

# Potential pitfalls of minor surgery in general practice

**T**HE general practice contract, in operation since April 1990, introduced payment for minor surgical procedures<sup>1</sup> and allows remuneration to general practice principals actively undertaking minor surgical work. Indeed, up to £1200 per annum may be generated by such procedures.<sup>2</sup>

Minor surgery in general practice has been shown to be cost effective,<sup>3</sup> convenient for the patient and satisfying for both the doctor involved<sup>4</sup> and the patient receiving treatment.<sup>5</sup> Against these potential benefits the general practitioner must weigh the disadvantages of potential loss of other income while operating,<sup>6</sup> the transfer of after-care costs to the practice<sup>7</sup> and the increased responsibility that all members of the primary care team must share. All these potential effects should be considered before a decision is made to provide minor surgery. Several other major factors which have recently received attention in the literature must also be considered and are discussed here.

Operator experience is dependent not only on 'hands-on' experience, but also on appropriate teaching. A recent multicentre study demonstrated that although 90% of vocational trainees intended to perform minor surgery, only one third were 'very confident' about excising a sebaceous cyst.<sup>8</sup> This evidence is supported by a questionnaire completed by another group, of 74 trainees, of whom none was confident about performing 10 selected procedures on the minor operations list.<sup>9</sup> Of those trainees who are confident to perform minor procedures, past experience shows that confidence does not equate with competence.<sup>10</sup> While 41% of a group of general practitioners already on the minor operations list stated that they had gained sufficient experience during their surgical house officer post and 36% had gained their experience in general practice (the remainder acquiring experience while medical students),<sup>11</sup> the data would suggest that most general practitioners excise fewer skin lesions per year than most dermatology senior house officers excise per week.<sup>12</sup> All this evidence suggests the need for a formal training programme for general practice trainees so that on completion of their training they are both competent in minor surgical procedures and able to recognize conditions/procedures beyond their capabilities. Indeed, the need for formal training has been publicly endorsed by the Royal College of General Practitioners.<sup>13</sup>

Acceptance of this argument raises many questions, for example, who should the trainers be, how, where and when should the training take place and how can continuing education be achieved? Suitable trainers would be specialists of senior registrar/consultant status, or a recently retired consultant might be encouraged to act as an area tutor. Alternatively, an experienced general practitioner could provide the appropriate training.

The training could take place either during pre-registration posts or as part of the vocational training scheme. Since all medical graduates (and therefore all subsequent general practitioners) have to complete a pre-registration surgical post it would seem obvious for training in minor surgery to take place during this period. In order to release house officers for training in minor surgery their duties would have to be undertaken by another member of the medical staff, extending an already over-extended system even further. A solution to this problem might be to employ a clinical assistant to cover the duties of the trainee house officer during the training period. Alternatively, the senior house officer working on the same team could provide cover, although this would probably meet with resistance from many senior house officers who feel their own surgical training is at

best sporadic and sometimes non-existent. Many, although not all, vocational training schemes include accident and emergency posts during which training could take place within the department, or the trainee could be released to a specialist team for appropriate experience. The trainee's accident and emergency post duties could be covered as described above or the training periods could be incorporated into the duty rota.

Ideally, the training would consist of sessions, held at least once a week, of one-to-one practical experience when the trainee would first be shown how to perform a procedure and then perform it under the direct supervision of the trainer. These sessions would ideally be held in appropriate surroundings such as an operating theatre, day unit or suitable practice premises, and trainees would have to satisfy their trainer that they were competent to carry out all the procedures on the minor operations list.

Continuing education in minor surgery could take the form of study days, held at least once a year, and regular audit sessions of local groups of general practitioners, to ensure a consistently high standard of practice. A post-training review procedure supported and recognized by the medical profession would also help to ensure that standards were maintained nationally. The construction of a structured training programme is fundamental to the provision of good care as no amount of unsupervised service experience is a substitute for supervised training.

Appropriate training is also important in determining the extent of surgical resection required. Numerous reports demonstrate a consistent difference between the adequacy of surgical excision of malignant lesions carried out in hospital and general practitioner excisions.<sup>14-16</sup> As many as 80% of malignant skin lesions are incompletely excised in general practice,<sup>14</sup> probably as a result of failure of pre-operative diagnosis — squamous cell carcinomas represent the most difficult diagnosis.<sup>12</sup> Indeed, a correct pre-operative general practitioner diagnosis was reported in just three out of 10 cases of malignant skin lesions.<sup>14</sup> Histopathology laboratories report dramatic increases in the number of general practice specimens since the change in contract,<sup>12-14</sup> although not all specimens excised in general practice are sent for histological assessment,<sup>17</sup> contrary to the guidelines issued jointly by the General Medical Services Committee, the Royal College of General Practitioners, the Royal College of Surgeons of England and Edinburgh and the Joint Committee on Postgraduate Training for General Practice in 1991.<sup>18</sup> Considering the failure of pre-operative diagnosis, the inadequacy of excision of malignant lesions and the increased number of skin lesion excisions performed in the primary health care system, it appears imperative that all specimens be sent for histological confirmation of the clinical diagnosis whether this protocol enjoys universal support or not.<sup>19</sup>

It is of utmost importance that the specimen be transported in the correct medium, adequate records be kept and patient follow up be arranged so that the potential for grave errors be minimized. Of the 14 criteria used to assess the adequacy of general practitioners' premises for inclusion on the minor surgery list in the Leeds area, poor record keeping was the major reason for failure.<sup>20</sup> Inadequate records also preclude effective audit which should be an integral part of the system. The other major reason why practices were not included on the minor surgery list was inadequate resuscitation equipment, as the most dangerous potential complication of minor surgery is anaphylaxis caused by the local anaesthetic. Adequate equipment was defined as an arti-

ficial airway and instant access to adrenaline; the provision of oxygen and full intubation equipment was considered unnecessary in this report.

Another potential source of problems in the practice is the need for sterile instruments.<sup>21,22</sup> These are best obtained by the use of an autoclave, and recent Department of Health circulars have set basic standards for sterilizing equipment in the practice setting. Alternatively, sterile instruments may be available from the local hospital's central sterile supply department either on loan or by lease agreement. Disposable instruments are unlikely to be the answer as many procedures will require a scalpel, forceps, scissors, needle holder and artery forceps, or any combination of these, some of which are not available as disposable items and even those that are available are often of poor quality so making the procedure technically more difficult.

The solutions to many of the points raised here are self-evident, but the provision and timing of appropriate training remains a source of great debate and is of fundamental importance if the role of general practice minor surgery is to receive universal acceptance in both the hospital and primary health care systems. This training should be supervised by experienced trainers so that eventually the 'minor surgery specialist' will be able to identify suitable patients and conditions, operate safely and appropriately and thus provide a service which is satisfying for patients and doctors. The recognition of a need for adequate and structured continuing education in minor surgery is something the profession should take up with enthusiasm, otherwise it is likely that regulations will be set by others who may not be as constructive in ensuring the maintenance and continuing development of this service throughout general practice.

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# Making changes? Audit and research in general practice

CONTRACTUAL obligations and financial incentives have been effective in modifying professional behaviour among general practitioners,<sup>1</sup> who are traditionally, some would say notoriously, resistant to imposed change. Blunt instruments have been needed to achieve the pace and scale of change demanded by the Department of Health, not least because grave concerns about the impact of reforms on professional relationships and patient care have impaired their early adoption. Audit and research are other potential agents of change with more intellectual appeal but which have more question marks over their efficacy.

Research and audit in general practice are both underwritten largely by rhetoric, but audit has also been supported by substantial central funding. Audit is participative and, because participation in change is more likely to make changes stick, it is thought to be a good way of effecting professional behavioural change.<sup>2</sup>

Little is known about the time, energy and money consumed by audit in general practice, or its opportunity costs and impact on the costs and quality of health care. Audit is not at present an explicit component of the National Health Service research and development strategy. Research in general practice, however, is more likely to be a solitary than a participative activity<sup>3</sup> and there is little evidence that it is a particularly powerful agent of change.<sup>4</sup> Although the management of change and the diffusion of innovation in general practice have received some attention,<sup>5,6</sup> there is incomplete understanding about the forces that initiate and sustain significant change and conversely about the factors which act as barriers to change.

Research involves the quest for new knowledge while audit incorporates that knowledge into a process aimed at improving care. A national conference on medical audit and medical