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EDITORIAL

Crucial Controversies in Surgery

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I am honoured to have been invited be the Editor to contribute to this issue. The challenge before me was to write a discursive piece on "Crucial Controversies in Surgery". As a regular and privileged visitor to India in recent years, I have been fascinated and enthralled at the challenges faced by Indian surgeons in India, and at the remarkable progress made in delivering a modern service to a significant proportion of the Indian population. To a very considerable degree, British and Indian surgeons share a common heritage in the health infrastructure of the nation. Many of the great Indian medical institutions can trace their roots to the British Administration of a century or so ago, and many Indian trained surgeons have become successfully established in the UK in the past half century, within a vibrant Anglo-Indian community.

Surgeons occupy a very privileged place in Society, with the opportunity to bring considerable influence to bear on the political establishment in the socio-economic wealth and health development of a state. However, while surgeons occupy a significant position in the medical and social hierarchy, surgery itself is not a major determinant of the health of nations. Civil engineering, including the provision of clean water and efficient waste disposal; basic education and literacy; thriving primary and public health care sectors and vaccination programmes, as but examples, all have a major role to play in creating and supporting a healthy population. We are in an era of tight financial resources relative to potentially unlimited health demand. Wise surgeons will recognise that their own demands for an excessive share of this resource for headline grabbing, high tech and expensive treatments in late cancer care, cardiothoracic surgery or transplantation, for example, will produce huge distortions in the health economy at the expense of the underprivileged, and at the risk of growing social instability. Surgeons must be seen to be playing their part in ensuring an equitable distribution of resources across the nation and across health sectors, such that the urban supercentres do not race away from the under-resourced rural heartlands.

At a national level, the competing needs of health services provision must give politicians and government economists many headaches: how best to allocate resources between primary, secondary and tertiary health care, and between the competing demands and specialities at each level; how to deal with the challenges of a huge and aging population, in which the surgical needs and surgically treatable diseases increase dramatically with age; how to balance public and independent provision of medical care; how to determine the size and quality of the health care (and surgical) workforce; how to meet unmet demand for mental healthcare, end of life, palliative and terminal care and so on.

In focussing on the practice of surgery and on the professional lives of surgeons specifically, it is instructive to consider how practice has change in the UK in recent decades, and how this might in due course affect the practice of surgery in India. When I visit India, I am struck that the governance environment of surgical practice, as opposed to the specifics of skill, technology and technique, is much as it was in the UK several decades ago, since when many changes have progressively constrained the practice of individual surgeons.

In the UK, as in Europe and the USA, there has been a progressive expansion of the consultant workforce and a move to consultant led care, in conjunction with much

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greater specialisation and restriction on the scope of practice of individual surgeons within specialities and subspecialities. The true generalist surgical practitioner is now virtually extinct. Training has been progressively curtailed on the back of working time directives and legislation to the point where many more experienced surgeons consider it to be dangerously inadequate. A new consultant may now expect to be appointed with 8,000 h of "coal face" clinical experience, as opposed to 20–30,000 h of two decades ago.

The governance environment is now very different. Surgeons are expected to practice in an evidence based way, with less scope than of old for personal opinion in decision making. Multidisciplinary teams are the norm in cancer and other areas of specialist practice. The regulatory, complaints and disciplinary environments are much more stringent than of old. They are (rightly) much more biased in favour of the patient, and possibly the pendulum has swung to an excessive degree away from the clinician. Data collection and analysis systems are increasingly exposing the work and outcomes of individual hospitals, surgical teams and individual surgeons to public and comparative scrutiny, and individual surgeons are well advised to keep detailed and transparent records of their work.

The status of surgeons is also changing, both in terms of public trust and in terms of the employment environment. Surgeons are increasingly treated as rank and file employees, and much of the former independence and freedom of action of surgeons within institutions has disappeared. Taken in the round, many of these changes are for the greater public good. They help ensure professional and political control over a field of human endeavour which is inherently dangerous, and where mishap, misjudgement, error and avoidable failings can have a profound impact on the lives of patients and their families.

Set alongside these global trends in the profession and practice of surgery and in the coffee room controversies that they generate, are the debates on specific aspects of the practice of surgery. Some debates arise from difficult choices around the allocation of resources to desirable ends, such as the development of national screening programmes for a range of diseases of surgical significance, including breast, bowel and prostate cancer, aortic aneurysms and diabetes. Other debates arise around the optimal way of addressing surgical problems, as for example the debate around the relative merits and risks of relatively mature technologies for laparoscopic hernia and bowel surgery, or for one or other type of joint replacement. Yet other debates arise over the rate and safety of the introduction of new devices and implants. In recent years, our concerns within the Association of Surgeons of GB and Ireland about the lack of a national risk register for implantable devices and our efforts to address it have been overtaken by national media coverage of the defective PIP breast implants, and the unexpectedly serious morbidity of certain "metal on metal" hip implants, as but examples.

In 30 years of front line postgraduate surgical practice as a trainee and consultant surgeon in the UK, I and my contemporaries have witnessed, experienced and adapted to all of these changes. Surgery remains an intensely rewarding and occasionally an intensely distressing field of human endeavour. The greatest challenge for all of us is to adapt what was once a highly personal craft to the digital age. The tools of the internet and mobile telephony in particular are transforming our personal and professional lives with the democratising tsunami of information, from the trivial to the profound. My principal plea and advice to colleagues is to embrace and adapt the information revolution to a better understanding of clinical and surgical outcomes, so that professional controversies are illuminated by fact and knowledge rather than by heresay and opinion. By this means, some controversies will evaporate, while others will emerge. Controversy is the perpetual partner of innovation. I wish the editor and his readers well in absorbing the content of this issue of the Indian Journal of Surgery into their own practice, and in pursuing long and successful careers in Constructive Controversy.