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Minor surgery in general practice

SURGERY is an important element of medicine: it plays a major part in the undergraduate curriculum and a surgical house job is a prerequisite for full registration with the General Medical Council. Historically, surgery has always been seen as an integral part of general practice. However, because it requires particular skills, is time consuming, and needs special equipment and facilities, few general practitioners are actively undertaking minor surgical work. The new regulations for general practice[1] will allow a list of accredited practitioners to be remunerated for such work and this will lead to a reappraisal of professional attitudes.

Minor surgery in general pratice is cost-effective, is convenient for patients and is professionally satisfying for the doctor,[2,3] but against these factors must be set the cost of equipment, fear of litigation if things go wrong and the demands on available time. Despite the hostility of most general practitioners to the imposition of the new contract the proposals for minor surgery may be perceived as more of a challenge than a threat. In future there will be a list of general practitioners who are accredited to perform a range of minor surgical procedures not only upon their own patients but upon the patients of colleagues in neighbouring practices who may be referred to them. This novel feature recognizes officially what is common knowledge within the profession, that special skills exist in general practice as well as in hospital. If the opportunity afforded by this element of the contract leads to the establishment of a number of recognized minor surgery experts who receive cases from local colleagues then the way is open for extension of this principle into other clinical areas such as diabetic care, menopausal clinics, psychiatry — this list is long. The evolution of real specialism within general practice raises many interesting prospects, not the least of which is a diminishing requirement for much traditional hospital based activity.

Remuneration at the level proposed is only a token, covering the time spent by the doctor; it does not begin to cover the cost of equipment which the general practitioner must buy. Every minor surgical procedure carried out in general practice reduces the pressure on hospital waiting lists, and since equipment in hospitals is paid for by the health authority, general practitioners will need to bring pressure to bear on the Department of Health to make arrangements through health authorities for the free supply of sterile surgical packs to general practice. The decision to link remuneration to a target is unfortunate and could encourage unnecessary operations; symptomless and harmless nodules and cysts might be removed simply because a target must be attained.

Entry of a general practitioner to a minor surgery list will be granted by the family practitioner committee (health board in Scotland), but on what basis? Different committees are apparently using different criteria in approving or rejecting applications. The guidelines being produced by the Royal College of General Practitioners in conjunction with the Royal College of Surgeons will help — but problems remain. Initial interpretation of the regulations by the Department of Health requires doctors to certify their competence to perform all of the procedures currently listed. What of the general practitioner who is confident injecting joints but has no wish to remove cysts or ligate veins? As the rules exist, the doctor will not be

eligible for inclusion in the list. How then will such a doctor fare when a procedure performed in good faith and to the best of his or her ability goes wrong and the question of litigation arises? What will be the response of the defence unions to such a doctor who is not on the minor surgery list? These questions are urgently in need of an answer. The 'all or none' ruling by the Department of Health makes little sense, the composition of the list itself defies logical interpretation, and the exclusion of the 'suturing of lacerations', surely one of the commonest minor surgical procedures performed in general practice, is incomprehensible.

With goodwill a more flexible and sensible list of procedures can be agreed and clearer criteria of competence established. Specific training in minor surgery is likely to be included in vocational training schemes and assessed as part of the MRCGP examination. The way forward for this aspect of the new contract is not entirely clear, nor is it for most of the other elements of the contract, thrust by a determined government upon a reluctant profession.

Minor surgery affords an excellent opportunity for audit. The clinical condition is clear, and the outcome is capable of precise measurement. Peer review and audit have been accepted by the profession as the way in which we can set and maintain our own standards. However, we have been too slow and now for the first time in the history of medical practice, family practitioner committees and health boards are being asked to judge our competence to perform normal medical procedures. It is up to us to regain the initiative and to show that we can keep our professional standards in good order, so that the public can continue to be assured that they are safe in our hands. Minor surgery in general practice offers a golden opportunity to do this.

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Anger in the consultation

ANGER is a frequent concomitant of the doctor–patient interaction. It may arise on either side and has many outcomes, a few of which can even be therapeutic. For example, if the physician handles his patient's anger with tact, temporarily humbling himself, the latter is given an opportunity to be magnanimous and forgiving. At the other extreme, patients stir up feelings in us, often at a subconscious level where we are dimly aware of the salt being sprinkled on our own unresolved conflicts. If it is true that our faculties for observing the doctor–patient relationship are inherently unreliable,[1] then the distinction between two 'sides' of the relationship is an artificial one and we must bear this in mind when trying to analyse the source of anger for doctors and patient separately.

The physician is most likely to become angry when he feels that his professional competence or integrity is being impugned. In a general way one might call this a disappointment of expectations on his side because he believes that, for the most part the patient should react to his ministrations with gratitude and admiration. Examples of the doctor's competence being questioned are the patient who asks for referral before he states his chief complaint — an almost daily occurrence in general practice — and the mother who flaunts a letter from the regional emergency room where little Johnny's cough was diagnosed as pneumonia 'when you said he only had a cold'. It is interesting that the diagnostic process seems far more emotionally charged for patients than does treatment and that in primary care we are more likely to be taken to task for overlooking a condition, no matter how benign, than for the worst imaginable therapeutic misadventure. Missing a diagnosis suggests that the physician did not believe the patient whereas an iatrogenic disorder confirms that he was out there trying his best.

The doctor is particularly prone to anger when the propriety of what he does is challenged. A man who does not belong to the practice but whose mother, with terminal cancer, is a patient, is allowed to jump the queue in order to get a prescription for her and a letter to the oncologist. The doctor regards these proceedings as justifiable and considerate and does not feel he owes an explanation to those who came earlier. However, should the next patient remark on the irregularity of what occurred, the doctor may well feel insulted and interpret the complaint as expressing a lack of confidence in him.

On the patient's side, too, disappointment of expectations is the chief cause of anger. At the lowest level, he may have expected a sick note or a letter to social services or a prescription for antibiotics when the doctor believes that none of these is indicated. In a system of pre-paid medicine such requests are often reinforced by a strong sense of entitlement.

On a higher plane, patients and doctors may be frustrated with the shortcomings of medicine as a whole. As general practitioners we represent a profession that has no cure for most of the disease processes besetting humanity, among them diabetes mellitus, hypertension, atherosclerosis, rheumatoid arthritis, asthma and duodenal ulcer. This uncomfortable state of affairs, applying as it does to hundreds of millions of people throughout the world, is often obscured by brilliant successes with narrow applicability: chemotherapy for testicular cancer and Hodgkin's disease, organ transplants and the like. The best that general practitioners have to offer in most instances is a kind of secondary prevention: expensive, protracted and damaging to the quality of life. An illustration of the anger of those who apply to us for relief is the 64-year-old man with cirrhosis and an abdomen distended by ascites who is being treated by a state-of-the-art hepatology clinic. He comes to his general practitioner (who else can he turn to?) and asks: 'Can't something be done for this terrible belly?' The doctor, who sincerely believes he has done his best, experiences a moment of irritation, as if to say: 'Why is he making me feel guilty?' As front-line doctors we must face the fact that when we undertake a career in medicine the guilt becomes collective and we cannot simply shift the blame to the researchers.

The doctor, who is seen as the expert in the encounter with the patient, is felt to bear ultimate responsibility for the way matters proceed,[2] and life is often made difficult for the individual practitioner by the profession's penchant for raising expectations in the public. These are mostly of a biomedical kind — molecular cures for molecular derangements.[2] As we lose our homey, old-fashioned prestige, we look for a place in the sun of science, forgetting that it is a critical attitude, not statistical rigour, that makes a man a scientist.[3] We change the recommendations for staying healthy as often as we change our socks,