IN SEARCH OF RECOGNITION

The timelines in the history of Pediatric Surgery date back to the fifteenth century handwritten Turkish manuscripts describing extensive surgical procedures in children. But when in 1917, a tragedy struck at Halifax, Canada, William E. Ladd, a renowned American Gynecologist sought a pivotal career change and the foundations of modern Pediatric Surgery were laid.

Pediatric Surgery was born out of a need for total child care. The central theme was the principle of "first call for children"–implying that children ought to have the highest priority on resources of societies. It was appreciated that every measure that would contribute to the best available care for children everywhere must be encouraged. The sentiment of Sir Denis Browne–"the aim of pediatric surgery is to set a standard, not to seek a monopoly"–is the embodiment of this principle.

Whereas in the West, Pediatric Surgery has made galloping progress in the last four decades, in India it is still crawling on its knees, struggling for its rightful recognition and due fillip.

Indian Scenario

From a modest beginning of 10 members in 1965, the Indian Association of Pediatric Surgeons today has a membership of over three hundred individuals who are either solely or mainly practising Pediatric Surgery. The Madras University takes the credit of having first started a training programme in Pediatric Surgery in 1966. Today there are over 15 such training centres from which 30-35 freshly training Pediatric Surgeons qualify each year. Against this encouraging training base there is, paradoxically, a dismal picture of dissemination of knowledge and expertise of these qualified surgeons. Only about a fourth of the medical colleges in India are currently able to utilize their clinical services.

The total bed strength allocated for Pediatric Surgery including that in some private institutions, is approximately 2000; which is expected to cater to a total pediatric population in excess of 30 million. This is a meager figure particularly in the light of the Medical Council of India recommendation that in all undergraduate training institutions, the overall quota of surgical beds will include beds earmarked for Pediatric Surgery.

Facilities for the care of the surgical neonate in India are woefully inadequate. Only a handful of centres provide a set-up that barely resembles a neonatal intensive care unit. This is reflected in the survival results in babies operated upon for tracheo-esophageal fistulae. In the West, overall survival rates of these babies exceed 85% and represent the gold standard for judging the level of available neonatal intensive care facilities. In India, even at the leading tertiary centres the results still hover around 45-50%. In a majority of other hospitals in the country, survivors of tracheo-esophageal fistula are still only anecdotal.

Maladies

Thus, somehow, over the years a peculiar situation has emerged. There is an evergrowing need of Pediatric Surgical Units in the country, but they are not coming up as fast as they should. There is a new generation of highly qualified surgeons and equally well trained supporting staff, but they do not have the avenues for their proper absorption and utilization. The net result is a brain drain. Many are forced to look for openings abroad; or they find no alternative but to settle in a lesser role not commensurate with their valuable expertise.

No greater misfortune could have befallen Pediatric Surgery than for it to have been labelled a super-speciality. By virtue of this it was unfortunately elevated to a pedestal of glamor and luxury, than be rightfully placed alongside its sister speciality of Pediatrics and its parent–General Surgery.

The slow progress of the speciality is, in part, due to a misconception that it is nothing more than miniature adult surgery. Its development has never received encouragement from adult surgeons who have feared a further splintering of their speciality. Despite all odds, Pediatric Surgery thrives the world over because not only physicians but also parents of sick children appreciate that there are fundamental differences in the surgical care of children when compared to adults. And, this care can best be provided by those who in addition to their operating skills can deal with infants with a great deal of pathophysiologic understanding and compassion.

Comprehensive surgical care of children in our country is still a mirage. A point in case is the plight of babies born with spina bifida–not an altogether infrequent congenital anomaly. While a large number of these babies may have their spinal lesions repaired by surgeons–some trained, some untrained, only a few will be able to get a shunt put in for the treatment of their hydrocephalus. Yet, how many will find a surgeon who will look after their urinary and bowel incontinence. These babies are destined to become stinking social outcasts, living a life full of misery and ridicule; and their families suffer silently.

The concept of Mother and Child Welfare has of late received the attention of the Government and has been identified as a priority area. Somehow in this concept, the surgical care of children has been unable to find a place. In any Mother and Child Welfare Scheme the inseparable triangular liaison of Obstetrics, Pediatrics and Pediatric Surgery needs to be underscored. It is further confounding that "baby–friendly" hospitals, or hospitals dedicated to sick children have eluded the imagination of the Government and philanthropic organizations in India, alarmingly in the North. This has prevented the growth of Pediatric subspecialities like Cardiology, Endocrinology, Neurology, etc. on the medical side and similarly, Pediatric Cardiac Surgery, Neuro-surgery, Urology, Orthopedics and Neonatal Surgery as subspecialities of Pediatric Surgery.

Remedies

In the first instance we must unequivocally recognize that Pediatric Surgeons are broad based General Surgeons for children. This should not imply that all operations in children must be performed by them alone. Not only is this physically impossible, given the small numbers of trained Pediatric Surgeons, but also undesirable. Surgeons must continue to perform routine operations like herninotomy,

orchiopexy, appendicectomy among others. However, in order that children receive the best surgical care, General Surgeons must be trained to perform non-index cases by Pediatric Surgeons during their surgical training programme.

In the same vein, the undergraduate medical curriculum as well as the training programme for post-graduates in Pediatrics ought to be reorganized to appropriately cover the surgical diseases in children. The medical student must become familiar with the fundamental physiological differences between infants and adults. They must learn to recognize the common congenital malformations and other surgical problems of infancy and childhood. Just as the general surgical trainees must undergo training in a Pediatric Surgical Unit, likewise post-graduates in Pediatrics must receive an orientation in Pediatric Surgery. This is of paramount importance as the family physician or the pediatrician is usually the first-contact doctor who will encounter a surgical problem. The background knowledge and awareness will contribute to an earlier diagnosis of surgical problems as well as prompt institution of emergency primary care before transfer to the nearest surgical facility. This alone will go a long way in reducing surgical morbidity and mortality.

So far in our country the emphasis has been on increasing the number of training centres for Pediatric Surgery. No doubt we must continue to train more surgeons; but what we truly need is to provide these trained surgeons with a basic infra-structure of minimum facilities to cover a larger population. It would appear more logical if the thrust would shift towards service-oriented units. There is a pressing need, therefore, to create a section or department of pediatric surgery in each medical college of the country, a hope that was expressed in this very column 18 years ago(1). It would be appropriate that pediatricians demand that services of a dedicated, qualified surgeon be made available for the surgical care of their babies.

The pediatric surgeon has to be grounded in the principle of general surgery, but must impart an atmosphere of total child care. In addition to his major role of performing index operations, he must assume other equally important responsibilities of; (*i*) training general surgeons to perform non-index operations in children; (*ii*) training post graduates in Pediatrics in the recognition of and the emergency treatment of surgical diseases in children, particularly neonates; (*iii*) ensuring that common surgical problems in children are adequately covered in the undergraduate training programme; (*iv*) establishing contact with the primary health workers, particularly dais and midwives, and training to identify common congenital malformations in neonates; and (*v*) serve as role models for medical graduates so that some may get attracted to the speciality for a career.

Anurag Krishna,
Reader, Department of Surgery,
University College of Medical Sciences,
Guru Teg Bahadur Hospital,
New Delhi 110 095.

REFERENCE

1. Upadhyaya P. The first decade of pediatric surgical training in India, Indian Pediatr 1974, 11: 89-92.

With this issue we intend to start a regular section on *Pediatric Surgery* as our small contribution for this 'search of recognition'.

– Editor