COMMENT ON

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A Owais, T Wilson, N Sethi, MI Aldoori. Whose appendicectomy? Do laparoscopic appendicectomies impair SHO training? *Ann R Coll Surg Engl* 2008; **90**: 577–80

COMMENT 1

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Laparoscopic appendicectomy: training implications

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Owais and colleagues have concluded that the proportion of acute appendicectomies performed by SHOs in a district hospital have remained relatively static during a period of prolific growth of laparoscopic appendicectomy.

While we agree with the authors' comments regarding the effects of changes in working patterns, we believe that the increasing use of laparoscopic appendicectomy is further eroding operative opportunities for SHOs.

We conducted a prospective study of acute appendicectomy at Leeds Teaching Hospital NHS Trust between August 2007 and February 2008.¹ Overall, 117 appendicectomies were performed: 99 (85%) laparoscopic, 8 (7%) open and 10 (8%) laparoscopic conversions. All were performed by SHOs or SpRs. SHOs performed 15 (15%) of the laparoscopic appendicectomies, 5 (62%) of the open appendicectomies and 4 (40%) of the laparoscopic conversions.

In institutions embracing laparoscopic appendicectomy, the majority of appendicectomies are performed by SpRs. We believe that Owais and co-workers failed to demonstrate a reduction in SHO operative experience due to the relatively low utilisation of laparoscopic appendicectomy during the study period.

Our findings emphasise the need for the development of laparoscopic skills early in surgical training supported by expansion of college-run courses.

Reference

1. Laughlan KA, Needham PJ, Botterill ID, Ambrose NS. Laparoscopic appendicectomy: training implications. Birmingham: ASiT Conference, March 2008.

AUTHORS' RESPONSE 1

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We agree with Laughlan and colleagues that the proportion of laparoscopic appendicectomies performed in our district general hospital is considerably less than those performed in a teaching hospital, and that this could explain why our study did not demonstrate the reduction in SHO operative experience we expected to find. Nevertheless, we believe that our data are likely to reflect the situation in many district general hospitals, with the change in working patterns having a far greater influence on SHO training experiences over the last 10 years. Despite this, the data provided by Laughlan and co-workers suggest that the further popularisation of laparoscopic appendicectomy is likely to contribute to the depletion of SHO training opportunities. This serves to highlight the pressing need to re-examine the way in which junior surgeons are trained.

COMMENT 2

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Lack of laparoscopic training at the junior level

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The article by Owais and colleagues rightly addressed the potential negative effect of the implementation of the European Working Time Directive (EWTd) on training opportunities for junior doctors. A significant reduction in the number of open appendicectomies performed by the SHOs has been demonstrated. Although the SHOs did not perform any of the laparoscopic cases, their proportion of overall appendicectomies remained the same.

We believe that the results of this study are alarming. The further increase of the laparoscopic procedures is predictable and already in progress. Against the background of the described 60% reduction in the proportion of the cases being performed by the SHOs, it is worrying that no practical step has been taken towards an early implementation of laparoscopic training at the junior level.

Although the learning curve for laparoscopic procedures seems to be longer, there is no evidence that previous exposure to basic open surgical operations enhances the learning period. However, there is strong evidence that a proficiency-based, virtual-reality training curriculum shortens the learning curve on real laparoscopic procedures when compared with traditional training methods.¹

Therefore, we not only strongly suggest improvement of the postgraduate simulated training programmes of basic and advanced laparoscopic skills, but also encourage the implementation of practical basic laparoscopic training in the daily clinical practice of junior doctors pursuing a surgical career.

Reference

1. Aggarwal R, Ward J, Balasundaram I, Sains P, Athanasiou T, Darzi A. Proving the effectiveness of virtual reality simulation for training in laparoscopic surgery. *Ann Surg* 2007; **246**: 771–9.

AUTHORS' RESPONSE 2

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We thank Ahmad and colleagues for their positive comments regarding our article and share in their concern about the quality and quantity of training to which basic surgical trainees are exposed. Although their suggestion that basic trainees should be exposed to more laparoscopic cases is laudable, we are concerned as to how this would work in practice.

Increasing amounts of the SHOs' time are now given over to acute day- and night-time service provision, which includes cross-cover for a number of specialities. This environment offers little in the way of training opportunities and we are finding that SHOs are increasingly unavailable to involve themselves in simple out-of-hours operations like abscess drainage or appendicectomy. Moreover, this schedule of acute commitments, along with enforced leave to maintain compliant weekly hours, is compressing the day-

time elective exposure of trainees. This includes access to CEPOD lists along with the opportunity to pick up operative experience (laparoscopic or otherwise).

As a result, we are now finding that some newly appointed higher surgical trainees are lacking experience in basic surgical procedures. This perpetuates the problem as the higher trainees then utilise training opportunities of interest to the basic trainees, in order to acquire proficiency in these procedures. We believe that any solution must ultimately lie in freeing up training opportunities for basic trainees and providing them with their own dedicated training lists.

COMMENT 3

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Guidelines on the number of times a procedure should be performed by trainees

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We agree with Owais and co-workers that the introduction of the European Working Time Directive (EWTED) has had a negative impact on the surgical experience gained by SHOs. They also show that popularisation of laparoscopic appendicectomy had no negative impact on this. However, in their study, none of the laparoscopic procedures were performed by SHOs. Inevitably, if it were not for these cases, more appendicectomies would have been performed by SHOs. From their Figure 1, it is evident that since February 2004, when laparoscopic appendicectomies were increasingly performed, they have been inversely proportional to the number of appendicectomies by SHOs.

One method to ensure unbiased training opportunities is having guidelines on the number of times a procedure should be performed by trainees. As the ability to train others is a reflection of surgical proficiency, there should also be a required number of times a senior trainee has to supervise juniors performing appropriate procedures. This will free up the number of procedures available for juniors and, at the same time, senior trainees will get due credit. Since the inter-collegiate surgical curriculum is used by trainees across all stages and has already got benchmarks for each level, it is an ideal platform for delivering such coherent guidelines.¹

Reference

1. Intercollegiate surgical curriculum programme. <<http://www.iscp.ac.uk>>.