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Education versus service

I was surprised to read your Editors' View in the October 2000 issue of the *Canadian Journal of Surgery* (page 326) on the challenges facing surgical training programs in balancing the various demands on time. I write to express serious concern about your conclusions.

There will never be any debate about the need for adequate "hands-on" experience in the real clinical world for surgical trainees, but I think it is unfortunate that there is any debate at all concerning the need for time to be spent on ethics, communication and clinical epidemiology, for example. I am in complete agreement that in the real world the necessary ethics and communication skills would be learned at the side of role models in the clinical setting. Fortunately, there are many shining examples of such role models in the surgical ranks, but unfortunately there are many examples to the contrary, both in academic and in community surgical practice. This issue is simply too important to be left to chance, to be picked up by those surgical residents who are fortunate enough to have good role models.

In our death-denying technology-filled society, ethical problems abound and, in my experience, trainees need and appreciate help in coming to grips with a basic approach to ethical decision-making. It is becoming increasingly difficult to know the difference between what we can do and what we *should* do in surgical practice. How often are surgeons asked to deal with end-of-life care decisions, to intervene heroically in situations where the balance of potential benefit and harm is unclear, to insert various feeding devices in unconscious patients?

Concerning communications skills, I believe that surgeons are no more exempt from Robert Burns's admonition than any other group: "Oh wad some power the giftie gie

us to see oursel's as others see us!" I am certainly prepared to concede that communications skills depend more on personality, attitude and other unteachables, rendering an effective educational program very difficult to construct, but many physicians need all the help they can get in this area.

Finally, clinical epidemiology is no longer a special interest for researchers, but rather a necessity of life in the clinical trenches. We have lived in an unevaluated clinical world too long, and surgeons preparing for the next decade in clinical practice are going to need an understanding of test statistics, critical appraisal and the techniques of program and outcomes evaluations to deal with the accountability that is going to be demanded. All these can be acquired by osmosis with an excellent surgical role model, but it would be foolish to think that all surgical residents are going to achieve an adequate understanding by that route. The Royal College of Physicians and Surgeons of Canada has made some very appropriate, timely decisions concerning the need for training in these areas, and it would be extremely regrettable if their value were not appreciated by surgeons themselves.

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Accessory bile duct in the gallbladder bed

We wish to report the case of a patient with a severed accessory bile duct that illustrates an important anatomic point.

A 23-year-old man presented with a self-inflicted stab wound to the

right upper abdominal quadrant. At laparotomy, he was found to have a wound directly through the liver (segment 5), gallbladder and into the hilum of the right kidney. After right nephrectomy and cholecystectomy were done and bleeding from the liver wound was controlled with sutures, the gallbladder bed was inspected. A bile duct was seen running within the lateral side of the gallbladder bed. This duct entered the bed about halfway up; it could be seen coming from a crease in segment 5 (Fig. 1) above a deeper sul-



FIG. 1. Subvesical bile duct (arrow) in the gallbladder bed.

cus. The liver wound, seen to transect the gallbladder bed and to sever the bile duct completely. The duct was about 1 mm in diameter, and bile was seen leaking from the side nearest the common hepatic duct. There was no bleeding from around the severed duct. Both sides of the duct were suture ligated, and a drain was placed. Postoperatively there was no bile leakage and the patient recovered without complication.

This unusual case demonstrates several points that are important for surgeons when they excise gallbladders. First, bile ducts are often present between the gallbladder and the liver parenchyma. The presence of these "subvesical ducts" has been documented in several anatomic studies at a rate ranging from 12% to 50%.¹ They rarely communicate with the gallbladder. Michels² meticu-

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lously studied 500 cadavers and failed to find one such communication. Second, there is a "plate" of thick fibrous tissue found between the gallbladder and the liver. This gallbladder plate was initially described by Couinaud³ and is basically an extension of the better known hilar plate. In our case, a subvesical, or accessory, bile duct was found to run in the gallbladder "plate" for at least part of its course.

Surgeons should be aware of the gallbladder "plate" and strive to leave it intact when removing diseased gall-

bladders. Damage to the plate risks damage to these subvesical ducts with resulting bile leakage postoperatively. Surgeons should remember to "stay on the gallbladder wall" or as this case demonstrates "stay away from the gallbladder plate."

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