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Editorial

Revolutionize it – Time for big change

The contribution of technology to our orthopaedic teaching is awe-inspiring; we no longer have to wait for our guide or senior orthopaedic surgeon whims and fancies to teach us clinical tests and skills. Open Google or any video website and there you are watching all of the clinical material. We no longer are dependent on our colleagues for their notes just before our postgraduate examinations. They are available on the worldwide web. It does not mean that technology can substitute for our respected teachers and professors; they are indispensable in our postgraduate teaching, in developing our practical skill in outpatient inpatient and operation departments. This is because the real art is learnt by ones touch; we learn to operate only if we hold the knife and do the surgery ourselves. Nobody can learn car driving without driving oneself alone, experiencing all the anxiety, apprehension and fear of making an error. Same is true of surgery, you have to do it to learn it, do it confidently in future and ALSO do innovations on it. Medical teaching requires not only a sincere student but a sincere teacher also. They both have to develop a harmonious and meticulous teaching schedule. We should take help of our SISTER DEPARTMENTS in this while doing training as registrar, and learn from neurosurgery, plastic/vascular surgery departments. The thing lacking most in our training is the practical teaching, lot of it being done at the inter-resident level, the most important team member being Senior Resident. So, he is the crucial link who can fine tune postgraduates, twist their ears and discipline them as he is their most proximal teacher. He is the vital link between postgraduates and professors/consultants. He should realize this; they should not sit in rooms, use their mobile phones to take rounds telephonically from their juniors. Registrar–resident rounds are a must, as he learns art of bandaging and traction, dressing, splinting etc. or pearls of ward/inpatient care during these rounds. He should catalyze the consultants so they strive to go higher academically and surgically as a team.

The practical surgical training in our system should be focused as this training will not only affect our lives but lives of thousands of people in future. Let's inculcate surgical training on cadavers; a surgeon should operate on cadavers before doing it live. Our resident log book shows how many surgeries they have assisted as first assistant etc. or what all surgeries they have done. I think they also should show their

remarks that whether their teacher is showing them surgery, has he shown nerve root today during the discectomy procedure, did he show all the joints and ligaments during paediatric foot surgery, did he show the art of suturing in layers, did he show cotyloid fossa or transverse acetabular ligament in total hip surgery, did he show the parts of rib resected during anterolateral decompression of spine, did he show them how to do proper tension band wiring of fracture patella, was he shown all structures during knee/shoulder arthroscopy, or all the nerves and vessels encountered in any surgical approach from Henrys approach to ilioinguinal approach. It is very important to show our residents anatomic structures during operations for skill development. Further we should take help of technology and develop simulators for surgeries such as arthroscopies or acetabulum surgeries. The other thing teacher can develop upon if they don't like operation theatre teaching is to make their ideally done surgeries video and show postgraduates during their multimedia classes. Good practical teaching and work is the harbinger of good publications and research and is much more important than academic teaching. All postgraduates should show a decided number & types of operated cases for internal assessment of their masters' examination.

Besides this, the young generation should not be swiped by new techniques advertised, but learn the experience of teachers as it is the gold standard and tried and tested cost efficient technique for their patient. They should not fix all fractures but learn the art of closed reduction and traction. All new fixation materials and arthroplasty material of different sizes and shapes should not be used at the outset but only after proper clinical trials on our patients and for the right indications. Old is gold and we should not shun open for minimally invasive techniques or plain nailing for locked nailing or old dynamic compression plate for locking compression plate, ceramic/multipolar for old cement/metal on poly arthroplasty just because they are in fashion, more colourful and glamorous but develop indications for each implant and orthopaedic material. The paradox to this is, we should not hesitate to use technology at the outset be it imaging for surgical planning & diagnosing judiciously, as they may show early signs of infection, avascular necrosis or clinical wonders.

We as an association should earmark committees for making standard treatment guidelines or protocol for

particular patient scenario as osteoarthritis, osteoporosis polytrauma cases, open fractures, pelviacetabular fractures, avascular necrosis of hip, arthritis, fracture neck of femur, spine trauma, fat/venous embolism etc.

Lastly I appeal to all that they use their mobile gizmos purposefully for PUBLISHING their TRICKS, original works, thesis jugads & SURGICAL VIDEO. Our orthopaedics should be more indigenous not firangi based. This Delhi Orthopaedic association journal is OUR MOUTHPIECE to the world, it is a good platform for publishing not only our written work but also our multimedia. So, let's all actively send our work for this journal which is for us, by us and for our excellence.

Embarking on the present issue, this journal touches common topics like use of bisphosphonates, how long to use them, do we need a break, when and why do we need it and above all which patients need what drug during that break. The other activity which is indispensable to our surgery that is drilling – its use, physics and how to make it less harming to tissues has been dealt threadbare. The management of

fracture scaphoid is well dealt like in a desi manner as to which is the best investigation for early diagnosis of X-ray-occult fractures, management of acute scaphoid fractures and nonunions. The topics on blood products and bleeding that is use of platelet rich plasma – what is it and how is it useful; and how does tranexamic acid fare in reducing blood loss in knee replacements are clinically useful.

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