The Future of GI Surgery in India

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After a rather uncertain beginning in the early 1980s GI surgery has now become firmly established as a super-specialty in this country. Indeed it may have become the specialty of choice for most qualified Masters of Surgery having usurped cardiac surgery, neurosurgery and even urology from their former prime popularity positions. The largest numbers of applications for entry into the 13 M.Ch. (largely public) and 21 National Board Diploma (mainly private) courses are now for GI Surgery and with its flagship procedure liver transplantation, being performed successfully in more than 25 centres nationwide figuring prominently in the media, the specialty has acquired more than a touch of glamour.

But what of the future? Are we going to consolidate our gains and then progress cautiously and scientifically basing our decisions on the relevant (to us) evidence available or are we going to get seduced by some dubious technological ‘advances’ where the procedures we perform are going to become more and more complicated and more and more expensive without really improving patient outcome.

This is probably an opportune moment in an editorial in our leading surgical journal to speculate on in which directions and how we should make our way forward.

The first and most important of the three pillars of healthcare practice is how we treat our patients (the others being education and research). In this area it is unfortunate that many of us will inevitably and unthinkingly be seduced by the industry-driven, high tech procedures of trying to do more ‘accurate’ diagnostic investigations through imaging

procedures like the PET-CT and SPECT as well as to perform supposedly ‘less traumatic’ operations through smaller and smaller incisions without assessing whether they actually make a difference to prognosis. Laparoscopic, natural orifice and robotic surgery for oesophageal, colorectal, pancreatic and even liver resections will be increasingly offered, mainly in corporate health centres, to enhance their image and, not least, to increase their coffers. However the touted advances of these techniques – better cosmesis, less pain and a shorter hospital stay (statistically significant but perhaps not so important in the Indian context) – will have to be evaluated carefully against their safety and high cost. There is a well documented increased risk of serious operative complications of these minimally invasive procedures especially when they are performed by inadequately trained surgeons who are not accountable to anyone but themselves. In the future there will have to be a national or at least statewise auditing of not only minimally invasive but all operative procedures with their indications and results which will be scrutinized by some central authority similar to the National Institute of Health and Clinical Excellence in the United Kingdom and similar monitoring and advisory organizations in the USA and Europe. There will probably be stricter accreditation for surgeons regarding who should be allowed to perform certain restricted operations in their hospitals. This will result inevitably in the more complex procedures being centralized to high volume centres. Most importantly this authority should evaluate carefully whether all these so-called ‘advances’ are cost beneficial and appropriate to our country. This will apply especially to procedures like liver transplantation with its high capital costs and continued expenditure on immunosuppression (as well as with their occasional unreported living donor deaths). The central organization will also have to choose who should embark

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on pancreas, small intestine and multivisceral transplantation providing reasons for their decisions. However we must also debate the larger issue as to whether these procedures should be largely restricted, as they are at present, to just a few centres in the private sector or should become more widely available considering that presently 90% of liver transplantation is being done in the private sector and costs 18 lakh rupees. Perhaps there will be a greater private-public partnership with their present clear distinctions becoming blurred.

However instead of concentrating on these complicated techniques which save only a few lives we should, pay more attention to our second pillar, education, which for us is the spreading of skills in GI surgery by improving the training of the young, intelligent and enthusiastic trainees who are rushing into the specialty in such large numbers. To do this I believe it is important to choose them more carefully not only on the basis of their ability to recall facts by answering multiple choice questions but to assess their motivation and ability to be able to stand such an exacting course of training and practice. Many models for such entry tests exist in Europe where candidates are put through not only written examinations but interviews, skills assessment and even some psychological tests before being inducted into the specialty. We should work towards designing a nationwide course curriculum, designing a uniform structured residency programme and a careful and continuous evaluation of a trainee's performance using surgical skills laboratories which are the feature of many major institutions abroad where would-be surgeons are instructed in both open and minimally invasive techniques.

The third healthcare pillar, that of GI surgical research, has been neglected in public hospitals for lack of adequate motivation because of the iniquitous timebound promotion systems and in the private sector because it is thought not to bring in any money. This can only change in public institutions if selection and promotion are based on merit giving due weightage to research output and not on political influence. For the private sector too I feel neglecting investment in research is a shortsighted outlook because it is crucial to sustaining our advancement in GI surgery. In this we should follow the lead of the major non-profit institutions in the USA like the Mayo and Cleveland Clinics whose reputations have been enormously enhanced by the quality of their publications which not only provide

answers to many of the health problems of America but also serve to attract to them not only patients but also trainee doctors from all over the world. We should choose our research projects carefully and instead of the whole world jumping onto the bandwagon of stem cell research we Indian GI surgeons should concentrate on our many unsolved problems like whether or not all patients with obstructive jaundice need to have magnetic resonance imaging to what is the aetiology of some of our common problems like non-specific intestinal ulcers, extrahepatic portal venous obstruction, mesenteric venous thrombosis, gall bladder cancer and chronic calcific pancreatitis. To arrive at answers we will have to take the help of and upgrade the research output of our basic science laboratories, geneticists as well as our fellow clinicians. We have to look into our own problems ourselves because no one else will and in the future we should concentrate on publishing the results of high quality studies in our own journals, like the Indian Journal of Surgery, rather than seeking approbation in the West through so-called 'international' publications.

What has been the most worrying recently has been the drift of GI surgery into commercial and sometimes unethical practice which we must curb in the future. Because its profile has been raised by the more and more complex procedures performed for greater sums of money GI surgery is considered now to be a major attraction for healthcare investors and this has resulted in an exodus from the public to the private sector and the temptation to do unnecessary investigations and operations not to mention the system of kickbacks to referring physicians which seem to have become the norm rather than the exception. With a closer scrutiny of hospital practice in the future accompanied by exemplary punishment for errant doctors this will, I believe, be easily controlled.

In spite of all the obstacles before us I think that the future of GI surgery in India is bright if we start evaluating ourselves through a careful and compulsory auditing system of our performance, weighing whether a technical innovation is actually useful, choosing and training our residents better and placing much more emphasis on high quality academics and relevant research. We have a large pool of unsolved problems and enthusiastic and committed surgeons. If we remain focused on the tasks at hand and are not led astray by the lure of money there is no reason why GI surgery in India should not, in the very near future, lead the world.