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WHO SHOULD GET SURGICAL PRIVILEGES IN HOSPITALS?

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THIS important and difficult question is answered in widely different ways by various segments of the medical profession. For example, the American Academy of General Practice holds that the family doctor should be entitled to surgical privileges, while the American College of Surgeons maintains that the practice of surgery in hospitals should be limited to qualified surgeons. What is the background of these conflicting views? The controversial issues may be indicated by four propositions. There are a number of important side issues, but let us examine these four propositions:

1. Surgical problems can be divided into "major," "minor," and "intermediate."

This appears at first to be a reasonable statement of fact, supported by logic as well as by long tradition. Excision of moles or warts is performed by many physicians who would not dream of attempting a gastrectomy; they act on the obvious presumption that gastrectomy is a larger and more difficult operation than removal of a mole, and associated with a greater morbidity and mortality. Equally true, but much less evident is the possibility of fatal complications from an inadequately treated mole that turns out to be a malignant melanoma. Such an instance illustrates forcibly the danger and artificiality of dividing surgery into "major" and "minor." We still have textbooks of "minor surgery," but the authors generally stress in the preface the virtual impossibility of establishing a division from "major" surgery.

With this in mind, it is apparent that "intermediate" surgical operations defy analysis; indeed, the whole idea of such categories is based on the false premise that the only significant factor in the surgical experience is the operation itself. This is not to deny the importance of the operative procedure; if done badly, the patient may die despite masterful pre-

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operative care. On the other hand, the most deftly performed operation will fail to benefit the patient if it is unnecessary, incorrectly chosen, poorly timed, or associated with inadequate preoperative and postoperative management. In the interest of the patient, the only conclusion to be drawn is that *all* surgery is of major significance and that the categories of "intermediate" and "minor" surgery should be abandoned. From such considerations we come to the second proposition.

2. Physicians can be divided according to their capacity to undertake operations of increasing magnitude.

This proposition is based on the incorrect assumption that surgery consists essentially of a group of small and large operative procedures. A man with privileges to do certain "major" operations, such as appendectomy, may not be permitted by the medical staff to do bowel resection, because he is not competent to perform this procedure. But what happens when this man unexpectedly encounters a malignancy of the cecum during the course of operation for supposed appendicitis? Does he proceed with the resection? Does he keep the patient under anesthesia, while he sends out an emergency call for a specialist to come to his rescue? Or does he terminate the operation, send the patient back to bed and call in a specialist to do the bowel resection later? And even if he has a specialist as his technical assistant at the original operation, has the patient been properly prepared for a bo l resection? In any of the four urses of action open to the op ating "surgeon" in such a misadv ture, the patient takes all the ris

If surgery is not just a g up of operations, then the grad g of physicians according to op ative procedures which they ha per- formed is improper. None eless, there are many hospitals this country where certain ph cians without formal surgical ining have for years performed a rrow range of operative proced es. It is not practicable to alter s denly this *status quo,* but one sh d recognize that the operatic per- formed by such practition s may be associated with a demo trably higher rate of complicatic s than similar operations perfor ed by men with specialized train g.

For example, an audit of ecords of some 9,000 patients w had a tonsillectomy performed 1958 showed a postoperative mmor- rhage rate of 26 per thous nd ton- sillectomy patients. When the operating doctor was a general surgeon, the rate was 24 per thou- sand; the ear, nose and throat specialist had a rate of 19, and the general practitioner had 34 post- operative hemorrhages per thou- sand cases. In eight additional cases, the general practitioner re- admitted the patient to the hospital for hemorrhage, while the readmis- sion rate for general surgeons and specialists was less than five per thousand. These were serious hemorrhages requiring transfu- sions in 11 per cent and return to the operating room in 27 per cent.

The magnitude of the problem is obvious when we project the data from these 9,000 patients to the more than one million patients undergoing tonsillectomy each year in the United States. Some 10,000 to 15,000 additional patients with hemmorrhage present a strong argument against the contention that tonsillectomy is a "minor" procedure which the experienced general practitioner can perform as well as a surgical specialist.

The physician should not embark on any surgical procedure in which his complication rate is alarmingly higher than the rate for the same operation by trained surgeons. Neither should he begin any "standard" operation such as appendectomy in which unexpected findings may lead him beyond his technical competence to the serious disadvantage of the patient. He should be able to handle adequately any surgical problem he encounters during an operative procedure, or he should not operate.

3. Physicans rated as capable of performing "minor surgery" may graduate to higher privileges by in-hospital training while continuing to carry on a general practice of medicine.

This proposition is advanced as a substitute for residency training in surgery,[1] despite wide agreement that the best way to educate surgeons is by an accredited surgical residency program which schools the candidate in fundamentals of surgical diagnosis, pathology and therapy in an integrated fashion with the gradual assumption of increasing responsibility under supervision. The improvement in the general level of surgical care since this plan has been widely adopted is apparent. Why then do some advocate a loose form of preceptorship training? Simply stated, the standard surgical residency is "unduly burdensome and time consuming."[2] Moreover, in the case of a general practitioner, it "would place disproportionate emphasis on surgery"; in effect, he would be overtrained in one aspect of his diversified practice.

Qualified surgeons would agree that a four-year residency training period in surgery would tend to convert a general practitioner into a surgeon, so that he would give "disproportionate emphasis" to the surgical aspects of his practice. The same surgeons would state that a man should not be half-trained or quarter-trained in surgery because a half or a quarter of his practice calls for surgical management. There is involved here the same basic misconception previously noted, that surgery consists of learning a number of technical procedures, to be applied to patients in the same way one prescribes a drug or a hot water bottle.

It is true that surgical training is "burdensome and time consuming," but these burdens rest equally heavily on all surgical trainees, be they fresh from their

1 Thorpe, George L., "Surgical Training for the Practicing Physician," *GP,* XV: 147, March, 1957.
2 *Idem*: p. 148.

internship or securely established in practice. Indeed, one might argue that the established practitioner is able to withstand the financial and other stresses better than the young man whose entire career has been marked by financial outlays so that he is increasingly involved in debt. But such an argument about degrees of inconvenience is irrelevant to the central issue, that one cannot educate surgeons well on a painless, casual, learn-as-you-earn basis. A surgical residency is a full-time enterprise, and those who expect to achieve the same result by in-hospital preceptorships are closing their eyes to the necessary qualifications of a modern surgeon.

Let us examine what is offered as one substitute for residency training. The article previously cited describes an "active, working plan by which general practitioners are gaining increased surgical privileges." After completing 25 minor operations under supervision, the candidate may be granted "minor surgical privileges" and may then "proceed to higher categories" without interrupting his practice.

The further progress of the plan will be outlined only briefly. The aspirant to "advanced" surgical privileges must complete 100 major procedures arising from his own practice; the first 50 as assistant to a supervising surgeon and the rest with their roles reversed. After suitable assessment by the hospital surgical committee, the applicant may be granted additional surgical privileges.

This preceptorship type of training falls far short of providing the kind of surgical competence which can cope with any situation that arises. Consequently, if the best treatment for patients is our criterion, it is hard to justify two standards of surgery in hospitals where qualified surgeons are available. Recognizing that the "apprenticeship" or "in-training" type of surgical education is inferior, the American College of Surgeons forbids its fellows to train non-surgeons by this method.

4. Restriction of surgical privileges may be justified in large urban hospitals but is unrealistic in smaller community hospitals.

Some have said that in rural areas with excellent hospital facilities, the family doctor is the only available surgeon. "It is futile to discuss surgical residencies, Board certification, pathologic audits and hospital surgical privileges under such circumstances. If the patient needs surgery, the family doctor operates. There is no practicable alternative."[1]

As convincing as this may seem at first, one cannot withhold the hard question: "Why can't the patient be sent to a nearby hospital with qualified surgeons in attendance?" Modern transportation puts the most advanced surgical care within easy reach, generally in less than an hour. If the best surgical management is our goal, are we going to sacrifice this to the convenience of the patient, the relatives, or the attending physician? In urgent emergencies, the initial operation may have to be done locally, but this does not prevent subsequent transfer for the specialized care that may be even more important than the operative procedure.

Keeping the patient in an institution close to home has been invoked to justify another pernicious practice — that of itinerant surgery. The patient is operated on by a visiting surgeon whose sole activities may be the operative procedure and the collection of the fee. Even if he furnishes consultation and examination before operation, he fails to provide care and advice in the critical period after operation. All too often the door is opened to ghost surgery, with the patient unaware of the identity of the surgeon, who arrives and leaves while the patient is anesthetized. This article will not discuss the financial implications of these improper practices.

It is true that there are at present not enough "Board qualified" surgeons to staff every hospital in the country. In some of these hospitals there are physicians who by long years of surgical practice or by preceptorship and self-education have made themselves into competent surgeons. These men were formed in another era, before the widespread adoption of the residency system of training. There is no desire to legislate against such men or to quarrel with the statement that some excellent surgeons have been produced by the apprenticeship system. Today that system is not only unfeasible, it is manifestly inferior to residency training. Its continued advocacy as a means of changing general practitioners into surgical practitioners by a painless, learn-as-you-go mechanism is a backward step in improving the surgical care of patients.

Who should get surgical privileges in hospitals today? Clearly it should be the qualified surgeon, as recognized by eligibility for, or membership in the American College of Surgeons.

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[1] *Op. Cit.*, p. 71.