CIRUGÍA ESPAÑOLA

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Editorial

Has academic surgery been fatally wounded? A rhetorical question

¿Ha sido la cirugía académica herida de muerte? Una pregunta retórica

In the past, surgery was learned alongside a ''master surgeon''. This vertical transmission of knowledge had advantages and drawbacks depending on the transmitter, and teaching was empirical, since it had no scientific basis but was instead based on the particular experience being showed. This way of teaching made surgery somewhat poor and full of components that threatened any advancements, for instance applying individual experiences to all patients (''operating like this works well for me...''), underestimating what other surgeons did (''well, *we* do it like this...'') and excluding any kind of questioning or critical thought. Thus, dogma prevailed. As a result of this method of learning and transmitting surgery, other medical specialists may have been led to consider surgeons as simple ''performers'' of surgical treatments that are decided by other medical specialists.

Academic surgery could be defined as the choice of how to develop professionally within the specialty, based on three basic pillars: clinical practice based on the best available evidence, persistent teaching, and continuous research. It could be said that academic surgery has played an essential part in mitigating the ''devastating'' effects of surgery, understood as merely a technical art that is transmitted from master to apprentice, which turned us into ''extractors''. Academic surgery is probably one of the best ways to convey to our trainee surgeons the *lex artis ad hoc*. On the other hand, academic surgery enables us to pursue a professional life project and promotes critical thinking, while academic enrichment and stimulation reduce the much-feared burnout associated with our profession. Furthermore, academic surgery also make an essential contribution to how we visualize our patients – not only from a purely clinical/technical point of view, but also as individual people.

Has academic surgery been fatally wounded? Perhaps it is a personal perception, but when one attends meetings or conferences of our specialty, in many, only values of technical art inherent to the development of our profession as surgeons prevail. We observe little tolerance for constructive criticism and/or argumentation when what is presented at the podium is not based on data and is not the product of research, Moreover, on many occasions the wheel is being permanently reinvented, which denotes a lack of individual study and *academic culture*, which is somewhat worrisome. From my standpoint, these circumstances result from the following: 1) A *university crisis*, where, with few exceptions, the university has become a passive spectator of the decline in academic surgery, perhaps because it is considered inefficient. It is likely that universities have currently given way to a socio-labor system that requires doctors and specialists to adapt to it. It is also likely that ''global'' university training, which includes a critical spirit, thorough analysis with an overall vision, social concern and the ability to modify our environment, has easily given way to the training of compliant doctors or specialists that can be easily incorporated into a factory-type ''professionalized'' medical specialty, where there is no room for global training of the characteristics described; 2) A *social crisis of values* where political correctness prevails. The saying that ''hell is full of good intentions'' means that having good intentions is not enough – it is necessary to act. Political correctness and niceties make solidarity, tolerance and misunderstood dialogue their poster child, perhaps making it difficult to set limits or say ''no'' to requests or demands. For all of the above, surgeons who have been steeped in correctness are fertile ground for trends or fashions because they lack their own criteria to guide them when determining what to think or do because they lack individuality, not because they are being told what to do or to feel part of a group; 3) A loss of the moral value of self-sacrifice, which is the effort needed to achieve greater benefits, overcoming one's own desires, interests and comfort. This goes hand in hand with a loss of resilience to the adversities of a life of patient care, teaching and research; 4) Academic surgery can be unattractive in our country. Such dedication and effort are not compensated by low salaries and lost hours of personal and family life. In addition, for health managers, academic surgery

can be expensive and unprofitable given our factory-like healthcare structure and organization.

Not all trained surgeons need to be academic surgeons. Probably, and for different reasons, a large majority of trained surgeons will never be academic surgeons. However, academic surgery must be part of their training so that, once the residency period is over, they retain a critical spirit, aptitude for slow analysis, and an overall vision of the individual patient. Thus, by attending surgical meetings or conferences, they will be able to present coherent research papers, not just brilliant and flashy ''technical art'', and they will be open to actively participate in tolerant, constructive discussions.

Academic surgery is essential if we do not want to return to surgery dominated by dogmatic surgical ideology. After all, ideologies are only cages, where nothing new is generated and where we distance ourselves from investigation and the free discussion of ideas.

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