abdomen is likely, within five years, to incorporate this technique in his armamentarium. When that becomes true, and at least for those procedures like cholecystectomy that are common, every surgeon will presumably be able to train his junior. At present, the use of the technique is already widespread but far from universal, and it is therefore important for training to be concentrated in those centres that have made good progress. It is particularly interesting that video is so important to the technique: it raises the possibility of teaching at a distance, the supervisor taking the trainee through an operation from a remote station. Apart from cholecystectomy, however, the role of laparoscopy in abdominal surgery is far from defined, although colonic resections, the repair of hiatal hernia, and proximal gastric vagotomy are promising. It is even possible that the balance of treatment in the last two conditions, so much displaced towards medicine rather

than surgery at present, may be swayed back towards surgery if the operations can be done safely for a one to two day stay in hospital.

The great success of laparoscopy has raised an interesting point for the specialists to argue with the generalists. In the field of surgery, with its great emphasis on manual dexterity and skill to achieve the best results, is it possible that specialisation according to organ group is the wrong road to follow? Maybe gastroenterological surgeons should be divided into laparoscopists, endoscopists, and open operators? Although it would be a pity if the surgeon who found a contraindication to laparoscopic cholecystectomy was not competent to convert to the open procedure.

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Clinical training – back to the future

'Experience is the name every
one gives to their mistakes'
Oscar Wilde, *Lady Windermere's Fan*

More than a decade has passed since our welfare state displayed a health service second to none. This distinguished era in Danish medicine came to an abrupt end in 1981, when a new agreement was forced upon junior doctors by the government against the advice of all Danish doctors, their professional associations, and their scientific societies. The authorities required that working hours, including night service and time for training, were reduced to 40 hours a week. Having reached the goal the government was forced to a further reduction in working hours to 37 hours a week as a result of a new compromise with the unions.

This offshoot of the general community policy in Denmark originated in the politicians' ambition to improve environment and working conditions for all wage earners in the country. As predicted by junior as well as senior doctors a disastrous discontinuity in clinical work and clinical training was soon revealed. In an attempt at compensating for the reduction in working hours a structural change of postgraduate education and training has now been introduced with the purpose of speeding up the production of specialist doctors. Unfortunately, no economic resources for training programmes were allocated and no time for senior doctors to accomplish bedside education, performance feedback, and on the job surveillance was granted. Frustrations bloom, especially among junior doctors, who admit that nothing in their student careers prepared them for clinical work. The particular Danish experiment, which was carried into effect under nearly absurd conditions, may have satisfied politicians' and hospital administrators' wish to see specialist doctors perform patient care. By doing this at a discount price clinical training threatens to mirror H C Andersen's fairy-tale *The emperor's new clothes*. To add insult to injury the implementation of the junior doctors' agreement has turned out to be used as a concept for calculation of wages by foregoing 150% or more to

compensate for night work. One question that now remains to be answered is what challenges policy makers will face when the National Health Service reacts by squeezing still more junior doctors through the education system in still shorter periods of time? Another question to be answered is how drastic will qualifications of future consultants, in particular surgeons, decrease when the opportunity of acquiring practical skills is lost?

There is little information on the way in which politicians and hospital administrators cope with their mistakes. What we see is that they still display the principle of the greatest happiness of the greatest number of patients – other things being equal at the expense of the patients. The short working hours combined with a severe pressure from the junior doctors union explain why there has never been so many doctors employed in Danish hospitals. It is also true when politicians argue that there has never been so many permanent positions in the Danish health system. A 37 hour week, however, permits less than 50% of junior doctors to be present at all times and a future surgeon will typically have only 70–80 days during a 9 month training period to perform his practical skills during work on the day shift. This provides the important obstacle for maintaining continuity in patients' care and junior doctors' education. The 'inappropriate' use of doctors is a problem that has defied solution in Denmark, partly because the problem has itself originally been defined by doctors, produced in excess during the late 1970s, and not by patients.

A multi-level of permanent posts for senior doctors was recently introduced to obviate the lack of qualified doctors in the hospitals. The new reform of genius, converting educational posts into permanent posts threatens to eliminate the first – and ultimately the problem itself – when educational posts no longer exist. The French would say '*après nous le déluge*', but in Denmark we are more steady – awaiting how and when qualified candidates for the new permanent posts will appear.

A third important question, which remains to be answered, is whether research makes better doctors.¹ The short answer given by many junior doctors may be no, but

a moment's reflection will show the misleading simplicity of the question. Although some doctors may benefit from research training more than others, Danish gastroenterology needs, in addition to innovative research, clinical researchers who can catch up with the newest developments and integrate new information. Although McCormick's dictum, 'medicine is not science, and it is certainly not art',² may also be valid for gastroenterology, progress of the discipline is a scientific activity, rooted in both basic and clinical research. Every gastroenterologist should, therefore, have sufficient scientific background to understand and recognise sound scientific arguments for changing a clinical practice. Clinical training, which might be shortened if combined with clinical research, would also

benefit by this approach. Training programmes that meet the postgraduate doctors' needs for education to become an expert in gastroenterology remains, however, a promise unfulfilled in Denmark, if experience is not learned from mistakes.

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- 1 Anonymous. Does research make for better doctors? [Editorial]. *Lancet* 1993; **342**: 1063–4.
- 2 McCormick J. The contribution of science to medicine. *Perspect Biol Med* 1993; **36**: 315–22.