Adequacy of general practitioners' premises for minor surgery

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Abstract

***Objective*—Assessment of facilities for minor surgery in general practitioners' premises.**

***Design*—Independent inspection of premises and equipment.**

***Setting*—Large urban district.**

***Subjects*—Premises of all general practitioners who applied to be reimbursed for minor surgery.**

***Main outcome measure*—Fulfilment of 14 preselected criteria.**

***Results*—69 of 111 premises met all criteria and were approved; 23 failed on only one criterion. The commonest reasons for failure were inadequate record keeping and lack of resuscitation equipment. Twelve practices had out of date adrenaline.**

***Conclusions*—Most premises are suitable for minor surgery, some with attention needed to record keeping. Practices must pay careful attention to the expiry date of adrenaline.**

Introduction

When general practitioners started to be reimbursed for performing minor surgery family health services authorities became responsible for both the practitioners and their premises as suitable for these procedures. Though the procedures listed and competence of doctors have been contentious issues, approval of the premises and equipment has received little attention. No central guidelines for criteria of acceptance have been available. We present the criteria used by the Leeds Family Health Services Authority and review the results of our inspection of premises using these criteria.

Methods

Leeds Family Health Services Authority serves a population of 709 000, with 400 general practitioners in 133 practices providing medical care from over 185 premises. Of these 133 practices, 110 applied to be remunerated for minor surgery. We inspected 111 practice premises during July 1990 to November 1990.

We drew up the criteria for inspection on behalf of the then Leeds Family Practitioner Committee and the district health authority, in conjunction with a general practitioner representative from the local medical committee. The criteria were subsequently adopted by the family health services authority. Fourteen criteria were used in all, and these were divided into nine categories as follows.

Record keeping—All practices must keep a comprehensive record of procedures undertaken and outcomes; this is equivalent to an "operating book." The record would also provide evidence to substantiate claims for payment in cases of dispute and allow audit of individual practitioners or practices. A formalised reliable system for follow up of samples sent to laboratories was expected. General practitioners must be responsible for ensuring that results of investigations are returned and associated with the correct patients. In practice this entailed a "check out check in" system for specimens. Such systems were often already operating in practices and in those in which they were not the concept was well received by practitioners.

Sterilising systems—A suitable, working, and adequate method of sterilisation was the only criterion. Sterilisation by boiling in a custom built appliance was considered the minimum acceptable, and, although approved, suggestions were often made that better facilities would be advisable. Most sterilisers were steam or pressure machines, and the most recent service was checked in the service manual. Provided that the appropriate regulations and advice were adhered to sterilisation by immersion was also acceptable.

Adjustable lighting—Although many surgeries had adequate natural or fixed roof lighting, an adjustable or directional light was thought necessary. This did not have to be a permanent fixture: a mobile Anglepoise type lamp was adequate.

Back up staff—Minor surgery should be conducted only when another person is present in the building (either a nurse, another doctor, or a receptionist). Practitioners had to provide an undertaking that this was so. Most doctors in fact operated only when their nurse was present as assistant.

Resuscitation equipment—The minimum requirements were an adequate airway device (such as Guedel or Brook airway) and instant access to adrenaline. The most dangerous complication likely to arise from minor surgery is anaphylaxis caused by the local anaesthetic. Practitioners can more readily maintain an airway if an airway device is available and adrenaline can be administered. We thought it unreasonable to insist on full intubation equipment as its use requires practice and constant updating of skills not often used in general practice. Similarly, oxygen provision was thought unnecessary for minor surgery.

Operating table or couch—This had to be flat and able to accommodate a large adult. An examination couch was considered adequate, and tipping was not essential.

Operating room—The room should be suitable, clean, and in good decorative order. No size was dictated, and the room did not have to be dedicated to minor surgery.

Instruments were to be (a) suitable for the procedure, (b) readily accessible during the operation, and (c) housed on a surface other than the operating table or couch. A trolley was ideal, but fixed surfaces were equally acceptable. A fourth criterion was a minimum set of instruments for basic minor surgery, which we defined as a scalpel (metal or disposable), forceps, scissors, a needle holder, and clips or artery forceps.

Washing and scrubbing up—Hand washing facilities had to be available close to the room but not necessarily in it. Gloves were not considered necessary for sterility but were recommended for hygiene.

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General practitioners were not informed of the criteria before their practices were inspected. One of us (NZ) visited the practices and documented pass or fail for each criterion. If all components were satisfactory the application was approved without further qualification.

Results

Sixty nine premises fulfilled all the criteria and were approved. Table I shows the number of criteria the remaining 42 failed on, and table II which criteria the practices failed on. The largest number of practices (30) failed on record keeping. Of the 22 premises which failed on resuscitation equipment, 14 had no airway device, and 12 had out of date adrenaline.

TABLE I—*Number of criteria failed by inspected premises*

No of criteria (n=9)	No of premises failing (n=111)
0	69
1	23
2	13
3	5
4	
5	1

TABLE II—*Reasons for failure in 42 practices not considered adequate*

	No of practices failing
Record keeping	30
Sterilising systems	3
Adjustable lighting	7
Back up staff	
Resuscitation equipment	22
Operating table or couch	1
Operating room	
Instruments	6
Washing and scrubbing up	

Discussion

Reimbursement for performing minor surgery has resulted in most practitioners applying to be on the list for this service (83% of those covered by Leeds Family Health Services Authority). Inspection of practice premises offered an unparalleled opportunity to assess the quality of current services as general practitioners were unaware of the criteria before inspection. The views of a local general practitioner, an accident and emergency specialist (NZ), and a member of the family health services authority involved in implementing the new general practitioner contract (GH) were incorporated into the criteria.

We realised that the criteria might engender some discussion and hostility from practitioners, but most accepted them and found them soundly based. Many spontaneously commented in later correspondence with the authority how they had appreciated the opportunity to audit their facilities and receive advice on requirements for performing minor surgery. Whether politically, financially, or ideologically based, this encouraging attitude of general practitioners to self audit and their intentions to improve facilities for patients must augur well for primary health care.

Two thirds of the premises immediately fulfilled all the requirements. The requirements may have been too lax, but we thought that stricter criteria would not add to the safety of procedures: operator technique would be more relevant. With suitable competence in the procedure being performed, we believe that no practitioner would be putting patients at risk by complying with only the minimum requirements. Many practices provided facilities far above our requirements, and this, of course, is to be encouraged.

If practices failed on any of the criteria they were informed in writing of the reasons for their failure. They were allowed provisional approval for minor surgery on an undertaking to make good any deficiencies identified by the inspector. This covered many practices that failed on record keeping because they had not been peforming surgery before inspection. Compliance will be checked by further inspections.

Twelve practices had out of date stocks of adrenaline. Unfortunately, this drug has a short shelf life, but it is usually part of a "shock pack" available for practice staff to treat anaphylaxis or other emergencies (for example, after immunisation). It is therefore important for the practice to maintain fresh adrenaline not just for minor surgery.

Although inspection was initially resisted by the local medical committee, individual practitioners were usually aware of any shortcomings of their practice and used the inspection to discuss any deficiencies in their premises and how they might be corrected. As the criteria became known during the inspection, most practitioners were grateful for advice and recommendations, and those who complied fully often asked advice on improving facilities even further.

In conclusion, many practices already have high standards for minor surgery. Nevertheless, the failures remind all practices that attention must be paid to accurate record keeping and to providing in date adrenaline.

We thank Dr M Brown, for help in drawing up the criteria and with the initial inspection.

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MATERIA INDOMEDICA

Shortage of bodies to dissect

If this headline in *The Times of India* dated 21 August 1990 was riveting, what followed was perplexing. "Medical institutions in Bombay have complained about the shortage of human bodies for dissection," proclaimed the reporter. She pointed out that although the coroner's court received around 500 unclaimed bodies a year, few of these were passed on to the departments of anatomy at the four medical colleges in the city. By law the bodies have to be kept in storage for three days before they can be termed "unclaimed." Most bodies putrefy during this period as the conditions under which they are stored are far from ideal. Malfunctioning air conditioning plants and the hot humid climate of the city conspire against preservation. Bureaucratic delays compound the decay. With 600 students entering the medical colleges in Bombay each year it is not uncommon to see a crowd of students around each part under dissection.

One professor of anatomy estimates that we need at least a million bodies annually to meet the need for cadavers, organs, skeletons, and individual bones for special study at all the medical colleges in the country. There is a trend towards willing one's body for dissection, but this can be frustrated by next of kin who repudiate the dead person's wishes. The anatomy department at a suburban medical college receives 120 registrations of such wills annually but only 10% of the bodies actually reach it. In separate statements representatives of the Hindu, Moslem, and Christian faiths emphasised that their religions did not object to donation of the body for a good cause once the last rites had been performed.

Ironically, in conversation many teachers of anatomy claim that the emphasis on dissection is misplaced. Most students, focusing their attention not on the structure of the human body but on the marks to be scored at the first MB BS examination, feel that instead of "wasting time on dissection" they could study specimens in the museum and memorise details for regurgitation. Not surprisingly, such students fare disastrously in clinical subjects, where a poor understanding of the fabric of man disallows competence in medicine and surgery.

It is indeed sad that in this overpopulated country opportunities for the acquisition of immensely beneficial knowledge and skills provided by nature and society are wasted or neglected.—SUNIL PANDYA