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EDITORIAL

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Changing trends in gynaecological surgery—a challenge for training

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As gynaecology develops and grows, so does the range of surgical procedures we have to offer our patients. In the fields of both benign gynaecology and gynaecological oncology, there are many examples of the value of endoscopic procedures, both for diagnoses and therapy [1, 2]. How do we learn surgery, and how does it influence what we do? Traditionally, we have learnt from our teachers during our training, but increasingly this approach must be complemented by the foundation of evidence-based practice, structured formal training and careful supervised surgical technique.

In the first issue of *Gynecological Surgery* it was suggested that the ESGE educational project is focussing specifically on delivery of quality educational programmes in the field of endoscopy and is well on the way to achieving this. As we move forward with this project, it is therefore timely to review where we have come from to reach the surgical standards we achieve today. In addition, it would be useful to reflect on the challenges ahead and how we can continue to improve our techniques to offer the highest level of care to our patients.

The first consideration is the question, "What is the best place for surgery?" Traditionally, surgical procedures have always taken place in an operating theatre. Increasingly, we are seeing procedures that may be performed in the outpatient or office setting. As technology improves and the morbidity and pain of surgical procedures can be reduced, it may be that more operations need no longer be performed in the operating theatre setting. There has been a growth in "day surgery units", "office-based procedure units" and the like, as the benefits of less medically invasive treatments are appreciated. Hysteroscopy is increasingly performed under local anaesthetic in the outpatient setting. It is even possible to perform relatively major surgery in some cases under local anaesthetic [3]. Diagnostic and therapeutic colposcopy is nearly always performed in the outpatient setting. Other procedures such as some bladder neck suspensions can be performed away from the traditional operating theatre environment. Global ablative technology in the treatment of menorrhagia is also another area where the treatment is increasingly leaving the operating theatre and moving into the office environment.

Such fundamental changes in operating practice have many advantages. Firstly for the patient, not going into the operating theatre may be less stressful and anxiety provoking. For the surgeon, there is often a greater turnaround in the out-patient setting where the patients are waiting outside rather than the operating theatre where patients may have to travel from hospital wards, meaning a greater work-rate is possible.

Secondly, there have been major changes in the need for general anaesthetic. The majority of gynaecological surgical procedures are still performed under general anaesthetic. As these procedures develop, and as our understanding of analgesia grows, so it is becoming increasingly possible to undertake many procedures under local or regional anaesthetic.

Endometrial ablation, anterior colporraphy and bladder neck procedures can now all be performed under local anaesthetic [4]. Not only does this reduce the need for conventional anaesthetic support by avoiding general anaesthetic, but also the sickness and postoperative nausea can be abolished. Fifteen years ago patients undergoing hysterectomy would routinely spend up to 12 days in hospital, now it is only 3 or 4 days, and some colleagues perform the operation on a "day case" basis [5].

There has been an explosion in the development of new instrumentation for gynaecological surgery. One only has to wander through a medical exhibition at a conference to be aware of the massive developments in medical instrumentation over the last 10 years. Are we as surgeons being "hoodwinked" by the equipment companies that all of these new instruments, many of them disposable, are

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essential to the development of good surgical skills? Or have there been genuine developments that we must examine carefully in order to improve our surgical skills? The answer of course is somewhere between these two views.

The development in the quality of surgical endoscopes in gynaecology, the laparoscope and hysteroscope, has been nothing short of awesome. Not only is the visual quality improving to give us brilliantly clear detail, the size of the endoscopes is reducing dramatically, thus making hysteroscopy and less so laparoscopy entirely feasible under local anaesthetic. These factors coupled with the developing growth of camera and monitor technology, with the new single-chip cameras being almost as good as the triple-chip cameras, are leading to the level of clarity that allows advanced laparoscopic surgical dissection in anatomically challenging areas to be entirely feasible and possible.

Finally, we are slowly seeing the change of training structures in medicine. Traditionally we have had the apprenticeship structure. We have worked with consultants, and their skills have been informally transferred to us. Training has been poorly monitored and supervised, and the skills of trainees at the end of their training time has been varied. In Europe, the length of training is being shortened. This factor, coupled with the reduction in doctors' hours, leads to an obvious paradox. How is clinical training maintained if clinical exposure is shortened? Nowhere is this more difficult than in teaching of surgical skills.

Formal training schemes in which trainees are taught and assessed are slowly being developed. It is laudable that the ESGE through its training programme in both hysteroscopic and laparoscopic surgery is hoping to both develop and deliver in this area. Their efforts deserve our full support, and it is both in our interests and the interests of our patients that we should do our best to accelerate this process, not only to help existing clinicians, but also to train the consultants of tomorrow.

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