

Foreword



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Deep down inside—we're all superficial.
—Walter B. Goldfarb, MD

Anyone who has completed surgical training and developed a practice can attest that one learns a lot about surgery and operating in the first year of practice. For most people it is an eye-opening experience of a high order. Also, there is no such thing as a minor operation for the patient or the surgeon. Any operative procedure has the opportunity to go very well or turn out very badly. Most surgeons who have practiced for any length of time have seen plenty of examples of both types of outcomes from large, complex operations and also from operations that started out as less complex procedures.

Surgeons have a long tradition of sharing their knowledge and have written extensively about diseases that affect only a few patients and about complex procedures that even fewer surgeons will ever perform. A great source of irony in surgery is that it is not so easy to find collective writings about disorders that are far more common and about procedures that almost any general surgeon will perform someday. This collection of articles was gathered in an attempt to compile information about the more common operations surgeons perform that are discussed formally less often. For the most part the discussions involve operations that can be done in environments with limited equipment or as outpatient procedures, but some of the discussions address more complicated matters.

Although this issue addresses some of the common conditions surgeons encounter, it is worthwhile to ask why significant exposure to these common conditions is becoming more limited in current surgical education. The process of surgical education is designed to provide the surgical trainee with gradually increasing responsibility until she or he is sufficiently experienced to function safely without supervision. Overall, surgeons and surgical training programs seem to do a pretty good job in providing a mechanism for training surgeons to the degree of competence desired. There are, however, some subtle (and not so subtle) shifts in training exposure that are modifying and challenging the ability to meet those objectives.

The first shift that is noticeable is the relative point in training when the medical learner is exposed to direct patient care and intervention. Opportunities formerly available to junior residents and even to medical students are less likely now to occur at that level of training. There are many reasons for this shift. Among the most difficult to refute are the reasons deriving directly from the patients. Many patients are better informed consumers of medical care than in the past and are more insistent about whom they will and will not allow to participate in their care. Some of these concerns are media driven, and some probably simply reflect a shift in patient preference. The net effect remains: direct patient care is shifted to more advanced trainees and providers.

Another general shift in training programs is a change in the expectation of when along the training curve learners encounter situations that allow for personal growth. Policies are trending toward much more direct supervision, even of senior residents. There are many reasons for adopting these changes; among them are increased guidance from regulatory authorities such as the Review Committee-Surgery (RC Surgery) and the American Council for Graduate Medical Education (ACGME), increased guidance from the Joint Commission (JC), and changes in local hospital and practice policies based on concerns about litigation and risk management, and other adverse reactions.

Although many changes are attributed to these reasons, perhaps the most influential reason is simply the time available for teaching and learning. To be sure, there are still 168 hours available per week, but the allocation of these hours for clinical learning opportunities for the surgical resident has diminished and probably will continue to do so for the foreseeable future. These hour limitations have several intended consequences, but they have several unintended consequences, as well. The final net effect of these changes is uncertain at this moment, but one indisputable effect is that a new set of priorities for patient-learner interaction has developed. Gone are the days of having senior and junior residents available to participate in profoundly complex cases so that the junior resident might have more familiarity with certain operative issues when she becomes a senior resident. Also, given the present workload, senior residents are highly unlikely to perform “minor procedures” when there are “bigger” cases to cover—at least until they are within sight of residency completion; then one frequently sees a heightened and renewed interest in hernia repairs and other “intern” cases.

The fiscal pressures on staff-level surgeons are also steadily increasing and add additional impediments to incorporating and educating residents more fully in less complex procedures. “I can do this procedure alone if you have something else you need to do” is faculty code-speak for “I can get this done a lot faster by myself, and skip the beta-blockers.”

The final result of the various forces involved is complicated: (1) learners encounter procedures later in training than in previous years; (2) they have fewer opportunities to participate in less complex procedures at a more advanced phase of training; and (3) they are less likely to supervise a junior learner directly in the performance of a less complex procedure with or without the presence of a staff member. In turn this system produces recent graduates who may be far more comfortable with some complex operations than they are with less complex operations performed on patients who commonly are awake and aware.

My senior partner in practice at the beginning of my career, whom I quoted above, told me, “You will have to see a lot of itchy [perineums] for every pheo you see.” He was right—very right. Having a source of information that helps one deal with the more commonly seen conditions may be very valuable. To that end we appreciate

the efforts of Dr. Radke and his colleagues for assembling this collection of articles. We also are appreciative of our colleagues from the *Clinics in Plastic Surgery* who prepared the informative reviews on dealing with acute wounds and skin closure techniques, which are included in this issue for our subscribers' benefit.

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