Careers will continue to exercise us all, especially in surgery where craft skills must be obtained. Do surgeons in the 21st Century with their service commitments have time to fulfil an educational contract as well? Further funding will have to be found and maybe education divorced more from service provision. Will the new training with its increased specialization and narrowness lead to inability to communicate across the specialties? An interesting paper concerning the indifference between Obstetrician and Paediatrician will address

this aspect in another paper to be published. The future, despite the changes in the type of surgery and how it is learnt and taught, I believe is still rosy. It will be very different but just as challenging and satisfying.

Reference

1. Kneebone R, Nastel D, Yadollahi F, Brown R, Nolan C, Durack J, et al. Assessing procedural skills in context: exploring the feasibility of an Integrated Procedural Performance Instrument (IPPI). *Med Educ* 2006;**40**:1105–14.

R. David Rosin, Editor-in-Chief,
International Journal of Surgery,
Royal College of Surgeons of England,
Praed Street, London W2 1NY, UK
Tel.: +44 207 087 4260.
E-mail address: rdrosin@uk-consultants.co.uk