Redressing the brain drain

Sir,

We read with interest the editorial by Bailey and Trewby (vol 72(2), 2011, p. 66), describing the Medical Training Initiative – a scheme helping to redress the brain drain – by enabling international medical graduates to embark on formal training pathways within the UK health-care system before returning to their mother country.

Many health-care professionals from the western world visit the developing world every year wishing to make a difference, generously volunteering their time and skills to directly undertake clinical work and teach local health-care professionals.

The internet has heralded exciting new means through which UK doctors can continue to contribute to international health-care systems on their return home. MedicineAfrica (www.medicineafrica.com) is a website which allows doctors in the UK to teach trainees abroad, using clinical details and images which can be uploaded by students or teachers, and discussed in real-time online using an instant messaging portal (Finlayson et al, 2010). The scheme has been successfully piloted in a collaboration between King's College Hospital (London, UK) and Amoud University (Somaililand), establishing a regular post-graduate training scheme for junior doctors and senior medical students in two universities in Somaliland and is being extended to other countries in Africa and the Palestinian territories in 2011.

By marrying traditional medical training with innovations in communication, we can marshal the enthusiasm of UK doctors passionate about improving global health care to bolster medical education in the developing world.

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Finlayson AET, Baraco A, Cronin N et al (2010) An international, case-based, distance-learning collaboration between the UK and Somaliland using a real-time clinical education website. *J Telemed Telecare* **16**: 181–4

The enhanced recovery programme in colorectal surgery

Sir,

We read with interest the article by Messrs Marzook and Anwar on enhanced recovery in colorectal surgery (vol 72(3), 2011, p. 151), and wish to make a number of observations.

Figure 2 shows the key features of an enhanced recovery programme and we feel it is quite confusing. The authors having correctly described the current evidence regarding issues such as bowel preparation and use of nasogastric tubes, but it appears from the figure that both bowel preparation and nasogastric tubes are key features of the programme, when of course the complete opposite is true.

We would like to comment on the use of epidural analgesia for postoperative pain relief, which the authors themselves admit is a contentious issue, but state that this is the preferred regimen. It is unclear whether or not the authors themselves prefer an open or laparoscopic approach. We agree that a thoracic epidural has a proven benefit for open surgery, but we have not found this benefit to be transferrable to laparoscopic surgery.

Our recent randomized controlled trial compared the effects of different analgesic regimens on outcomes following laparoscopic colorectal surgery. Patients were randomized to have epidural, spinal or morphine patient-controlled analgesia. We found that patients who received epidurals were more immobile, received more fluid and had a longer time to return of bowel function and hospital discharge than either the spinal or morphine group (Levy et al, 2011).

In another study we found that with an enhanced recovery programme, together with spinal analgesia and goal-directed fluid therapy, patients undergoing laparoscopic colectomy can be discharged safely after 23 hours (Levy et al, 2009). We feel that these very short postoperative lengths of stays are only achievable in patients who undergo laparoscopic surgery and avoid epidurals which can reduce the patients' postoperative mobility.

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Levy BF, Scott MJP, Fawcett WJ, Rockall TA (2009) 23-hour-stay laparoscopic colectomy. *Dis Colon Rectum* **52**: 1239–43
Levy BF, Scott MJ, Fawcett W, Fry C, Rockall TA (2011) Randomised controlled trial to assess the optimal analgesic regimen for patients undergoing laparoscopic colorectal surgery. *Br J Surg* (in press)

Sir,

We would like to thank Dr Jones and colleagues for their letter highlighting a few important points about the enhanced recovery programme and our article.

Figure 2 highlights the key areas where enhanced recovery has made a difference. Having outlined them in the figure our intention was to expand on their role in the enhanced recovery programme, in detail, in the main text of the article. However, we take the point that to a cursory reader this might be a bit confusing. We hope that most people interested in the enhanced recovery programme would also read the text rather then just looking at the figure.

The readership of *BJHM* comprises a large group of non-specialist clinicians, so our intention was to avoid going into the detailed evidence surrounding the contentious issues of pain relief in the enhanced recovery programme, especially in the context of laparoscopic and open surgery. We belief that the enhanced recovery programme should not be 'synonymised' with laparoscopic surgery and should be applicable to open procedures as well. Both groups benefit equally from this programme.

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