

Who will do general surgery?

Advantages to patients of a single anaesthetic for more than one operation are obvious; attracting generalist surgeons, training them and ensuring they have adequate credentials remain hurdles

With the inexorable increase in specialised surgery, the concept of “general” surgeons, what they do, and what they represent, is difficult to categorise. Indeed, is there a need for a generalist surgeon when it seems that most areas of our bodies have a designated subspecialist?

In this issue of the Journal (page 337), Wilson, a general practitioner–surgeon makes a compelling case for the continuing existence of the general surgeon.¹ He presents an affirmative argument through the details of his experience in performing multiple elective surgical procedures on individual patients. Most of the procedures were relatively minor, yet traversed a wide range of subspecialties. The complication rates were low, and there can be no doubt that the patients benefited from a single visit to an operating theatre to have multiple problems treated.

Where can a trainee gain experience in many of the minor procedures described by Wilson? Emphasis in tertiary hospitals has traditionally been on major caseloads, yet a veritable goldmine of minor operative cases are present in day-surgical units. With a little imagination and cross-specialty cooperation, a 6-month term exclusively in a day-surgical unit would provide a trainee with a solid grounding in minor operative surgery. Rotations through regional surgical centres, where general surgical operative lists continue to remain varied,² would provide another significant learning opportunity for trainees.

However, the role of the GP–surgeon in major population centres seems limited, especially in view of credentialling requirements imposed by health care authorities. The issues of credentialling, clinical governance and continuing professional development have been highlighted by the Royal Australasian College of Surgeons (RACS) as being of critical importance for the practising surgeon, and much effort has been invested in formulating policies to reflect this and, in turn, maintain a high standard in surgical care. Who is responsible for ensuring that practitioners who are not fellows of the RACS comply with accepted surgical guidelines? While Wilson describes himself as a “GP–surgeon”, he is a fellow of both the Royal Australasian and Edinburgh Colleges of Surgeons, a factor that would certainly ease the path of credentialling in his case. The ongoing need for GP proceduralists in rural regions is unquestionable, and the various support and training mechanisms have been described at length in the Journal.³ The RACS has clearly outlined the general surgical curriculum.⁴ It states, “trainees should gain sufficient experience in operative surgery to achieve competency in managing common surgical conditions and emergencies as outlined”, and subsequently lists a comprehensive range of surgical conditions. Currently, most advanced trainees seem to attain competency in a core group of the listed procedures and then move into subspecialty regions, rarely to venture outside their chosen field. The lack of young, qualified surgeons to serve the community in a range of generalist procedures will become magnified by the ageing and eventual retirement of a substantial

proportion of the Australian surgical community.⁵ It is precisely this group of surgeons who, by virtue of previous training and experience, remain adept at a wide range of general surgical procedures. There appears to be an opportunity for senior surgeons, perhaps wishing to step back from on-call emergency work, to become “day surgery specialists” and impart invaluable knowledge and skill to junior colleagues.

The concept of a general surgeon able to perform a range of procedures on a single patient under a single general anaesthetic is worthy. While there is no rigorous evidence to prove it, anecdotally, at least, there is a definite need for such individuals within the medical community. The importance of performing minor surgical procedures well needs to be re-emphasised, and while the major cases may have more “lustre” for trainees, it soon

becomes apparent during surgical practice that much patient satisfaction can be derived from successfully curing ingrown toenails, carpal tunnel syndrome or anal fissure.

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- 1 Wilson RE. Multispecialty surgical pathology in general practice. *Med J Aust* 2005; 182: 337-339.
- 2 Tulloh B, Clifforth S, Miller I. Caseload in rural general surgical practice and implications for training. *ANZ J Surg* 2001; 71: 215-217.
- 3 Green AJ. Surgical services and remote referrals in rural and remote Australia. *Med J Aust* 2002; 177: 110-111.
- 4 Royal Australasian College of Surgeons. Surgical education and training handbook. Available at: http://www.racs.edu.au/edu/training/seth/seth_11.pdf (accessed Feb 2005).
- 5 Australian Medical Workforce Advisory Committee. The general surgery workforce in Australia. Sydney: AMWAC, May 1997. (AMWAC Report 1997.2.) □