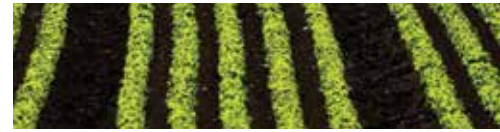




RACGP | Rural

The Fellowship in Advanced Rural General Practice (FARGP)

Advanced Rural Skills Training – Curriculum for GP surgery



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Recommended citation

The Fellowship in Advanced Rural General Practice (FARGP): Advanced Rural Skills Training (ARST) – Curriculum for GP surgery. Melbourne: The Royal Australian College of General Practitioners, 2014.

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ISBN: 978-0-86906-420-7
Published August 2014

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Acknowledgements

The Royal Australian College of General Practitioners (RACGP): Council endorsed this Fellowship in Advanced Rural General Practice (FARGP): Advanced Rural Skills Training (ARST) – Curriculum for GP Surgery as the RACGP curriculum for this advanced skill training on 23 April 2014, until such time as the Joint Consultative Committee for General Practice Procedural Surgery (JCC-GPPS) approves a GP Surgery curriculum.

The RACGP Rural Board would like to thank Dr Cameron Loy, Dr Peter Joseph and the RACGP staff who have led the RACGP Rural efforts to update this curriculum. The RACGP Rural Board would also like to thank the many people who have provided advice and feedback through the project, including:

- Dr Andrew Cronin
- Dr Kathryn Kirkpatrick
- Dr Peter Maguire
- Dr Chris Mitchell
- Dr Tim Mooney
- Dr Sue Page
- Dr Gerry Purcell
- Dr Ayman Shenouda
- Dr Richard Tan
- Dr Olga Ward

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1. Introduction to the FARGP

The Fellowship in Advanced Rural General Practice (FARGP) is a qualification awarded by the Royal Australian College of General Practitioners (RACGP) in addition to the vocational Fellowship (FRACGP). The FARGP cannot be undertaken as a stand-alone general practice qualification.

The FARGP has pathways for both general practice registrars and practising GPs. Its aim is to assist general practice registrars and GPs develop advanced rural skills and broaden options for safe, accessible and comprehensive care for Australia's rural, remote and very remote communities.

The FARGP requirements are:

- completion of the FARGP learning plan and reflection activity
- 12 months in a rural general practice setting
- 12 months of Advanced Rural Skills Training (ARST) in an accredited procedural or non-procedural training post
- completion of a 6-month 'working in rural general practice' community-focused project
- completion of the FARGP emergency medicine activities, including satisfactory completion of two (2) advanced emergency skills courses.

A core requirement of the FARGP is the completion of 12 months of ARST in an accredited procedural or non-procedural training post. Although candidates are free to choose whichever advanced skill discipline or disciplines they wish to concentrate on, it is recommended that the needs of their community are taken into account when making the choice.

2. Aim of this Curriculum

The aim (and purpose) of this ARST – Curriculum for GP Surgery is to outline the knowledge, skills and experience that will enable a GP Surgical Proceduralist to safely provide unsupervised GP surgery.

The curriculum requires that, through their previous training, knowledge and experiences, trainees have already developed skills for the diagnosis and management of a broad range of conditions that involve surgical interventions.

The clinical experiences and learning outcomes of this curriculum will build on the following areas:

- Diagnosis and management (treat or transfer) of both elective and emergency surgical conditions:
 - Aetiology and pathology of common surgical conditions.
 - Patient assessment and history.
 - Patient management plan, including pain management.
 - Pre-operative, peri-operative and post-operative care.
- Principles of management (treat or transfer) of trauma patients:
 - Diagnosis of trauma patients.
 - Management of trauma patients.
- Ability to independently manage common surgical conditions/procedures appropriate to circumstances, experience and training.

3. Rationale

Skill requirements fluctuate throughout the career of a GP as they respond to the changing needs of their community (such as change in disease profile), up-skilling, ensuring practice viability, adapting to changes in government policy and environment (such as rural hospital closures), or change in areas of interest.¹ GPs may respond to these changes by the acquisition of advanced skills, beyond the broad generalist skills, to meet changing community need.¹ Advanced skills allow GPs to extend their expertise in a particular area and enhance their capacity to provide secondary-level care to their community.¹

GPs practice advanced skills in response to community need, and therefore the skills are determined by context.¹ A GP Surgical Proceduralist who has undertaken additional advanced skills training to develop specialist surgical skills can perform a broad range of surgical procedures. These surgical services are provided within the GP's local community on a needs-based approach, through the local hospital operating theatre or other appropriate medical facility, without the need for referral. Services provided will include emergency and elective procedures within the skill set of the individual, and knowledge of treat or transfer principals.

GPs providing surgical services make an important contribution to comprehensive care in communities, with the potential to reduce the need for patient travel and the waiting times for surgery. In addition, patients can have their specialised care delivered by a medical practitioner with whom they have an established and trusted therapeutic relationship. The procedures that the GP Surgical Proceduralist can perform are determined by the individual practitioner's training, accreditations, and the local infrastructure and support services available to them.

General practice registrars or practising GPs rely on appropriate advanced skills training in surgery in order to provide GP surgical services. Historically, this was a less formal apprenticeship training process and most GPs developed some advanced skills through on-the-job training.

The end point of the GP surgical training program must be recognition of a described capability to deliver safe, unsupervised, high-quality surgical services.

4. Duration, Setting and Supervision

The FARGP: ARST – Curriculum for GP Surgery requires that the candidate complete a minimum of 12 months' (full-time equivalent) supervised surgical training in an accredited training post. Accredited posts must be approved by the Royal Australasian College of Surgeons (RACS) and the regional training provider (RTO) for general practice registrars, or the RACGP Rural Censor for practising GPs.

The 12-month training period will include:

- a minimum 6-month general surgery rotation
- a minimum 3-month orthopaedics rotation
- a minimum of 3 months in another relevant surgical rotation or additional general surgery or orthopaedic rotations
- direct supervision by a Fellow of the RACS throughout the training period
- indirect supervision and support to be provided by a Medical Educator/GP Surgical Proceduralist approved by the AGPT approved RTO (for general practice registrars), or a GP Mentor/GP Surgical Proceduralist approved by the RACGP Rural Censor (for practising GPs).

5. Prerequisites

The ARST for GP Surgery is open to general practice registrars and practising GPs wishing to develop their knowledge, skills and experience in this discipline.

1. The candidate will need to satisfy one of the following two (2) criteria before commencing in a GP Surgery training post:
 - Minimum level of PGY-2 **and** be eligible to undertake an ARST post in accordance with the relevant Australian General Practice Training (AGPT) policies and procedures.

or

 - Experienced GP with FRACGP and appropriate supports to complete this ARST training program.
2. Before or during this ARST the candidate will need to successfully complete the Care of the Critically Ill Surgical Patient (CCriSP) course **and** at least one of the advanced trauma management courses from the list below:
 - Early Management of Severe Trauma (EMST)
 - Clinical Emergency Management Program Advanced (CEMP Advanced)
 - Emergency Trauma Management (ETM)
 - Pre-Hospital Trauma Life Support (PHTLS)
 - Rural Emergency Assessment Clinical Training (REACT)
 - An equivalent course approved by the RACGP Rural Censor.

6. Range Statements

The following statements and definitions are offered as a way to improve the understanding of a number of key terms used throughout this curriculum.

Treat or transfer – Appropriate and effective transfer of care arrangements are not an issue solely for patients with chronic disease; they are important for any patient who receives care both from their GP and in a hospital. Doctors can provide the best possible care when good communication exists between all treating medical practitioners at all stages of care, starting from the community setting, right through to acute or sub-acute care and subsequent return to the community.²

Critically ill patients generally have life-threatening injuries or illnesses that are associated with reduced or exhausted physiological reserves. Transferring (transporting) these patients exposes them to additional risks and requires the services of highly trained and skilled medical practitioners and other healthcare professionals.³

Safe transport of the critically ill patient requires accurate assessment and stabilisation of the patient before transportation. There should be appropriate planning of transport and optimum utilisation of communications. Safe transfer (transport) requires the deployment of appropriately trained staff with essential equipment, and effective liaison between referring, transporting and receiving staff at a senior level. As a guiding principle, the level of care provided during a transfer must aim to at least equal that at the point of referral and must prepare the patient for admission to the receiving service.³

Clinical handover – The National Safety and Quality Standards for Health Services (*Safety and quality improvement guide standard 6: Clinical handover*) requires clinical leaders and senior managers of a health service organisation to implement documented systems for effective and structured clinical handover. The intention of the standard is to ensure there is timely, relevant and structured clinical handover that supports safe patient care.^{2,4,5}

Clinical handover is an integral part of clinical communication and is practised in a multitude of ways within all health service organisations and is integral to ensuring optimal ongoing care of patients.² Effective clinical handover can reduce communication errors between health professionals and improve patient safety and care.⁶ Clinical handover must be structured, fit for local purpose and be appropriate to the clinical context in which handover occurs.⁶

Clinical handover includes the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.^{2,4}

Holistic approach – Refers to the practice of looking at the health of the whole person, not just the illness itself. The holistic concept in medical practice, which is distinct from the concept in alternative medicine, upholds that all aspects of people's needs, including psychological, physical and social, should be taken into account and seen as a whole.⁷

Health record or patient record – Patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes. A complete, highly-structured, problem-oriented health record will be invaluable to any medical practitioner.^{8,9}

Documentation – A comprehensive, factual and sequential record of a patient's condition and the treatment and support offered and provided. A complete medical record is essential for reliable continuity of medical care.^{8,10,11}

Informed consent – There are many definitions related to informed consent. While these definitions can vary between jurisdictions, the central requirement is that the consent process has been undertaken, recognised and documented.

The RACGP *Standards for General Practices* (4th Edition) state that patients require sufficient information about the purpose, importance, benefits, risks and possible costs associated with proposed investigations, referrals or treatments in order to enable them to make informed decisions about their health.⁸

The RACS informed consent policy further states that the informed consent discussion should ensure the patient has an understanding of the available options and the expected outcomes, success rates and/or side effects for each option.¹²

Common surgical procedures and GP surgical procedures and techniques – See *Appendix 1* and *Appendix 2* for examples of procedures and techniques. These lists are indicative, rather than exhaustive.

Problem solving approach – Expertise in problem solving varies greatly between individual clinicians and is highly dependent on the clinician's mastery of the particular domain.¹³ The initial assessment and management of seriously injured patients is a challenging task and requires a rapid and systematic approach.¹⁴ A problem-solving approach is a reliable method for assessing and initially managing the trauma patient and requires an organised approach for evaluation and management. The emphasis of trauma care is on the critical 'first hour' of care, focusing on initial assessment, lifesaving intervention, re-evaluation, stabilisation and, when needed, transfer to more appropriate or specialised facilities.¹⁵

7. Learning Outcomes

Competency-based medical education focuses on the knowledge, skills, attitudes and values that the candidate is able to demonstrate as a result of participating in a learning program and a process of assessment that are sufficient to practice safely and effectively.

The learning outcomes for this ARST – Curriculum for GP Surgery are structured under the five domains of general practice. They are intended to identify the additional breadth and depth of knowledge and skills necessary for assuming the full scope of the role of a GP Surgical Proceduralist.

Rural practice is significantly different from urban practice in that specialist support and advice is not always available. Therefore, these learning outcomes seek to account for the context of the work environment of the rural GP, who may be working in a large rural town with tertiary support or a one-doctor community in a geographically isolated area. These outcomes should be seen as competencies that enable GPs to provide effective and independent surgical services within rural general practice.

In the following tables, the terms in *italics* are further explained or defined in *Section 6*.

Domain 1 – Communication skills and the patient–doctor relationship	
Outcome	Performance criteria
1.1 Communicate with patients, relatives, staff and others to understand the effects and alternatives to surgery.	1.1.1 Demonstrate a <i>holistic approach</i> to identifying issues of most importance to patients' health and management. 1.1.2 Discuss options for surgery or non-surgery, including conservative management, with patients. 1.1.3 Complete appropriate <i>patient records</i> . 1.1.4 Obtain <i>informed consent</i> .
1.2 Manage potentially challenging or difficult situations in diagnosis, with at-risk patients and with sub-optimal results from surgery.	1.2.1 Identify stress and grief symptoms in staff members, patients and their relatives and friends, and provide empathic and culturally appropriate support and follow-up.
1.3 Record patient information accurately in a way that facilitates future patient care.	1.3.1 Take accurate and comprehensive patient records and complete relevant <i>documentation</i> as appropriate to the situation.

Domain 2 – Applied professional knowledge and skills	
Outcome	Performance criteria
2.1 Use current, and develop new, surgical skills and techniques.	<p>2.1.1 Demonstrate surgical techniques that are appropriate to the skill level of the GP and the context of the situation.</p> <p>2.1.2 Identify areas where GP surgical skills can be enhanced.</p> <p>2.1.3 Perform a range of <i>common surgical procedures</i>, initially under supervision leading to independent practise.</p>
2.2 Demonstrate clinical skills required to diagnose and manage common surgical conditions.	<p>2.2.1 Take an accurate and detailed surgical history.</p> <p>2.2.2 Perform a physical examination.</p> <p>2.2.3 Demonstrate skills in the pre-operative and post-operative management of a range of surgical conditions and their associated complications.</p> <p>2.2.4 Demonstrate a process of confident decision making via case history and examination.</p> <p>2.2.5 Complete quarterly audit of surgical cases log book.</p>
2.3 Work effectively as part of a multidisciplinary team in the emergency and intensive care management of seriously ill patients.	<p>2.3.1 Provide a <i>problem solving approach</i> to the appropriate early management of patients with trauma.</p> <p>2.3.2 Provide evidence of effective management of surgical crises and complications.</p> <p>2.3.3 Take actions and provide advice appropriate to the situation and team skill mix.</p>

Domain 3 – Population health and the context of general practice	
Outcome	Performance criteria
3.1 Address health risks to individuals and communities.	<p>3.1.1 Identify trends and patterns in surgical presentations in the context of the community.</p> <p>3.1.2 Demonstrate a planning process to address such trends and patterns.</p>
3.2 Provide GP surgical services appropriate for the community.	<p>3.2.1 Identify the role of other healthcare professionals in the community.</p> <p>3.2.2 Demonstrate a flexible approach to health management of those with cultural and social differences.</p> <p>3.2.3 Identify and document the scope of surgical services that can be safely provided in the community.</p> <p>3.2.4 Identify local processes/policies to ensure available health resources are used efficiently.</p>

Domain 4 – Professional and ethical role	
Outcome	Performance criteria
4.1 Build referral networks.	4.1.1 Establish and utilise a comprehensive professional and emergency referral network.
4.2 Practise GP self-care, self-evaluation and professional development.	4.2.1 Identify own strengths and limitations as a GP Surgical Proceduralist. 4.2.2 Identify the risks for a GP Surgical Proceduralist working in professional and/or geographical isolation. 4.2.3 List available resources and referral agencies, professional support networks and organisations to support improved self-care and self-reliance. 4.2.4 Identify professional development needs and opportunities and participate in professional development activities relevant to GP surgery.
4.3 Ensure delivery of patient-centred care.	4.3.1 Identify surgical services that best meet the needs of the patient. 4.3.2 Provide surgical services that are in the best interests of the patient.

Domain 5 – Organisational and legal dimensions	
Outcome	Performance criteria
5.1 Complete appropriate documentation relevant to the patient and context.	5.1.1 Write legally appropriate and medically effective patient records. 5.1.2 Complete reports according to jurisdictional, legal and legislative requirements. 5.1.3 Write reports required in the care of a surgical patient. 5.1.4 Identify the legal responsibilities regarding reporting of notifiable disease, birth, death and autopsy.
5.2 Obtain informed consent for all GP surgical procedures.	5.2.1 List the key components and legal requirements when obtaining informed consent, with regards to jurisdictional requirements and best practice guidelines.

8. Assessment

Satisfactory completion of the GP Surgery ARST will include the following activities addressing the learning outcomes and performance criteria, in addition to the 12-month (full-time equivalent) placement in an accredited surgical training post:

- 8.1** Satisfactory completion of all assessment review cycles conducted at 3, 6, 9 and 12 months. Each assessment review cycle will include all of the following:
 - 8.1.1** Audit of log book.
 - 8.1.2** Surgical supervisors report.
 - 8.1.3** One (1) Clinical Exercise (CEX) assessment.
 - 8.1.4** One (1) Direct Observation of Surgical Skills (DOSS) assessment.

Please note: each CEX and DOSS assessment must be completed satisfactorily, and must meet expectations for the stage of training.

- 8.2** Satisfactory completion of a CCrISP course. This can be completed during the ARST term or in the preceding 3 years.
- 8.3** Satisfactory completion of an advanced trauma management course as described in *Section 5*. This can be completed during the ARST term or in the preceding 3 years.
- 8.4** End-of-term assessment:
 - 8.4.1** Prepare four (4) case studies (from surgical cases log book) written in the style of a grand round presentation (approximately 1200 words) and addressing one or more of the learning outcomes prescribed in *Section 7*. Two (2) of these case studies will be selected for discussion during the vivas detailed in 8.4.2.
 - 8.4.2** Two (2) 30-minute vivas, using cases as detailed in 8.4.1, to be conducted by a Fellow of the RACS and a Fellow of the RACGP, neither of whom is the candidate's regular supervisor (vivas can be face-to-face or via video conference).

9. Recommended Resources

National Health and Medical Research Council. Australian guidelines for the prevention and control of infection in healthcare (2010). Available at www.nhmrc.gov.au/guidelines/publications/cd33

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Williams NS, Bulstrode CJK, O'Connell PR. Bailey and Love's Short Practice of Surgery (26th edition). Boca Raton: Taylor & Francis Group; 2013.

10. Contact details

For further information about any aspect of this curriculum please contact RACGP Rural on free call 1800 636 764, email fargp@racgp.org.au or visit www.racgp.org.au/fargp

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Appendix 1 (List 1)

The following list (List 1) is provided to give examples only of the types of procedures that, depending on years of experience, training and needs of a community, a GP would have knowledge, skills and experience of before undertaking GP Surgery advanced skills training.

- Punch biopsy of skin lesions
- Incisional biopsy of skin lesions
- Suture and repair of lacerations
- Excision of cutaneous lesions with simple closure
- Removal of superficial palpable foreign bodies
- Removal of toenail
- Wedge excision of toenail
- Application of plaster for undisplaced fractures of the upper and lower limbs
- Incision and drainage of cutaneous abscesses
- Cauterisation or freezing of skin lesions
- *Head and neck – ENT emergencies*
 - Epistaxis control/nasal packing
- *Head and neck – Assessment of deafness, ear infection*
 - Canal toilet
 - Eye trauma
- *Breast lump*
 - Triple assessment and referral
- *Chest trauma*
 - Diagnosis
 - Treat or transfer
- *Abdomen*
 - Diagnosis and management of abdominal pain
 - Bowel obstruction, diagnosis–resuscitation
 - Perforated viscus, diagnosis–resuscitation
 - Proctoscopy
 - Diagnosis and non-operative management of appendicitis
- *Neurosurgical (observe and describe)*
 - Care of closed head injury
 - Management of potential spinal injury

- *Vascular (diagnosis and non-operative management)*
 - Arterial/venous ulcers
 - Peripheral vascular disease/ Claudication
 - Superficial thrombophlebitis
 - Deep venous thrombosis
- *Genitourinary*
 - Groin/scrotal lumps – diagnosis
 - Testicular torsion – diagnosis
 - Testicular trauma – diagnosis
 - Renal pain – diagnosis
 - Prostate disease – diagnosis
 - Urinary tract infection – diagnosis/treatment
 - Drainage of hydrocele
- *Voiding difficulties*
 - Catheterisation
- *Gynaecology/Obstetric (diagnosis and non-operative management)*
 - Acute gynaecology conditions
 - Obstetric emergency
 - Ectopic pregnancy
- *Vascular*
 - Acute Ischaemic limb (diagnosis and non-operative management)
 - Arterial trauma – haemorrhage control
- *Musculoskeletal joint pain/injuries*
 - Intra-articular and percutaneous access
- *Musculoskeletal ligament injuries*
 - Diagnosis/splinting

Appendix 2 (List 2)

The following list (List 2) is provided to give examples only of the types of GP surgical procedures that could be undertaken by a GP Surgical Proceduralist. Note that some procedures, such as an emergency caesarean section, gastroscopy, colonoscopy and grommets, require additional specialised training and/or accreditation within other curriculums, such as Advanced Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (DRANZCOG). As such, they fall beyond the scope 12-month (full-time equivalent) ARST curriculum.

- *Skin/subcutaneous tissue*
 - Excision and suture of complex wounds
 - Drainage/debridement of infected or contaminated wound
 - Drainage of deep abscess
 - Drainage of haematomas
 - Removal of deep foreign bodies
 - Simple flap closure of wounds
 - Skin grafts – partial/full thickness
 - Removal of toenail and ablation toenail bed
- *Burns*
 - Staging diagnosis and dressings
 - Escharotomy
 - Escharectomy
 - Criteria for referral
- *Head and neck – Facial injuries (complex)*
 - Airway protection
 - Suture lacerations
 - Mandible stabilisation
 - Cricothyroidotomy
 - Tracheostomy
- *Head and neck – Management of open head injuries*
 - Suture
 - Transfer arrangements
- *Head and neck – ENT*
 - Incision and drainage abscesses
 - Tonsillectomy
 - Adenoidectomy

- *Head and neck – Assessment of deafness, ear infection*
 - Burns – major/minor
 - Penetrating injuries (assessment and referral)
- *Head and neck – Lump in neck*
 - Diagnosis
- *Breast abscess/infection*
 - Treatment and drainage
- *Chest trauma*
 - Pleural tap
 - Closure of open wounds
 - Management pneumothorax
 - Management of haemothorax
 - Management of flail chest
 - Emergency pericardial aspiration
- *Abdomen*
 - Appendicectomy
 - Repair of inguinal, umbilical and femoral herniae
 - Abdominal trauma, diagnosis–resuscitation
 - Abdominal mass, diagnosis and surgical management
 - Proctoscopy, rigid/fibre optic sigmoidoscopy and surgical management
 - Management of sigmoid volvulus
 - Acute gastrointestinal bleeding, diagnosis–resuscitation
 - Endoscopy
 - Colonoscopy
 - Gallbladder – cholecystectomy and cholecystostomy
 - Spleen – splenectomy
 - Over sewing of perforated duodenal ulcer
 - Laparotomy
 - Laparoscopy
- *Peri-anal*
 - Peri-anal and ischio-rectal abscess drainage
 - Laying open pilonidal sinus
 - Peri-anal haematoma (incision and drainage)
 - Rectal bleeding – colonoscopy
 - Banding of haemorrhoids

- *Genitourinary*
 - Groin/scrotal lumps – surgical management
 - Testicular torsion – surgical management
 - Testicular trauma – surgical management
 - Vasectomy
 - Circumcision
 - Surgical management of hydrocele
- *Voiding difficulties*
 - Urethral dilatation
 - Suprapubic catheterisation
- *Gynaecological/Obstetric (diagnosis and surgical management)*
 - Acute gynaecology conditions
 - Obstetric emergency
 - Ectopic pregnancy
- *Vascular*
 - Compartment syndromes – emergency fasciotomy
 - Ruptured abdominal aortic aneurysm – assessment and resuscitation
- *Musculoskeletal – Hand injuries*
 - Abscess drainage
 - Tendon sheath drainage
 - Terminalisation of digit
 - Tendon repair
- *Musculoskeletal – Limb fractures/dislocations*
 - Simple fracture management
 - Closed reduction of dislocations
 - Complex fracture management
 - Closed reduction of fractures
- *Musculoskeletal – Nerve entrapment*
 - Carpal tunnel release



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