Presidential Address

Surgical Life in the Country

C. C. HERRINGTON, M.D.

From the Department of Surgery, Huron Memorial Hospital, Bad Axe, Michigan

THE Rural Community Hospital is an integral part of the American surgical scene. These small hospitals must be able to provide the majority of the elective and emergency surgical needs of their service areas. In 1979, approximately 6,000 general hospitals existed in the United States, with a capacity of 1,000,000 beds. Surprisingly, the average size of these hospitals is 165 beds, the median being 75 beds.[3] Unfortunately, in our society bigger is usually equated with better. Nevertheless, most of these small hospitals are providing excellent care to their patients.

Providing first-class care requires, to a great extent, the presence of an interested, well-trained medical staff. Many of our small hospitals are in a "Catch 22" position in that they need a good staff to excel, but, at the same time, must be medical centers to attract talented young persons, meaning, for today's discussion, young surgeons. In the past, these small hospitals have been unable to lure surgeons of the various subspecialities to their rural areas. Fortunately, the law of supply and demand is now delivering more of these trained individuals that such areas would like to attract. Even more important, it appears that well-trained surgeons are becoming interested in rural practice. They are finding that a professionally satisfying life can be had in rural areas and that their training is not "wasted."

To be professionally satisfied, however, surgeons in search of a rural hospital must seek out an institution that has representation of the major subspecialities. They cannot be content to function as islands. The complexities of general surgical diagnosis and treatment today make it mandatory to have immediately available specialists, such as urologists, gynecologists, and internists, to name but a few. Although a complete complement of subspecialities will obviously not be available, the hospital and the surgeon must at least have such a cadre to call upon. Arrangements must also be maintained for the transfer of patients in need of more sophisticated treatment than can be provided locally.

In addition to professional help, adequate ancillary assistance must be available. In rural hospitals, this frequently requires combining various services and departments. We have learned to double the inhalation therapist as an EKG technician, and to train our x-ray technicians to be proficient in nuclear medicine techniques. However, we have been unable to transform existing equipment into expensive, sophisticated machinery. Obtaining this equipment, because of its increasing expense, is one of the greatest problems facing rural hospitals. In addition, the cost effective philosophy must be dealt with in that HSA and State Health Department approval is necessary before equipment can be purchased. Both expansion and new services lie within the domain of these two organizations. The Certificate of Need has become at once the stumbling and building block of our small hospitals.

Cost control in the rural hospital is as vital as in the metropolitan hospital. Surprisingly, statistics show that the common, elective operations done in the small rural hospital are almost as expensive as those performed in the larger institutions.[2] Although these statistics fail to account for travel expenses and room and board for families of the patient who must travel to the city, they nevertheless point out the need for effi-

Presented at the 22nd Annual Meeting of the Midwest Surgical Association, Mackinac Island, Michigan, August 14–16, 1980.

Reprint requests to C. C. Herrington, M.D., 125 N. Hanselman, Bad Axe, MI 48413.

0003-1348/81/0300/0093/$00.60

cient, economic management at the local level. In this day of centralization, cost control in the country by both hospital and surgeon is necessary, or the hospital may find itself in an untenable position. Some of the hospitals are solving this problem by adding chronic care facilities as a means of improving their financial situation.

Probably the most upsetting thought to surgeons considering rural practice is fear of wasted training. They may feel that they will be unable to do many of the procedures for which they were trained, that they will lose their skills as a result of rural practice and its alleged bread and butter cases, that they will have inadequate surgical assistance, and that they will be cut off from the university or medical center environment. None of the above has to be true. In answering these disturbing thoughts, the surgeon should be reassured that the percentage of pathology in the country equals that of the city. It is true that the population is smaller and that thus there are fewer patients, but there are also fewer surgeons. They will be rewarded by the variety of pathology encountered. Bread and butter surgery does become routine, but there are few regimens in surgery or elsewhere that do not consist of routine activities.

Surgical assistance in rural areas is extremely important. The optimum state of surgical assistance is, of course, a partner, associate, or other fellow surgeon who understands the case and is as interested in its successful outcome as the operating surgeon. Lacking this situation, the referring physician can develop into an excellent assistant with a reasonable amount of time and effort expended by the surgeon.

Finally, limiting one's practice exclusively to surgery in a rural area may be extremely difficult. A great deal of tenacity may be required in the first few months. To develop a rewarding professional life, one must not stray into nonsurgical fields. To enjoy one's profession and to attain long-term success, strict limitation of one's practice to surgery is an absolute necessity. This fact needs to be stressed to residents finishing their training, as in my experience there are too many rural surgeons gleaning their cases from their own general practices.

Although the rural surgeon and his hospital are geographically separated from the universities and medical centers, excellent rapport can and should be developed and maintained with friends and associates in the various departments of the centers. In the important area of continuing education for the rural surgeon, more direction from the centers would greatly improve postgraduate courses, which are now offered in excessive numbers and are easily available. Modifications in the traditional, continuing surgical education are possible that would make keeping current more valuable and more enjoyable.

The following are a few ideas that can promote practical, continuing education for the rural surgeon:

We have had experience with a tutorial program recently that was of great help and interest to me. It required attendance at a university center for two five-day periods within one year and involved an in-depth course devoted to a particular disease entity. It included didactic classroom periods along with clinical teaching. If similar mini-residencies could be set up by our larger departments of surgery, I feel the results would be far more beneficial than those derived from the usual postgraduate courses.

Another facet of postgraduate education and improved patient care can result from the use of visiting services. Our hospital has been fortunate in having twice monthly clinics by oncologists from a large metropolitan hospital. With the aid of local surgeons, internists, and the oncologists, many patients are receiving therapy at home without the expense and inconvenience of travel to the city.

A recent surgical journal described an exchange program for university surgeons and their rural counterparts.[1] These exchanges were carefully planned and required extensive scheduling arrangements. Nevertheless, the authors were convinced that both the rural and university surgeons were pleased with their new roles.

The presence of the senior resident surgeon in rural hospitals for short periods of time would provide intellectual stimulation for the attending surgeons and would acquaint the resident with day-to-day activity of rural private practice.

It is not difficult over the years for the rural surgeon to become unfamiliar with daily activities in the larger general hosptials. Similarly, many urban surgeons *never* become acquainted with surgical life in the country. Perhaps introducing programs such as those suggested above would help reacquaint city and country cousins. Perhaps such a familiarization would better provide the rural surgeon with a practical working knowledge of new techniques and methodology and in turn would forestall such questions from the urban surgeon as, "But what do you do when you need blood in Bad Axe?"

REFERENCES

1. Abernathy, C. M. (ed.): Symposium on advances in small hospital care. Surg. Clin. North Am. 59: 387, 1979.

2. Blue Cross/Blue Shield of Michigan: Average length of stay and per diem cost by five diagnoses for six health systems agencies. December 1979 report.

3. Weckworth, V. E.: Small rural hospitals. Mich. Hosp. February 1980, pp. 4–6.