It's OK to Disagree

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It has always amazed me that at our meetings very intelligent colleagues can have strong opposing opinions and disagree with one another. We have all witnessed debates concerning antecolic or retrocolic Roux limb placement, circular vs. linear vs. handsewn anastomoses, the best procedure for the diabetic patient, single- or two-staged procedures for the high-risk patient, and even which venue would be best to host the next annual meeting. In most cases, there is no right or wrong opinion. In fact, in most cases, both opinions can be correct yet opposite, and the “combatants” can both often find published articles to support their arguments. What are young clinicians to do in order to decide which opinions to adopt in their practices when both are correct?

Is it a good thing or a bad thing for us to have such discourse in our ranks? The more I ponder this predicament, the more I believe that it is, in fact, quite healthy and usually good. I believe that differences of opinion make one think harder. When someone disagrees with my opinions, I find it causes me to revisit my thought process and reassess how I came to such opinions. This will ultimately lead me to feel even stronger that my opinion is the “more” correct one or I might even determine that my opinion was in fact the “less” correct one and I will change to the other side. I believe that such self-assessment and the ability to change opinions, beliefs, or practice styles make me a better physician, surgeon, and person.

This issue of *Obesity Surgery* will be the first of many to include two articles written by experts with

differing opinions concerning a controversial topic that is important to the field of bariatric surgery: a literary “Point-Counterpoint” if you will. The objective of this feature is to present two very opposing but clinically valid points of view. The debate will take place in the form of paired review articles. These manuscripts will be scientifically prepared by well-recognized authorities on that topic and well referenced. It is our hope that you will not only find the papers to be educational, but thought provoking as well. Maybe some of you will change your opinion after reading the two papers.

In this issue, we will debate the merits of “metabolic surgery.” Should we offer surgery to a patient with type II diabetes mellitus if his/her body mass index is less than 35 kg/m²? Dr. Ricardo Cohen, a veteran bariatric surgeon from Brazil who is well known in our society and has researched and written extensively on the topic will, of course, support the notion. His position will be opposed by Dr. Harold Lebovitz, a well-regarded endocrinologist from New York, who has publically opposed operating on low BMI diabetic patients.

Enjoy!

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