



SARS-CoV-2: The Doom of Surgical Trainees?

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Editorial

The SARS-CoV-2 pandemic outbreak brought a revolution in the way of practicing and conceiving surgery. We were forced to moderate, discuss and limit indication to surgery [1]. Urgency and priority became the only convincing principle to bring a patient into the operating room, without distinction between election and emergency, not to waste what was already lacking [1-3]. Surgical volume, as we know was before the pandemic a goal to achieve at the end of the year as a mark of productivity, could be no longer be a target because the pandemic stole spaces, tools, and personnel from surgery, catalyzing all the available resources to face an unprecedented healthcare disaster [1]. In the apocalyptic scenario, some aspects were overlooked since all the public opinion was concentrated elsewhere, and all were more concerned with facing the actual difficulties, more or less consciously choosing to ignore what could be labeled as a future problem. The effect of this drastic reduction in surgical workload on surgical training, although it is only empirically intuible, was profound at every level and yet far from being fully understood [4]. To date, our knowledge of this issue is based on surveys that have suggested similar results worldwide, ranging from a significant disruption to a complete discontinuation of all aspects of surgical training [5-10]. The reduced elective and emergency caseload was not the only factors contributing to it [5]. Most of the surgical department adopted a consultant-only operating policy, supported by some of the published guidelines [11,12], further restraining training opportunities [5]. Other factors included focusing on service provision and discontinuation of teaching and training because of social distancing [5]. Redeployment was also vastly reported. The most common destinations of Redeployment were the medical/respiratory wards, intensive care, and the emergency department, halting surgical novices' technical progress [5,7]. The first doubt that we want to arise is if all of that was necessary. Nowadays, for example, there is no study demonstrating that an expert surgeon's performance could lead to a real benefit since the involvement of a novice latter does not lead to an increasing complications rate [13]. On the other part, the whole situation highlighted a substantial general lack of guidance and training regulation to be assessed to develop future structured training programs [13]. The second question that seems fair to us is: was it only a step back in training or a leap forward in the future? As history taught us, there is always something to learn from a disaster and adapting and evolving is what allowed a human being to survive throughout times. Surgical trainees, more like an endangered species, rapidly evolved and adapted to survive, identify new educational tools in webinars, online educational videos, virtual reality resources, and online learning methods [5-10]. From this point of view, the pandemic is boosted towards reorganizing training programs and even implementing simulators activities [4]. However, the introduction of novel training methods (or enhancement of pre-existing training methods such as simulation) was not without challenges, including technical issues in accessing online educational materials, small numbers of virtual or simulation training sessions, inappropriate timing of webinars, lack/inability to receive hands-on training on simulated patients or simulators, difficulty in engaging in and maintaining concentration during online sessions, and lack of interaction during online sessions [5]. These kinds of resources could, indeed, help mitigate the adverse effects of the pandemic on training and the possibility to utilize them in a structured training program in the future, regardless of the pandemic, seems tempting. We wonder, however, if this option could be realistic or will remain as a platonic proposal of a bunch of reasonable thinkers. The pandemic showed that this kind of resources are far from being universally accessible and, in our opinion, depending predominantly on them for surgical training, leads to the risk of creating a care of a few better-trained surgeons despite a more significant amount of them that are not adequately taught. So, as the waves continue, ongoing adaptation and reorganization are needed. New strategies for optimizing operative experiences and technical skills have to be introduced and integrated into the training programs and surgical trainees need to be adequately provided with tools helping them to progress in their training in the likely event that COVID-19 will become a chronic issue to be dealt with.

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