THE PRACTICE OF MAJOR SURGERY IN SOUTH AFRICA

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In June 1952 the Executive Committee of the South African Medical and Dental Council asked Prof. B. J. Ryrie (then Professor of Pathology and Dean of the Faculty of Medicine at the University of Cape Town) and me to write a memorandum on certain matters relating to the practice of surgery that had been brought to its notice. The present article is based on the joint memorandum and, in dealing with the problem as it presents itself today, emphasizes the portions that have special application to conditions of practice in South Africa. It is generally accepted that the life and health of an individual are of importance not only to himself, his family and his friends, but also to the State. It is the duty of the State to safeguard his life and health; and it is the statutory function of the Medical and Dental Council and the privilege of the Medical Association to advise the State how this can best be done.

Matters relating to the practice of surgery in this country come to the notice of the Medical and Dental Council, often indirectly, through complaints and enquiries. There has been evidence of operative procedures unwisely decided upon; there has been evidence of a remarkable amount of surgical work done in certain areas and of a startling proportion of operations in particular hospitals, anomalies difficult to account for; and there have been magistrates' enquiries into deaths referred to the Council. It is abundantly clear that this evidence can represent only a fraction of the cases in which informed medical opinion might doubt whether the patient had had the best surgical advice and service. It has therefore become an urgent question whether the public of South Africa can be assured that major surgical decisions and procedures are in the hands *only* of persons adequately trained and experienced.

In English-speaking countries — and there is no reason to believe that this does not obtain throughout the civilized world — surgery has become a postgraduate study, and it is held that major surgical procedures should be in the hands only of persons who have had the necessary postgraduate training under suitable supervision. Let me quote from the *Report of the Committee on Medical Training in South Africa* issued as long ago as 1939 (page 21):

'On the other hand, it would appear that there is a decided tendency on the part of general practitioners to perform an operation when the case might and should have been referred to the surgical specialist. This craze, as one might almost call it, to cut up the bodies of patients, should be discouraged during the student's medical course, for it often leads to irreparable harm. Even the high fees which the surgeon commands should not be an irresistible temptation. What sometimes appears to be a minor operation often becomes a serious operation through bad handling or bad diagnosis.

'Wherever a specialist is available, either close at hand or within such easy reach that the life of the patient will not be seriously jeopardised, the general practitioner ought to err on the safe side and hand the case over to the specialist'.

These views, expressed by a South African committee dealing with South African conditions in 1939, have been underlined by successive reports elsewhere, and time has only increased their validity.

The Interdepartmental Committee on Medical Schools, appointed in Britain in 1942, reported in 1944. Its report, the well-known Goodenough Report, states (page 163):

'36. Under the Medical Acts, every registered practitioner is entitled by law to practise surgery but in the interests of patients the trend of medical custom has been to restrict the practice of major operative surgery to those who have had postgraduate training and experience in this work. We consider that, with the promised development of an adequate hospital service in all parts of the country, the likelihood of any practitioner, other than one so specially trained, being called upon — even in emergency — to undertake major operative surgery is so small that it can be left out of account in framing the training of future general practitioners. We are, therefore, of the opinion that the technical details of operative measures, usually regarded by the layman as the whole content of surgery are without exception matters for postgraduate study'.

This Interdepartmental Committee spent 2 years getting evidence from the universities and medical schools, the General Medical Council, the Royal medical colleges, and the London County Council and other local authorities in Great Britain. They claimed that their views were supported by the vast majority of those who were responsible for and engaged in medical education and research in Great Britain. Their report is looked upon as a classic in medical education that cannot be disregarded.

The British Medical Association report, *The Training of a Doctor*, issued in 1948, was no less definite:

'In its consideration of the teaching of surgery, the Committee has had in view the basic needs of the practitioner on which further study can be founded, and it would suggest that the course should aim at teaching the principles of surgical diagnosis, early recognition of surgical conditions, especially emergencies in which timely operation might be a lifesaving measure, the elements of first-aid, the treatment of such minor injuries and conditions as a general practitioner might be called upon to give, the surgery of septic conditions, and the scope of operative surgery, but the technical details of operations should not be taught'.

There is thus unanimity on the point that only the principles of surgery concern the undergraduate, that he is not trained in surgery, that surgery is a postgraduate study, and that the practice of surgery is a matter for specially trained and experienced persons. But the matter goes further, and informed opinion holds that even the intern period is not a time for surgical training. In training a doctor we are no longer trying to train a surgeon. The Supplement to the *British Medical Journal* of 29 December 1951, describing a 2-year scheme of postgraduate training for general practice, states: 'Training in surgery will be confined to its diagnostic aspects, especially in emergencies'.

Prof. S. F. Oosthuizen, President of the South African Medical and Dental Council, in his report (1952) on 'The Training of Interns', based on information obtained from the New York Academy of Medicine, wrote:

'The . . . intern training for general practice, while in surgery, ought to be kept entirely out of the operating room.

so that he will never presume to think himself capable of doing anything but minor surgery . . . In the wards he should be trained in surgical diagnosis and surgical emergencies'.

This is the attitude of the medical educational authorities in the United States of America, a country with the same problems in relation to great distances and wide open spaces as we have in South Africa. In that country, which has had nearly 50 years' experience of compulsory training of interns, the authorities believe that the danger of an intern getting the impression that he is capable of undertaking major surgery is so great that they recommend that 'the intern training for general practice, while in surgery, ought to be kept entirely out of the operating room'. It must be accepted that all large countries have similar problems to ours in making suitable surgical arrangements for areas far removed from the large centres, and it would be an act of folly to disregard the lessons learned in the USA from their experience in the training of interns.

In the South African Medical and Dental Council's 'Criteria for the Training of Interns' (1959) the following appears:

'In the surgical wards the intern should be taught to recognize the emergencies of surgery. While it is desirable that he assists the surgeon at major operations it is not desirable that he himself undertakes major operations. He should be taught the principles of pre- and post-operative care and be given every opportunity to learn minor surgery'.

Finally, I wish to quote the following recommendations placed before the Medical and Dental Council by the Faculty of Medicine of the University of the Witwatersrand after considering our joint memorandum of 1952 (above-mentioned) and a memorandum by the Head of the Department of Surgery, University of the Witwatersrand:

'1. That Faculty unreservedly endorse the view "that neither undergraduate training nor even extended intern experience should be directed to making a doctor a surgeon nor do they justify a doctor in doing major surgery today".

'2. That the University request the South African Medical and Dental Council to bring to the notice of the Minister of Education that adequate provision should be made to ensure suitable specialized postgraduate surgical training in South Africa.

'3. That Faculty endorse the opinion that the regulations of the South African Medical and Dental Council should be directed towards preventing practitioners from performing operations unless qualified by adequate specialistic postgraduate training.'

With regard to the recommendation (3) that the regulations of the Council should be directed towards *preventing* practitioners from performing operations unless qualified by adequate specialistic training, rule 25 of the 'Rules Regarding Conduct of which the Council may take Cognizance', was promulgated for that specific purpose, and reads as follows:

'*Performance of operations by medical practitioners and dentists*

'(i) The performance by medical practitioners and dentists, except in an emergency, of professional acts for the performance of which they are inadequately trained and/or insufficiently experienced'.

In regard to this rule, the following paragraph in the appeal judgment (1954) of Mr. Justice J. M. Murray in the case of M. Shapiro and the South African Medical Council (1953) is of interest:

'I entertain no doubt that if an inexperienced young medical practitioner with relatively little experience and no special qualifications were to venture into a particular field of medical activity in which in actual fact his ignorance or inexperience would render his intervention a danger to the health or life of his patients, the Council could deal effectively with him under its disciplinary regulations'.

In Britain

What happens in Britain? In that country, where recently I made a special enquiry into the position, not only are these principles of surgery held, but they are put into practice, and in Scotland they have been in practice for the past 50 years. Under the National Health Service all hospitals, except private nursing homes, are State hospitals. In these State hospitals all major surgical operations are performed by surgeons who have had specialized postgraduate training in operative surgery. A large proportion of these operations are performed by consulting surgeons, who, after serving as junior registrar for a period of years, must have held a post as senior registrar in a teaching hospital. Thus, the training of a surgeon takes approximately as long as it does to train a doctor in the first instance. The consulting surgeon is a consultant in the special department of surgery concerned; general surgery is undertaken by a consultant in general surgery, gynaecology by a consulting gynaecologist, urology by a urological consultant, etc.

In South Africa

We now return to the question with which we started: Can the public in South Africa be assured that surgical decisions and surgical procedures are in the hands only of persons adequately trained and experienced? In my opinion, the public can rest assured that in the hospitals attached to the medical schools and in most other large centres major surgical procedures are in the hands of adequately trained surgeons; but that this does not apply to all country hospitals.

The following opinion expressed by Chief Justice Sir James Rose-Innes in van Wyk *v.* Lewis, 1924, is worth noting:

'The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care, whether he carries on his work in the town or in the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have a right to expect'.

During my years of service as a senior gynaecological surgeon at Groote Schuur Hospital, Cape Town, on a number of occasions we had to deal with cases that had been operated on by doctors who, being unable to complete the operation, had sent the patient to Groote Schuur for more expert treatment. This experience is far from unusual; a leading South African surgeon recently stated that about 10% of the cases he had to deal with followed a previous operation unsuccessfully performed.

While acting as Inspector of Internships for the Medical Council in 1958 I visited 22 hospitals in the Cape Province. I found that many a young doctor who starts practice in a village or small town without postgraduate training in surgery is under strong inducement to undertake major operations. Not infrequently he is appointed to the staff of the local hospital, and he soon learns that, in their

ignorance, the public believe that a doctor who operates is a better doctor than one who does not operate. Almost in self-defence, he starts to operate in an attempt to train himself as a surgeon. This is a dangerous practice and often results in unnecessary operations and avoidable maiming or even fatal results.

The self-trained surgeon is an anachronism. The revolutionary advances made in surgery within recent times require such vast resources that it should no longer be permissible for a doctor to adopt surgery as a side-line to his practice. In the old days of the ox-wagon and the Cape cart the country practitioner was compelled to undertake all types of surgery regardless of his post-graduate training for the work; but today, when facilities are available for rapid travel by motor-car or aircraft, it is indefensible.

CONCLUSION

It is now recognized that the time has come for serious consideration of this matter. As the result of incidents like the Greytown enquiry the South African public is seriously concerned about it. The Medical Association has sent a deputation to the Medical and Dental Council asking for action to be taken. The Council has discussed the matter on several occasions and at its last meeting, in September 1960, decided to appoint a fact-finding committee 'to enquire whether the manifold benefits of modern surgery were generally available to the public'. The following members were appointed to constitute the sub-committee: Dr. J. K. Bremer, formerly Professor of Surgery, Pretoria University; Dr. P. F. H. Wagner, Past-President of the Medical Association of South Africa; and Dr. R. Lance Impey (convener).