Sahaj shalya (slow surgery): An extension of the slow movement and slow medicine

VINAY KUMAR KAPOOR

FAST MEDICINE

Medicine today has become much too invasive, resulting in medical interventionism. The industry's push is directing a high-tech approach to medicine, promoting health consumerism. Patients have (and are being given) unrealistic expectations, especially in cancer. This causes medicolegal disputes, leading to defensive medicine—hyperinvestiga-tionism. 'Over' care causes waste of resources and results in unsustainable high costs of healthcare—overmedicalization. End-of-life (EoL) care has become life-prolonging therapy.[1] People constantly anxious about their possible future illness do not enjoy their current healthy status—cyberchondria.[2] Over-screening is uncovering asymptomatic findings of questionable importance. With universal availability and increasing use of imaging, e.g. ultrasound (US), computed tomography (CT) and magnetic resonance imaging (MRI), more and more asympto-matic incidentalomas are being detected in the liver, pancreas, kidney, adrenal, prostate, thyroid, parathyroid, etc. A majority of these are benign or slow-growing neoplasms of questionable clinical importance. However, once an incidentaloma has been found, it not only generates anxiety but also invariably leads to further investigations and some treatment which otherwise may not have been indicated. The universal healthcare programme in South Korea offered US screening of thyroid. This resulted in a 15-fold increase in the incidence of thyroid cancer (all papillary carcinoma of the thyroid [PTC], and increase in rates of thyroid surgery between 1993 and 2011.[3]

Healthcare has been shifted from the hands of medical professionals to management professionals. Medicine has changed from being a profession to a trade, patients have become consumers, doctors are now providers. We do not heal but only treat, we only manage and do not care, we do not look at the patient as a whole but only at the organs/systems and diseases and there is little person-to-person and face-to-face interaction between the patient and the doctor, especially a surgeon (Table I). Medicine today is a large and complicated corpus without a soul; there is increasing focus on technology while the person (patient) is getting ignored or even neglected. There is increasing paperwork (bureaucracy) in medicine;[4] less time is given to the patient while more time is spent on documentation.

The manic-type, machine-like fast-tempo work behaviour, i.e. trying to catch up with everything, not being left behind and moving ahead of everyone, is causing a lot of stress to health professionals. Medical profession, surgery even more so, is becoming extremely stressful and demanding. Physical and mental exhaustion leads to burnout. Stress is not necessarily related to dissatisfaction at work; it is not that they do not like their work. Excessive workload, long working hours, regulatory scrutiny and medicolegal issues including negligence claims are imposing much stress on healthcare workers, especially surgeons. Suicidal ideation was reported by 6.3% (1 in 16) of 7905 surgeons in the USA.[5] In a survey of 600 physicians in the UK, mental health problems were reported by as many as 85% (stress 75%, anxiety 49% and diminished self-esteem 36%). One-third experienced depression and one-in-eight had suicidal feelings. Nearly 40% of those with mental health problems were reluctant to discuss their issues with any one, and a quarter (24%) felt that a stigma was attached to it. The fear/risk of losing the licence/right-to-practice was the main reason for the reluctance to report and seek counselling/treatment.[6] Depressive symptoms were reported by one-third (29%) of 17 560 residents in a systematic review and meta-analysis.[7] The situation is worse in India as there is no support structure such as counselling; on the other hand, a doctor who reports mental health problems may even be thrown out of the programme. Burnout was reported in 170 (57%) of 300 resident doctors working in public sector hospitals across Mumbai.[8]

THE SLOW MOVEMENT

Carlo Petrini, a young Italian food critic, launched the Slow Food movement in 1986 to defend the local cuisine, e.g. food served by the Italian mamas in the neighbourhood cafes against mass-produced American 'fast' food when a McDonalds' outlet opened in Piazza di Spagna, near the famous Spanish Steps, in the heart of Rome. The Slow City (Cittaslow) movement again began in Italy in 1999; it resists globalization of cities and recommends a population of no more than 50 000 in a city with controlled development, e.g. less traffic and maintenance of

TABLE I. Examples of no-listen, no-see medicine

No-listen medicine
A young woman is found to have an incidental (asymptomatic) gallbladder stone on ultrasound of the abdomen–pelvis for some menstrual complaints. She comes to the consultant surgeon for advice. He looks at the ultrasound report and instructs the resident to give her a date for admission for laparoscopic cholecystectomy.
The resident works up the patient, but she walks out of the clinic without even a word exchanged between her and the surgeon who will operate upon her.
No-see medicine
The cardiologist works up a case of triple-vessel coronary artery disease. The cardiac surgeon looks at the coronary angiography in his office. The patient is admitted and posted for surgery.
The chief consultant cardiac surgeon has a heavy operating list for the week and has to operate upon all the cases, so the ward rounds are done by the junior consultant.
As it was an uneventful minimally invasive coronary artery bypass, the patient is discharged on postoperative day 3.
Follow-up again is with the cardiologist.
The patient had the operation but never even saw the chief consultant cardiac surgeon.

Department of Hepato-pancreato–biliary Surgery, Mahatma Gandhi Medical College and Hospital, Jaipur 302022, Rajasthan, India; *vkkapoor.india@gmail.com*

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local traditions and uniqueness. Slow Money includes shopping, selling and working in the local markets so as to support the local community and keep the money within it. Slow Travel is travelling by train or road (instead of air), avoiding big cities, having relaxed trips (instead of packed itineraries), staying with the locals in their homes (instead of in hotels) and walking around the city (instead of taking a car). Carl Honore, a Canadian journalist, in his 2004 book, *In praise of slowness: Challenging the cult of speed*, coined the term Slow Parenting, i.e. take pressure off the children, letting the children be and not burden them with too many activities. Authors Beth Meredith and Eric Storm described Slow Living as a 'less is more' approach—simplicity, decluster and minimalistic lifestyle focusing more on the quality of life. Snail and turtle are the mascots of the Slow Movement. The Slow Movement advocates slowing down of life's pace; it is about doing everything at the right speed. There is even a World Institute of Slowness created by Geir Berthelsen in 1999.

SLOW SCIENCE

The objective of the Slow Science movement is to enable scientists to take time to read and think as opposed to the currently prevalent 'publish or perish' culture.

SLOW MEDICINE

Even in ancient times, there was a choice between the aggressive Galenic methods (emetics, purges and blood-letting) and the conservative Hippocratic approach (wait, observe and console) for the treatment of ailments.[9]

Slow Medicine was founded in Italy in 2011 on the philosophy of *fare di piu non significa fare meglio* (doing more does not mean doing better). It aims to take care of the poisons of fast medicine; it has three cardinal principles—measured, i.e. moderate use of resources without waste; respectful, i.e. preserving the dignity of the patient; and equitable, i.e. appropriate care to all. Slow Medicine suggests the policy of waiting before rushing, sometimes even to do nothing.[10] It is hoped that the patients will be more satisfied if they are seen, heard, touched, related to and cared for. Slow Medicine will also result in better utilization of the already-scarce resources and will ensure welfare of a larger section of the society.

On the same lines as Slow Medicine, the Choosing Wisely Movement[11] was launched in the USA in 2012. There is a personal connection, relation and communication between the patient and the doctor. Management is based on reflection, insight, thoughtfulness and mindfulness rather than mathematical and statistical protocols and pathways. It involves listening (on the part of the doctor), dialogue and decision-sharing between the doctor and the patient who then together choose (plan) the care algorithm—only those tests and procedures which are truly necessary, supported by evidence and free from harm are advised; this results in appropriate use of procedures and treatments and reduces unnecessary tests and treatments. All scientific societies participating in the movement were asked to list five most inappropriate tests or procedures;[12] so far 44 societies have identified 230 tests/procedures that do not provide any benefit and may even cause harm.[13]

The Too Much Medicine initiative of the *BMJ*,[14] a movement involving doctors, researchers, policy-makers and even patients, highlights the threat to human health posed by unnecessary care. Some of the diseases are attention-deficit hyperactivity disorder, aortic aneurysm, bone fragility, chronic kidney disease, chronic obstructive pulmonary disease, gestational diabetes, mild hypertension, prediabetes, polycystic ovary syndrome, etc. Uncritical population screening, expanded definitions of diseases, medicalization of health, overuse of technology, vested commercial interests, increased expectations of the patients and fear of litigation are some of the causes of 'too much medicine'. The concept of quaternary prevention aims to protect people from overmedicalization and medical invasion. The Royal College of General Practitioners of the UK has constituted a group.[15] An international Preventing Over-diagnosis conference was held in Copenhagen, Denmark, in August 2018.

Several well-established screening programmes are being questioned.[16] The choice is between not to miss a sick individual (but at the cost of overtreating some healthy individuals) versus not to unnecessarily treat a healthy individual (but with the risk of missing a few sick individuals).

The Covid-19 pandemic has provided the world an opportunity to have a forced preview of Slow Medicine in the form of routine healthcare including hospital admissions/operations curtailed (or even completely stopped). We will have to wait to see its impact on the morbidity and mortality of various chronic diseases, as also the savings in healthcare costs related to these diseases.

Slow Medicine in India

Since the 1980s, healthcare in India has changed from being a professional service to a market-driven commodity and a field for capital investment.[17] Public hospitals are overcrowded and have long waitlists even for life-saving operations.[18,19] Shortage of beds often leads to stoppage of major operations.[20] This puts stress on healthcare providers—the mean 'age of death' for a Malayali doctor was 62 years. The life expectancy of an Indian being 68 years and that of a Malayali 75 years.[21] A lecture on Slow Medicine was delivered by Jose Carlos Aquino de Campos Velho of Brazil at the National Conference for Ethical Healthcare organized in New Delhi by the Alliance of Doctors for Ethical Healthcare in April 2018.[22]

SAHAJ SHALYA (slow surgery)

The current system of medicine is sometimes called the P4 (predictive, preventive, personalized and participating) systems medicine (P4SM).[23] The term 'slow surgery' has been used by Atenstaedt[24] (*UMJ* 2020) in relation to a 32-week programme of exercise classes at leisure centres with support from physio-therapists and dieticians in patients waiting for a hip or knee transplant with an aim to avoid the surgery altogether in some patients at least. I would like to propose the concept of *Sahaj* (slow), *Surakshit* (safe), *Safal* (successful), and *Sukhad* (satisfying) *Shalya* (surgery), i.e. S4 surgery. Some constituents of S4 surgery could be:

1. Best supportive care (instead of expensive invasive, and often futile, interventions) for advanced, especially metastatic, cancer.
2. Non-surgical (radiological and endoscopic) palliative treatment for unresectable incurable cancer.
3. Avoiding extensive extirpative surgical resections, e.g. hepato-pancreato-duodenectomy, pelvic exenteration and combined resection of adjacent organs, which have high morbidity and mortality and result in only anecdotal actual long-term survival.

4. Identification of risk factors for failures, i.e. death due to recurrence within 12–24 months, of resectional surgery for cancer and avoiding surgery in patients with these risk factors.
5. Liberal use of neoadjuvant therapy in patients with locally advanced possibly unresectable cancer in order to assess the biology of the disease and identify patients with aggressive tumours where the outcome is likely to be poor and offer surgery to a select group with favourable biology disease where the outcome is expected to be good.
6. Non-surgical intent-to-cure treatment (instead of major, complex, mutilating surgery) wherever it is a reasonable alternative, e.g. chemo-radiotherapy for squamous cell carcinoma of the oesophagus and anal canal and for adenocarcinoma of the rectum (the Habr Gama regime).
7. Watchful waiting in slowly progressive cancers such as those of prostate and thyroid.
8. Proactive surveillance (instead of anticipatory surgery) for some (benign and low malignant potential) cystic pancreatic neoplasms and neuro-endocrine tumours.
9. Non-surgical, i.e. radiological and endoscopic interventions for diseases such as severe acute pancreatitis and acute necrotizing pancreatitis, where surgical intervention has high morbidity and mortality.
10. Watchful waiting for diseases for which the natural history is unknown, e.g. asymptomatic gallstones, haemangioma liver, non-bleeding varices in portal hypertension and portal biliopathy in extrahepatic portal vein obstruction.

Many scientists and sociologists are predicting a 'new normal' of life including less travel, no large gatherings, ubiquitous use of face masks, etc., after the Covid-19 pandemic. Slow Medicine could also become a part of this 'new normal'. S4 surgery will not only result in optimal utilization of the limited healthcare resources (both human and material), particularly in low- and middle-income countries and maybe even in high-income countries, with more benefits to a larger proportion of society but also reduce the level of stress among the surgical fraternity, resulting in better quality of life for the surgeons and their families.

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