Canadian Journal of Surgery | Journal canadien de chirurgie





# Editor's View

This is an unusual topic for a surgical journal, because it concerns working less rather than working more! It's no secret that a significant mismatch now exists between physician numbers and patient demand. There has been widespread publicity about limited access to physician services in all areas of medicine, and waiting lists for some services have reached the stage where provincial health ministries are now taking note of these unacceptable delays. Compounding this problem for surgical specialties is the decreasing numbers of medical students applying for surgical training and changed priorities among surgeons entering practice and surgeons nearing retirement age.

One of the strategies to deal with increased waiting times for elective and semi-elective surgical intervention has been to increase the resources made available at the hospital level and to improve the efficiency with which these services are delivered. The fact that the number of surgeons has not increased substantially and certainly has not increased in proportion to the increase in resources available has led to the inevitable—surgeons working harder.

Surgeons and hard work are not strangers to one another—long hours and often physically demanding work are part and parcel of surgical practice. Many surgeons, however, were working at or near capacity before these new pressures of meeting wait-time expectations were brought to bear on the profession. These pressures have been uniform across surgical specialties and are equally felt in both community and academic practice. Surgeons in community practice are usually responsible for the comprehensive care of surgical patients from preoperative assessment through to satisfactory rehabilitation. If they have little or no help to manage these patients, expanding the size of the surgical practice to meet wait-time goals expands the overall workload substantially.

Surgeons in academic practice, on the other hand, usually have residents and, occasionally, clinical fellows to share the burden of patient care; therefore, the obligations of caring for individual patients may not be as strongly felt by these practitioners. However, academic surgeons usually have significant nonclinical roles in the hospitals and/or universities in which they work, and these obligations do not change despite the increased volume of patient care required. Therefore, surgeons in academic practice, just like their community colleagues, are devoting long hours to increased clinical care, often at the expense of their academic obligations.

We all recognize that the current system is not sustainable in the long-term and must be addressed by increasing the number of surgeons available to provide care for patients and improving the efficiency with which this care can be delivered.

In the short-term, surgeons should be prepared to recruit nonphysician care providers to assume some of the tasks traditionally performed by surgical specialties. The establishment of screening programs staffed by appropriately trained nurse practitioners or advanced care physiotherapists can greatly assist in ensuring that only those patients appropriate for surgical consultation are in fact seen by a surgeon. Trained nurse practitioners or physician assistants can function effectively as surgical assistants; appropriately trained individuals can also provide ongoing

postoperative management to ensure that patients receive appropriate postoperative surgical care and that the attending surgeon is promptly informed of any untoward events after the surgical procedure. Similar individuals can perform postoperative assessments, seeing patients in routine follow-up for suture removal or dressing changes or to review laboratory results. This will ensure that the attending surgeon focuses his or her time and attention on those patients who need it.

Surgery is constantly evolving; all of us are accustomed to changing our surgical practices to take advantage of new technology in our respective areas of specialization. The last big change in surgical practice, in my experience, came about with the advent of same-day admission for surgery, and the use of care maps to determine appropriate length of stay for patients in hospital. I think many of us were skeptical when these changes were introduced, as we thought they would lead to an increase in complications and would be vigorously resisted by patients. In fact, the experience has been just the opposite — complication rates have gone down as patients spend less time in hospital and are enthusiastic about decreased length of hospital stay. I feel the time has come for the next big change in Canadian surgical practice: the establishment of official alternative care providers to decrease the burden of work for practising surgeons. We will all be better off in terms of our professional and personal lives when this change is instituted in our own practices.

As always, your thoughts, comments and criticisms are welcome.

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**Competing interests:** None declared.

# Point de vue du rédacteur

Ce sujet est plutôt inusité pour un journal chirurgical, parce qu'il porte sur la réduction plutôt que sur l'augmentation du travail! Le déséquilibre important qui existe actuellement entre les effectifs médicaux et la demande des patients n'est un secret pour personne. L'accès limité aux services médicaux dans tous les domaines de la médecine a fait l'objet d'une vaste publicité et les listes d'attente pour certains services ont atteint le stade où les ministères de la Santé des provinces prennent maintenant note de ces retards inacceptables. La baisse du nombre des étudiants en médecine qui se dirigent en chirurgie ainsi que le changement des priorités des chirurgiens qui entrent en pratique et de ceux pour qui l'âge de la retraite approche, viennent compliquer le problème.

Une des stratégies adoptées pour faire face à l'allongement des temps d'attente pour des interventions chirurgicales électives et semi-électives a consisté à augmenter les ressources mises à la disposition des hôpitaux et à améliorer l'efficience de la prestation de ces services. Le nombre de chirurgiens n'a pas augmenté pour la peine et la hausse n'a certainement pas été proportionnelle à l'augmentation des ressources disponibles; résultat inévitable : les chirurgiens travaillent davantage.

Travailler fort, ce n'est pas nouveau pour les chirurgiens – les longues heures et le travail souvent exigeant sur le plan physique sont la norme en chirurgie. Beaucoup de chirurgiens travaillaient toutefois déjà à plein régime ou presque lorsqu'on a commencé à exercer sur la profession ces nouvelles pressions pour satisfaire aux attentes en matière de réduction des temps d'attente. Ces pressions se sont exercées uniformément dans toutes les spécialités de la chirurgie et se font sentir dans la pratique autant communautaire qu'universitaire. Les chirurgiens en pratique communautaire sont habituellement chargés du soin intégré des patients en chirurgie, depuis l'évaluation préopératoire jusqu'à la réadaptation satisfaisante. Si ces chirurgiens ont peu d'aide, voire même aucune, pour prendre ces patients en charge, l'expansion de la pratique chirurgicale pour satisfaire aux objectifs des temps d'attente alourdit considérablement la charge de travail globale.

Les chirurgiens en milieu universitaire, par contre, ont habituellement des résidents et, à l'occasion, des fellows cliniciens qui partagent le fardeau du soin des patients. Il est donc possible que ces praticiens ne ressentent pas aussi lourdement les obligations imposées par le traitement de chaque patient. Les chirurgiens des milieux universitaires, toutefois, ont habituellement des rôles non cliniques importants à jouer dans les hôpitaux ou les universités où ils œuvrent et ces obligations ne changent pas même si le volume de soin aux patients a augmenté. Tout comme leurs collègues communautaires, les chirurgiens qui pratiquent en milieu universitaire consacrent de longues heures à des soins cliniques accrus, souvent au détriment de leurs obligations universitaires.

Nous reconnaissons tous que le système actuel n'est pas viable à long-terme et qu'il faut le viabiliser en augmentant le nombre de chirurgiens disponibles pour soigner les patients et en améliorant l'efficience de la prestation des soins.