

Meeting future requirements in gynaecological oncology subspecialty training

Subspecialty training in gynaecological oncology in South Africa is a very young venture in the discipline of gynaecology. In 2008, the first candidate fulfilled the requirements for the College of Obstetricians and Gynaecologists of South Africa's subspecialty certificate in Gynaecological Oncology. As a subspecialty, gynaecological oncology adds significant value to the management and care of women who are diagnosed with gynaecological cancer, and enhances survival and treatment outcome.¹ Therefore, there is no doubt that it is judicious to train gynaecological oncologists in South Africa.

The improvement in the outcome of cancer treatment that is provided by gynaecological oncologists is well documented. To a large extent, it is based on concentrated skills in specialised centres.¹ Ovarian cancer survival, for instance, closely correlates with the quality of the primary debulking surgery that is performed. The same is true for radical hysterectomy and radical vulvectomy and inguinal lymphadenectomy.

Knowledge and surgical skills are two equally important pillars of fellowship training in gynaecological oncology. While it is important to have an appropriate working knowledge of gynaecological cancer to ensure that the right management decisions are made, it will not benefit the patient if the skills that are needed to perform optimal surgery are lacking. Overall assessment of fellowship training should not be limited to assessment of a candidate's knowledge and research ability, but should also include assessment of surgical skills.

Current guidelines for the certificate in gynaecological oncology stipulate a minimum two-year training period in a certified training unit, acceptance of a logbook and successful completion of a research project and an exit examination. During this two-year period, four months and three weeks are required to complete the prescribed rotations through other related disciplines. If two months' ordinary leave is taken into account, 17 months of gynaecological oncology training time remains, assuming there are no other factors, such as nonfunctioning theatres and illness, that could restrict this time even more. The logbook requires certain minimum numbers of surgical procedures to be

performed. In addition, competencies are required for five specified procedures.

Currently, none of the training units in South Africa offer fellowship posts that are funded by the Department of Health or any tertiary institution. Fellowship training is either self-funded, externally funded or funded out of departmental resources, for instance, making use of a consultant post for fellowship training. Training units frequently have to secure outside funding from a third party on a contractual basis for a period of time, in order to have posts available for fellowship training. Potentially this can result in a situation in which after 24 months, the funded training time for the fellow has expired, regardless if logbook requirements have been fulfilled or not.

Internationally, fellowship training in gynaecological oncology appears to vary widely on the surface, but in essence, it does not vary all that much. In the USA, training is three years typically, and in some institutions such as the MD Anderson Cancer Center in Texas, which has trained gynaecological oncology fellows since the 1950s, training is four years.² In Europe, many countries do not have recognised subspecialty training, and in those that do, training varies from two to five years.³ Generally, longer training time would involve up to two years of research, with minimal clinical training during the research component. It seems that most international training schedules take three years. Most of the international training units also provide training in laparoscopic surgery as part of the fellowship training programme.

To accurately assess where we are, and more importantly where we should be heading, we need to determine which skills gynaecological oncologists will require 10 years from now, and how training might differ in the future. Trends in surgical skills training are changing. The traditional training programme that is defined by time spent as a trainee will probably make way for competency-based training. Inevitably, this approach will produce its own challenges in terms of defining and developing objective measures of surgical skills assessment. Once skills that are required by the gynaecological oncologist of the

future have been identified, it might be necessary to adapt the training programme from a time and minimum logbook numbers-based format to one that includes competency-based assessment in addition to knowledge evaluation. This approach would require the availability of funded fellowship training posts to ensure a constant production of gynaecological oncologists to attend to the population's needs. It is not the primary responsibility of a gynaecological oncology unit to have to find funding to enable it to train fellows. The responsibility for this lies with the National Department of Health as fellows are also responsible for service delivery in the training hospitals in which they work.

There is little doubt that surgical treatment modalities in gynaecological oncology will change substantially in the next decade. Indeed, this change has already commenced and is progressing fast. Laparoscopic surgery is becoming the standard of care in early-stage cervical cancer and endometrial cancer. The evidence is clear that this approach results in quicker recovery and less blood loss in patients. It is also feasible, leads to shorter hospital stay and, most importantly, does not compromise cancer treatment outcome. In many units around the globe, laparoscopic surgery has already become the standard of surgical treatment, not only for many benign gynaecological procedures, but also for gynaecological oncology procedures such as the treatment of early-stage cervical and endometrial cancer. Currently, robotic surgery is following the route that was taken by laparoscopic surgery over the past decade.

Laparoscopic surgery in gynaecological oncology is the exception rather than the rule in South Africa. Many women who undergo surgical cancer treatment are in desperate need of the benefits of minimally invasive surgery. Patients who are not employed in the formal sector do not receive an income if they do not work, and they have to return to employment as soon as possible after treatment. A substantial number of South African patients are immunocompromised with resultant co-morbidities, and might also benefit from minimally invasive procedures. The health system will also benefit from this treatment modality if it is performed cost-effectively.

In 2005, Daniel Dargent wrote an editorial⁴ that discussed the slow uptake of laparoscopic surgery in gynaecological oncology globally. Besides the lack of good quality evidence for the laparoscopic approach at the time, he eloquently described an attitude of "we can do it easier and faster open" as a second important reason.

Laparoscopic surgery has its own learning curve. Modern-day trainers are required to facilitate the

mastering of yet another skill, in addition to the ones that have already been learnt after many years of training. The learning curve also requires theatre time, which needs to be balanced against the workload and service delivery component in every unit. Service delivery requires that as many patients as possible on every theatre list are operated upon, resulting in less training time, which is an essential requirement in gynaecological oncology fellowship training.

In addition, there is the issue of how fellows in South Africa should be trained to meet the future requirements of what is most likely to become the evidence-based standard of care. Should they be taught both open and laparoscopic procedures, or should they only be taught laparoscopic surgery for the treatment of the appropriate cancers? This is an important issue that will need careful deliberation. Although South Africa is a developing country with variable access to resources, cancer therapy requires specialised centres with appropriate resources to offer suitable treatment options to patients.

The current training programme and certification requirements for gynaecological oncology fellowship training are adequate and appropriate in terms of serving current training needs. However, there is little doubt that as far as laparoscopic surgery in gynaecological oncology is concerned, some effort is required to start turning the ship now to enable us to equip the subspecialty with appropriately skilled and competency-based trained specialists in the near future.

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