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Editorial

Specialist in Training: Revisiting Concepts

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Editorial

Without trying to re-invent the wheel, it may be time to revisit one old chestnut, namely, “uro-gynaecology”. I use quotes because it is a phrase, which leaves much to be desired for those who plan the utopian dream of the perfect specialist. In much of the civilised world, where the female patient is concerned, one finds the urologist and the uro- gynaecologist. However, I do believe that we should also cater for the place and the occasion where such neat classification of work may not be on offer. And, as a gynaecologist, I am interested in the evolutionary period of basic training of the young gynaecologist. However, one may also some extend the thinking to the urologist when dealing with that half of humanity called a female patient. A compulsory dose of gynaecological exposure in urological training, can only make for a better product. The normal training of a gynaecologist omits to a large extent, the practical knowledge which general gynaecological work entails. One may cut to the chase and counter the argument by stating that once the urological field is transgressed, a gynaecologist or a uro-gynaecologist should, and in some western countries legally must, take over the case. In my opinion, this is poor reasoning. One may even draw a further argument that a urologist in training need no general surgical experience to qualify and in practice. This reasoning entirely by-passes those situations, which may be one off in the western world, where the gynaecologist must plod on when faced with a urological challenge. Furthermore, there are many geographical regions in the big wide world, where the gynaecologist with the scalpel, is all that the patient will have. As a secondary argument, although the world of sub- and super sub-specialisation has narrowed the western gynaecologist’s field of surgical practice, let us not forget the anatomical closeness of the gynaecologist’s field of operation to that of the urologist.

The point of this editorial is to exhort the relevant gynaecological Colleges to include, a compulsory module of basic surgical urology in their training requirements. One must, for example, give evidence of being able to perform such procedures as a satisfactory uro-cystoscopy, repairing damage ensuing from gynaecological surgery, be able to expose the ureter in its lower abdominal and pelvic course, demonstrate his knowledge of anatomy in surgery to correct genuine stress incontinence. Such requirements, not only make a safer gynaecologist but instil a much greater sense of confidence and serenity in day to day work. The impression one gets in assessing a gynaecologist who is bereft of such basic knowledge, is one of anxiety in avoiding urological damage, however, well camouflaged. This often becomes overtly acute when encountering, for example, an unexpected case of severe endometriotic pathology. One may call for uncle Joe, the urologist in London or New York. It is another story when operating by hurricane lamp in a refugee camp in the middle of nowhere. In a way, this is turning the wheel backwards in a world where everyone is only allowed his small patch of turf and no further. However, if the present trend persists, gynaecological surgeons will soon have to perimeter off the pelvis with red tape, in case, God forbid their finger, or worse, their scalpel, strays the extra centimetre.