EDITORIAL

What Surgeons Can Leave to Other Specialists?

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The advances in technology has lead to paradigm shift in many traditional approaches to various surgical conditions. Minimal access surgery including various endoscopic procedures, are few examples. New equipments are made available and outcome based studies established their usefulness in the management of many diseases. While many surgeons are keeping pace with latest advances but in some specific areas it is observed that skills are either not up to mark or is left to other specialists. One of such areas is gastrointestinal including hepatobiliary surgery. On many occasions patients are referred to the gastroenterologists with expertise in endoscopic procedures by surgeons themselves. Does it mean surgeons have handed over these skills to other specialists? These questions need debate.

The issue may be discussed from various angles but few are presented in this write up. It appears that surgeons themselves are reluctant to equip themselves with new skills. The reason may be availability of equipment as well as training centers. This apologetic approach is easily discarded as gastroenterologists, in same set up, are moving forward in this field. Other reason may be addition of endoscopic skills into competency based residency program of gastroenterology while in general surgery it is not emphasized. Competencies in general surgery relate more to open surgical skills and few laparoscopic procedures.

The issue of training in endoscopy is debated in literature as well.[1] There have been various guidelines and recommendations regarding minimum requirement in terms of duration of training and number of cases one must perform to be able to receive certificate of competency in endoscopic procedures. Usually 2 – 3 months rotation in a department with high work load is advised. The minimum number of cases that an intern must perform has been on increase since it was suggested earlier.[2] Such procedures include upper and lower GI endoscopies including ERCP. The training must incorporate skills like dilatation of strictures using balloons / stricturotomy, injection sclerotherapy, retrieval of stones, various biopsies, stenting, to name a few.

Few studies in literature tried to establish superiority of gastroenterologists over surgeons and general physicians in terms of outcome and accuracy of the procedures performed.[3] These studies may be biased as groups identified may not be comparable. It is to be noted that when an endoscopist fails to treat a condition related to GI tract or if procedure results in complication, it is the surgeon who ultimately takes over the responsibility of managing the condition. It does seem appropriate that surgeons must embrace them with these skills and not leave it to other specialists.[4] There is a learning curve with all the skills. So with time improvement in outcome is expected.

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