Speaking for Ourselves

Specialization and the Indian healthcare scenario: Have we got it right?

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Three decades ago, when I graduated, specialization was uncommon, and many of my peers remained general practitioners (GPs) in their respective communities, and fulfilled a great void in healthcare in a developing nation. However, specialization was important to raise the bar of healthcare, and provide patients with complex healthcare problems a greater chance of a good outcome. During 1980–2010, specialization became the default option for medical professionals in India. This has meant that the cutting-edge of medical science and what is more, medical technology has been whetted. Has this really meant an advance? Is specialization optimized in India? I cannot help looking back over the past three decades to see the rather alarming dip in standards of comprehensive specialty training. I present a few points for your consideration:

1. We have a large number of specialty and subspecialty degrees which have allowed trainees to achieve greater knowledge and skill in a particular sphere. When I specialized three decades ago, this was achieved in a multidisciplinary environment which enabled a comprehensive knowledge of the disease process, and the optimal approach in a given case. There were many multidisciplinary clinics and academic sessions, where one became aware of the impact of alternative treatment processes and their outcomes. Physicians knew exactly when their patients would benefit from surgery and when not. I am a surgical gastroenterologist, and in my early years, my medical colleagues would often visit the operating rooms and thus gain valuable insights into the applicability, technical difficulties and, later, outcomes of surgical procedures. I have spent an enormous time in the radiology suite performing abdominal ultrasound examinations, and watching others, and in the endoscopy rooms. This helped refine my concepts as to make treatment choices for a given patient. However, over the past few years, there has been such compartmentalization in specialties that a gastrointestinal physician trainee has little interest or inclination to delve into the aspects of gastrointestinal surgery, and even official postings are allowed to go by without much activity. This has resulted in a number of junior consultants who have commenced their practice and who are in many ways unaware of (i) the availability of alternative treatment options and (ii) the skill levels available in specialists in the hospital or region.
2. There are three categories of specialists in India: (i) the qualified specialist who possesses a specialty or super (actually should be sub!) specialty degree, but with variable levels of training and capability; (ii) the specialist who is experienced and capable by virtue of training in a specialist department; and (iii) the overseas trained 'specialist' whose credentials could be variable.
3. The emergence of the private sector has opened up healthcare. It has also promoted aggressive marketing and even the public sector has resolved that it is not to be left behind—qualifications, experience and overseas training are all highlighted with gusto, but without any reference to standardization and credentialling.
4. The institution of family medicine and the GP (such a force in the National Health Service of the UK) has been sidelined and patients often see specialists in the belief that they may provide superior care. The number of qualified specialists have increased but without an increasing awareness of multidisciplinary care.
5. It is fashionable for medical professionals to achieve specialty degrees and once they qualify as specialists they require hospital environments with more resources, and unfortunately these are often not available in rural areas. This is a vicious cycle which eventually concentrates healthcare in the urban areas and neglects the rural part of the country.
6. India is a vast country, and a large proportion of its population still lives in rural areas. Specialists cannot alone get it right.
7. A by-product of this phenomenon has been the creation of numerous associations and societies which have a limited sphere of influence in healthcare. Some of these are technical and that may be quite appropriate in order to allow fine-tuning of skills. However, technical advances in the absence of systematized application of treatments would defeat the very purpose of healthcare.
8. Many of these societies publish consensus statements which are often one-dimensional and simply ignore the multi-disciplinary approach. Unfortunately, this is not confined to India but is a global phenomenon.
9. Many or all of these issues are global in occurrence, but a more regulated healthcare system has ensured some control. However, in India the system of privileges of a professional is yet to be applied, and therefore any medical professional could practically get away with any form of treatment. Providing privileges would also mean that periodic credentialling and certification would be a must. During this process, the multidisciplinary treatment process could be reinforced.

What should be done?

1. We must move away from aping the healthcare system of the developed world and modify the system to suit our large population which is distributed across the length and breadth of a large country.
2. A specialty board is a must and will enable candidates to be licensed who are optimally developed and trained. This is imperative given that there are so many categories of specialists as mentioned earlier.
3. The gulf between the qualified, unqualified but trained, and the overseas-trained must be bridged if at all it exists. We do

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need a uniform scale to measure the quality of the training. The picture gets further complicated when one adds the qualified, but poorly trained, and the unqualified but very exceptionally trained categories.

4. It would make a great improvement for the system to set up an official network of GPs who can and should form the bedrock of healthcare.
5. Regulation of specialty professionals can also provide a system of privileges for which the professional is competent to provide care, and so can ensure that the right treatment is given to the right patient by the right doctor.
6. Whatever training courses are offered must have well-regulated curricula that allow the trainee to have a well-rounded development, which permits the most appropriate treatment to be offered to the patient.

Specialized healthcare is a reality in India and many centres and departments offer treatments of quality on par or superior to others in the developed world. However, we need to get our house in order. A three-pronged approach is the key: (i) for the medical professional, a reinforcement of the age-old principle—'the patient's interests are always paramount'; (ii) for the educational institutions, a revamping of medical education to have appropriate specialists dealing with a disease process in a concerted manner so that the student imbibes the multidisciplinary mantra; and (iii) for the government, introduction of a system of privileges and credentialling/licensing.

Time is running out if India wants to become a world-class healthcare provider; for it is fully capable of it.

New from the NMJI

Managing Diabetes in Everyday Practice

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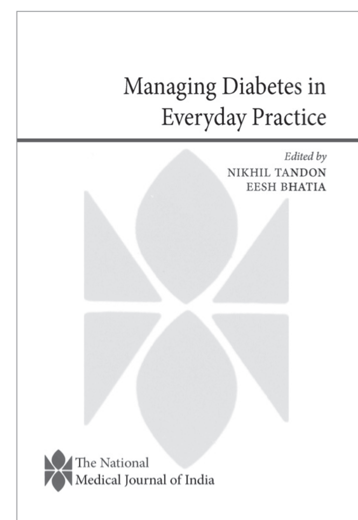

This monograph begins at the beginning—with a practical approach to a person with recently diagnosed diabetes, and then carries on systematically with a discussion on diet, physical activity, oral antihyperglycaemic agents and insulin. The latter half of the monograph covers the aspects of non-glycaemic management of diabetes, emphasizing that management of diabetes has to go beyond a glucocentric goal. This is followed by a discussion of the major microvascular complications of diabetes, namely retinopathy, nephropathy and neuropathy; and one of its most damaging complications—the 'diabetic foot'.

This book is an updated compilation of articles published in the Everyday Practice section of the *Journal*.

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