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EDITORIAL

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Training and the future of laparoscopic surgery

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This edition of Gynecological Surgery includes two essays that were marked as being at "distinction" level by the British Society for Gynaecological Endoscopy (BSGE)/ University of Surrey MSc in Advanced Gynaecological Surgery. Although different in style and content, they highlight the need to quantify the risks associated with different procedures and communicate that risk to patients, and all important, how to recognise and deal with complications as they occur. These essays show a strong degree of critical understanding, synthesis of the ideas presented, and ability to fuse these ideas into a coherent, readable, and literate argument.

Crucially, however, as students work their way through the course material of the MSc, they will gain a greater understanding not only of the technical aspects of this complex and specialised subject but also of the evidence base on which the discipline has developed and how to critically evaluate this research.

The framing of clinical questions, retrieval of appropriate levels of evidence, and, ultimately, the critical appraisal of this evidence are other important aspects of the MSc. As an example, students were asked to take a clinical question as might be raised by a patient—such as "Will an ultrasound examination help in diagnosing pelvic pain or, more specifically, in diagnosing possible endometriosis?"—and translate this into a question that can be used to search the appropriate literature, and having appraised the evidence, to translate this back into an understandable summary for the patient.

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Later in the MSc programme, students consider the principles of different research methods, learn how to translate these into viable and ultimately cogent research projects, and finally produce a dissertation based on a piece of research conceived and carried out over the course of the programme.

Teaching is seminar-based, with students being provided with a range of appropriate reading material on each module prior to attendance. Short presentations are followed by lively discussions, with "opinion headers" and experts dissecting and analysing the evidence to facilitate a fuller understanding of the strengths and weaknesses of the available literature and, importantly, how this relates to practice in the real world. It is this aspect of the MSc that differentiates it so clearly from other teaching programmes in the United Kingdom and across Europe, which are predominantly skills-based rather than theory-based and often provide little opportunity to challenge the currently accepted dogma.

In offering a combination of skills-based and theory-based learning, we anticipate that the MSc will train the future leaders of the growing subspecialty of gynaecological endoscopy. Skills are taught in the laboratory as well as in the operating theatre and at the bedside, with each student being supervised by a suitably skilled clinical preceptor. Skills are also graduated. Instrumentation, safety, and the more straightforward procedures, such as management of ectopic pregnancy, adnexal masses, and superficial endometriosis, are taught in the first year, leading to a postgraduate certificate. The clinical aspect of this is broadly similar to the training supervised by the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK. At the postgraduate diploma level, both the skills and the theoretical levels become more complex, with hysterectomy and management of infiltrating endometriosis being taught at this level. Optional modules in the areas of urogynaecology and oncology are likely to be offered in the next few years.

In the UK, at a time when the specialty of obstetrics and gynaecology fails to attract young doctors but when there is an overwhelming need to produce obstetricians, core

training is being reduced and simplified with a series of competency-based assessments requiring the barest minimum of either practical or theoretical training. This level of training may be adequate for office-based gynaecologists or those undertaking standard obstetric care, but it is neither sufficient for the specialists of the future nor sufficiently challenging for the generalist. We should not, therefore, be surprised that the speciality has a recruitment crisis. Complex subjects such as minimal access surgery will—in the UK certainly and elsewhere probably—be crammed into a series of 6-month modules in the last 2 years of training, with students emerging with a certificate of completed training.

In the UK at this time, postgraduate students can choose to undergo subspecialty training in fields such as urogynaecology, oncology, or fertility, but no such subspecialty training exists in minimal access surgery because it is seen to cross too many boundaries. The skills and competency, however, are unique to this branch of surgery, offering, as it does, appropriate, timely, and safe interventions for most adnexal disease, uterine disease, and, increasingly, pelvic floor surgery. Why, then, are women not offered the benefits of this surgery with its shorter hospital stay, quicker recovery, and, when competently performed, less morbidity?

If the answer is the unavailability of appropriate expertise, then as individual national societies and as the European society, we have an obligation to train and provide that expertise rather than, as is currently the case, fail to train at all.

If the answer is a belief that the evidence supporting the assertions in this leading article is not there, then we have an obligation to search out that evidence, examine, publish, and discuss it, so that the evidence base for what appears to be clinically apparent can be developed and disseminated.

A recent leading article in the British Medical Journal [1] makes the point that although translational research (i.e. research from the lab bench to the clinical situation) is lacking—with clinical trials merely saying that, in general, one treatment is better, worse, less hazardous, or more hazardous than another—basic observational research is even more neglected despite its being vital for informing clinical practice. Although reams have been written about the biology of endometriosis, it remains as little understood now as when it was first described at the turn of the 19th century. Yet we are unable to answer fundamental questions about how to make the diagnosis, although some authorities suggest that this of itself is unimportant [2]. Nor can we answer questions sensibly about the risks of poor treatment outcome and how individual characteristics influence that outcome. Although clinical trials, such as they are, will show that, generally speaking, treatment is likely to do more good than harm, we are less confident about how we might translate these population-based risks and benefits to individual patients who are seen in everyday practice. It is perhaps time that our research has a stronger clinical base, ideally being carried out by competent clinicians working with patients and colleagues to collect and collate the appropriate clinical data to answer meaningful questions.

The MSc in Advanced Gynaecological Endoscopy not only sets out to provide the appropriate training and skills to help gynaecologists build this clinical-based research, but ultimately it encourages participants to contribute effectively to the evidence that underpins this growing subspecialty. We commend the students for their intellectual curiosity and sharing of their time and intellect, often at their own expense, to become the thinking, enquiring, and research-based clinicians of the future. We welcome you all to join us on this quest.

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