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Editorial

Editor's perspectives – September 2014

Are we training future Doctors/Surgeons correctly and adequately? It seems to me absurd to teach a medical student from a third world country, who intends to return home after qualifying, how to read a CT or MRI scan, learn about robotic surgery or genetic engineering when none of these will be available to him/her. Teaching a student who intends to be a supra-specialist in Secondary Care about tropical diseases or indeed about General Practice seems equally absurd. Another debate is whether Anatomy should be an undergraduate or postgraduate study. A knee surgeon no longer wants to study the inner ear.

Should we have different Medical Schools for different students? The Chinese have separate schools for Western and Chinese Medicine. Some years ago they tried to launch a "bare-foot doctor" programme in Africa. These "doctors" would diagnose and treat common infectious diseases and nothing else. I like the idea of separate curricula for students who will practise in resource-limited countries only, those who know from the outset they intend to be General Practitioners and for those who intend to be hospital based Doctors in resource-adequate countries. These curricula could run concurrently with cross-fertilization between General Practice topics and the other two streams.

Whilst discussing medical student teaching, although much of the last century practice needed modernizing, much has also been lost. I recently watched a TV film made to save Westminster Hospital and Medical School, London, from closure entitled "The Horseferry Boys". What impressed me most in this film made in the early 1980s was the amount and depth of bedside teaching which nowadays seems to be taking a back seat in many institutions. Not everything old is wrong and antiquated; not everything new necessarily better. In our last edition we published a paper showing medical students were ill prepared to perform simple invasive tasks on qualifying. Imagine if one was taught the theory of how to drive a motor car, took one's test, passed but had never actually driven. It would be insensible. In my next editorial I may develop more thoughts on surgical specialist training, but first let us look to what this edition provides. As our Journal enlarges it is impossible to discuss everything so I will mention some only but let me assure you there is something for every surgeon in these pages.

We include 6 papers on Hepato-Pancreatic-Biliary surgery and 6 on GIT subjects. The latter specialty includes 2 Best Evidence Topics; one on the LINX reflux management system to treat GORD which seems to have good short and medium term outcomes although the authors of the 3 papers studied were all involved with the company. The other looks at Laparoscopic CBD Exploration compared to pre- and post-surgery ERCP. LCBDE is cost effective with a shorter hospital stay, but local expertise is necessary. The paper on strategies for the prevention of oesophageal adenocarcinoma is important as there is a dramatic increase in this disease especially in Europe and the USA. Aspirin and statins are chemotherapeutic agents which significantly protect against this malignancy and endoscopic treatments can eradicate dysplasia with prevention of progression to adenocarcinoma. I believe anti-reflux surgery also has a place for younger patients as it prevents both acid and bile reflux into the oesophagus.

From Korea there is an article showing that antibiotics alone can be a safe treatment for uncomplicated appendicitis when the diameter of the appendix is <10 mm. For the General Surgeons we include 2 papers on hernias. One from the UK demonstrates that US is poor at diagnosing occult hernias, but a negative scan maybe useful. The other paper from the USA and Malawi looks at the ratio of emergency to total hernia repairs in their countries and state that the ratio is a potential measure of surgical capacity. There are only two Colo-Rectal papers. One from India is an RCT on the role of diversion ileostomy when performing low anterior resection. Anastomotic leaks were less in the ileostomy group (6% v 11%), there was a decrease in post-operative ileus, a speedier return to diet and a decrease in wound infections. However, there were stoma-related complications, especially skin excoriation.

We include 3 experimental studies. From Iran a study shows the beneficial effects of tramadol on ischaemic and reperfusion injury in rats' skeletal muscle. From the USA there is a study on the haemostatic efficacy of a pig-coated collagen pad which provided faster haemostasis than surgical in both animal vascular and hepatic models with impaired coagulation. The third experimental study is on the effect of infliximab on the healing of intestinal anastomoses in rats. The Greek authors show decreased inflammatory activity and increased tissue remodelling activity.

There are many other papers not mentioned including cardiac, breast, bone density after obesity surgery, the use of paravertebral blocks for VATS and paediatric topics. There is also correspondence on goitres and from Russia an adhesion prevention strategy. I will end on the article on whether Bier and Sauerbach, two German surgeons in the first half of the last century, should have received Nobel Prizes. Hitler had prohibited all Germans from accepting a Nobel Prize in 1937. I found this a fascinating article and was impressed that the German author agreed that these surgeons, although great and innovative, did not warrant Nobel prizes as their research was not original enough. Bier had been proposed 42 times and Sauerbach 65 times. The decision was not a political one and it demonstrates that a lobby is not enough for these prestigious awards.

Conflict of interest

None declared.

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