Editorial

Why have Guidelines on Best Practices in Endocrine Surgical Care, Education, Training and Research?

In this era of evidence-based medical practice and consumer awareness and high expectations, we have to choose between incremental benefits of expensive new technologies and need to provide affordable, cost-effective modern medical services to the majority of our population. Both the insurers and those who cannot afford health insurance expect the best treatment at the lowest cost. We have to convince each patient about each procedure, its cost, its probable outcome and complications. Two sets of recommendations by professional association like ours (Indian Association of Endocrine Surgeons) will help immensely. One set of recommendations of best practices should be for tertiary care centers with latest facilities, adequate funds and highly trained personnel. Another set of recommendations for minimum expected standard of care in primary and peripheral centers with minimal facilities, funds and personnel. These guidelines should be flexible enough to permit individualized management of each patient, advisory rather than compulsory and will have to be regularly updated to keep up with new evidence, emerging technologies and techniques. For this, we should have timely feedback mechanisms in place, feedback from both clinicians and patients. There should be no conflict of interest concerning the members of the group involved in preparing guidelines.

These guidelines will help our colleagues in various socioeconomic conditions in different parts of the world to meet reasonable standards of surgical care and justify their decisions to patients and in case of litigation to the court. Most clinicians neither have access to recent literature nor do they have the time to make sense of the enormous data even when available. Minimum requirements' recommendation will hopefully be considered in legislations like the recent clinical establishments act instead of maximum requirements which cannot be provided in peripheral establishments or those with basic facilities only. Uniform guidelines will also help our candidates in surgical examinations to deal with controversial topics. Guidelines will also help us and our trainees to follow a clear line of management, to provide uniform instructions and skills, to collate multi-institutional statistics. Guidelines will also help patients to make rapid informed decisions and avoid confusion due to contrary opinions from multiple sources. In addition to guidelines, setting quality parameters and then supplying compliance data with a peer comparison would further improve standards of care.

Once we have a consensus, we should reach out to our surgical colleagues through telemedicine, internet and surgical skill centers. We should mentor them to develop their skills to provide minimum acceptable standard of care even in peripheral and basic healthcare facilities. There has been a mass migration of senior and specialist faculty from medical colleges to corporate hospitals in India and abroad. Meanwhile, there has been a major increase in the number of medical colleges leading to acute shortage of senior and specialist faculty. Unlike in commonwealth and other nations, the postgraduate medical-surgical education in India has been the prerogative of medical colleges in India under the Indian Medical Council Act, 1956, till the setting up of the National Board of Examinations in 1975 with the objective of improving the quality of the medical education by establishing high and uniform standards of postgraduate examinations in modern medicine on all-India basis and utilizing existing healthcare infrastructure for capacity building. Most medical colleges are also finding it difficult to keep up with rapidly changing technology which requires retraining of staff in addition to acquiring new equipment.

In this scenario, I propose that professional associations like ours should set up four-phase training, especially for our colleagues in peripheral centers as follows:

1. Design of self-training kits like the laparoscopic simulators and box trainers. These should be leased or sold to the trainee. This is to be followed by online teaching of basics, surgical management, surgical skills and equipment handling.
2. The trainee then should be provided an attachment with the trainer so that the trainer can personally supervise the trainee at the trainer's institution.
3. The trainer provides telementoring or the mentor visits the trainee's center (if reliable telecom facilities are not available) and mentors him/her.
4. The trainee appears for an examination of knowledge and skills to qualify for a fellowship certification of the association. Continued certification will need periodic upgrading of skills.

We should also set up a national/international registry and encourage our members to pool data and participate in population surveys and multi-institutional clinical studies. For these uniform guidelines, acceptable to all is essential. We should encourage surgical innovation, original, clinical and basic research and publication. Ensuring that journals honor

their obligation is a challenge that the scientific community must rise to. In all the above efforts, ethical standards have to be maintained. We do not want the kind of deplorable situation exposed by John Bohannon in his sting operation for the reputed Journal Science.[1]

REFERENCE

1. Bohannon J. Who's afraid of peer review? Science 2013 Oct 4;342(6154):60-65.

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