

GPs WITH ENHANCED SURGICAL SKILLS: A QUESTIONABLE SOLUTION FOR REMOTE SURGICAL SERVICES

I respond to arguments by Drs. Vinden and Ott in “GPs with enhanced surgical skills: a questionable solution for remote services” (December 2015). We welcome an evidence-based debate on how to best meet the surgical needs of rural residents in Canada.

The definition of safety in surgery has focused on hospital-based activity related to procedural interventions.¹ However, quality of care must also include dimensions of acceptability, accessibility, appropriateness, effectiveness and efficiency.² Our patients’ definition, similarly, will include impact of travel on finances, loss of supportive relationships, and sense of “community belonging.”³

After all, location of care is not solely the doctors’ decision; patient- and family-centred care means that patients and their families (and rural communities) decide where they receive care, informed by data about relative risks and outcomes.⁴ “Nothing about us without us.”⁵

As for the breadth of the skill set proposed, rural population distribution matters. The degree of generalization required to practise in any given setting is inversely proportional to the human resources available. This means that in rural Canada, with its low physician numbers, a broad skill set is necessary and will continue to be practised.⁶ “The generalist physician is prepared and willing to reach across the existing gaps in the health care delivery system.”⁷ The ESS physician crosses one of these gaps.

Any critique around competency-based training must be given within the context of the current curricula redefinition for general surgeons.⁸ The published draft was a scaled-down version, designed to convey the procedural con-

tent. The program itself provides foundational content, milestones, etc.

Disparity of time frames in training, although less relevant in a Competence by Design (CBD) framework, is offered as evidence of the inadequacy of the ESS training program. Unlike the vast majority of “rookie” R1 surgical residents, however, ESS residents are not postgraduate year (PGY)1s, but are licensable physicians, with at least 2 years of clinical knowledge and skill acquisition, often acquired in low-resource settings where decision-making skills have been well tested.

Regarding gastrointestinal endoscopy training, the American Board of Surgery (similar to CAGS⁹) reiterates the importance of rural care and of de-emphasizing specialty designation, stating that “patients will be best served by establishing validated quality indicators for proficiency, (...)using these more objective standards.”¹⁰

How does centralization of care affect care delivery? Malik and colleagues¹¹ argue that a massive shift toward geographically centralized care would imperil a host of other services, and thus argue strongly against such centralization (despite demonstrably worse outcomes). Safety and quality must have a broader context than hospital statistics.

Finally, will the current “surplus” of surgical human resources solve rural surgical issues? New general surgeons who are prepared for rural practice are rare, but even those who are will bring with them substantial resource requirements.¹² Rural places would welcome such an influx, but for now will continue to provide the best possible care with the available resources.

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