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Editorial

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Global Surgery in Rural Settings: Where are the giants?

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Rural Surgery is a bad phrase. It is bad because it means different things to different people. It can generate images of dimly lit, desperate operating rooms. It can also spawn stories of lives saved and smiling outcomes. “Surgery conducted in rural spaces” may be more specific but that is quite a mouthful. Regardless of the lack of clarity on what it is, silent surgeons in rural settings continue their tryst with disease and illness unfeted, unfettered, and as best they can.

As surgery evolves into a mechanical beast with four arms, and a screen for eyes, most of the rural world watches, wondering. On the average, 40 percent of the world and 20 percent of most high income countries are represented by a rural population, a figure that escalates to 70 percent in LMICS like India. In terms of population, this is a huge representation. It is a representation that fails to find a place in academia, and within the march of surgical evolution. A PUBMED search of the literature found only 207 references to the rural surgery in the past ten years. This lacuna has been identified as a real and present danger, and its quantification has helped establish surgery, or the lack of it, as an international public health problem.

Identification of the monster does not help us tackle it. Recognition of the problem permits emergence from the denial of it. The three delays, bellweather procedures, and catastrophic expenditure have been milestones published along the journey to find its heartbeat. There is no clear roadmap to deal with the Minotaur just yet. Humans have tended to find solutions from the soil that spawned the problem. Lister, Semmelwiess, Koch, Pasteur and a host of others grappled with problems that bedeviled them in the lair of the beast. Rural surgery should be no different.

Community participation, responsibility for their own health, training the community in the recognition of surgical conditions, and defining pathways to early treatment would be essential threads that lead out of this dark and limitless tunnel. Equipping general surgeons and alternate health providers in a wide range of essential surgical procedures would widen the repertoire of procedures performed in remote areas.

Licensing today is removing this capability from the wielders of surgical craft in remote areas rather than strengthening them. Anesthesia is a huge issue that partners with surgery and most of those on the operating floor find themselves dancing with an absent partner. Specialization and super-specialization look at surgery through the telescope, and then the microscope, with the imminent danger of finding its objective lens buried in the sand.

The cry of the rural world to broaden perspectives rather than narrow them is aphonic in the sterile air of surgical research. Research papers and databases of international trials have “missing millions” of the unrepresented rural patients. The work of the Global Surgery Collaborative has been a refreshing breeze in the right direction, and it should open fences that lead out from tertiary towers of academia into the wide-open spaces. There be the giants. Our surgical academic world should look up and engage.

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