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Research Article

**THE SURGEON ENTERING THE PRACTICE WAS ADEQUATELY PREPARED BY COMPARING THE TYPE AND VOLUME OF SURGICAL PROCEDURES PERFORMED IN PAKISTAN**

<sup>1</sup>Dr. Muhammad Tahir Abbas Ranjha, <sup>2</sup>Dr Muhammad Muaaz Akram, <sup>3</sup>Dr Saad Ullah

<sup>1</sup>Shaikh Zayed Medical Complex Lahore

<sup>2</sup>Department of Biochemistry & Chemical Pathology Shaikh Zayed Hospital Lahore

<sup>3</sup>Shokat Khanum Memorial Cancer Hospital Lahore

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**Abstract:**

**Aim:** Clinical planning specialists are a difficult task for postgraduate programs throughout Pakistan. The reason for this study was whether a single specialist who had entered the practice sufficiently developed by contrasting the type and volume of the surgeries that have been performed over the last 3 years with that in the principal year of clinical practice.

**Methods:** I have logged both approaches over the last 3 years of the planning of a surgical treatment. The British Columbia Medical Services Plan (MSP) records all methodologies in realistic terms. I ordered the methods I used during my first year of training using MSP settlement studies. Our current research conducted at Mayo Hospital, Lahore from March 2019 to February 2020. I have introduced and listed the quantity of techniques in (general, colorectal, laparoscopic, endoscopic, hepatobiliary, oncologic, pediatric, thoracic, vascular and other). I contrast residency training and network experience at that stage.

**Results:** Over the last three years I have logged a total of 1170 methodologies. 452 of these were carried out during pivots of the network. 382 generals, 19 colorectal, 245 laparoscopes, 103 endoscopes, 85 hepatobiliary, 142 oncologic, 1 pediatric, 78 thoracic, 94 vascular tubes and 18 more may be divided in residency approaches. In the primary training year, I played a total of 1440 methods. 399 generals, 15 colorectal, 101 laparoscopic, 654 endoscopic, 2 hepatobiliary, 78 oncologic, 10 pediatric, 0 thorax, 70 vascular and 115 different were included in the separate.

**Conclusion:** In general, residency gave amazing planning to clinical practice dependent on my experience. Regions of potential improvement included endoscopy, pediatric medical procedure and "other," which involved generally hand a medical procedure.

**Keywords:** surgeon, type and volume of surgical procedures performed in Pakistan.

**Corresponding author:**

**Dr. Muhammad Tahir Abbas Ranjha,**  
Shaikh Zayed Medical Complex Lahore

QR code



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**INTRODUCTION:**

In Pakistan, there has generally been a tremendous need for "generalists" or comprehensive general specialists who rehearse in a networked fashion, but Canadian preparedness programs have been delayed to meet this need [1]. A general practitioner could be characterized as a specialist who carefully examines most or all of the methodology typically used for general medical procedures, as well as some systems of non-general medical procedures that depend on the need of the network in which the individual practices [2]. Generalist specialists repeat in smaller networks in different countries; for example, Australia has recognized a similar requirement for generalist skills. In a new survey of networked generalist specialists, 85% of specialists felt decidedly ready or better prepared for networked practice [3]. In this equivalent review, specialists in smaller networks (< 54,000) generously implemented a more non-general medical procedure strategy, e.g., plastic medical procedure, urology, gynecology, and muscle health; preparation for the implementation of these strategies came not from essential cooperation but from the network's senior partners. Studies conducted in Pakistan and India have demonstrated a successful introduction to the preparation of trained professionals and general practitioners by consolidating academic and country preparation sites [4]. At the University of British Columbia (UBC) located in Vancouver, the Global Medical Procedure Preparation Program allows residents seeking a vocation in the medical procedure network to adapt their tours to extend the presentation to a non-general medical procedure area; in addition, to networked preparation destinations. The reason for this study was to decide whether this methodology was successful by examining my experience as a new alumnus of this general medical procedure preparation program [5].

**METHODOLOGY:**

The UBC General Medical Procedures Preparation Program is a 6-year program consisting of mandatory and optional rounds. Due to its extra year and the rarity of mandatory rounds, a high degree of adaptability is allowed in the determination of the rounds. Our current research was conducted at Mayo Hospital, Lahore from March 2019 to February 2020. My pivotal residency plan is shown in Table 1. The compulsory revolutions, including in any case 3 months of network a medical procedure, for all inhabitants are indicated by a reference point. I had 21 months of preparation for a general medical procedure in 2 school clinics located in Vancouver, and spent one year in 5 network medical clinics located in Vernon, Chilliwack, New Westminster, Prince George and

Vancouver, British Columbia. This experience is considered a routine experience for a resident organizing a profession in the field of Networked Medical Procedures. The determination of the revolutions is dictated by the Residency Program Leader, but careful consideration is given to residents' requests based on professional goals and meetings with the Program Leader at normal semi-annual intervals. The administrations of thoracic and vascular medical procedures were concentrated in Kelowna, a network located 55 km away, which prompted the specialist who gave these administrations to leave the program. There are no plastic surgeons or neurosurgeons at VJH, either currently or in general. Other VJH support providers include 1 low maintenance and 8 full time association-prepared anesthesiologists, 1 low maintenance and 5 full time internists and 2 pathologists. In addition, there are 4 general radiologists, 1 radiologist specializing in atomic drugs, and the administrations integrate radiography, fluoroscopy, ultrasonography, recorded tomography and atomic drugs. There is a 10-bed unit for serious cases and a 27-bed crisis division, including a 2-bed injury unit, open 24 hours a day.

**RESULTS:**

Table 2 provides an overview of employment experience by category. I practiced relatively fewer general, laparoscopic, hepatobiliary, oncology, thoracic and vascular methods in network practice than in residency. On the other hand, I have practiced relatively more endoscopic, pediatric and different methods through and through than during my residency. Only colorectal strategies were compared between the two periods. Remarkably, endoscopic strategies accounted for over 48% of the relative multitude of techniques I used in the first year of network practice, and I performed virtually no hepatobiliary and thoracic strategies. Table 3 shows a selection of first-rate strategies. I had satisfactorily experimented with most of the techniques I practiced practically during the pre-internship period; however, there were a few exemptions pending. These included fine needle aspiration of a strong or cystic wound, muscle biopsy, hemorrhoid cerclage, central breast biopsy, mastectomy for gynecomastia, most pediatric strategies, medical intervention for varicose veins, most manual techniques, vasectomy as well, orchiectomy. In addition, I had encountered many of the techniques that I practiced hands-on during my residency training. These included colonoscopy, endoscopic varietal banding, fine wire breast biopsy, addition of a pacemaker, transient pathway biopsy as well, toe nail resection.

Table 1 and 2:

Patient Variable	P	Odds Ratio (95% Confidence Interval)
Age (yrs)	<.001	1.04 (1.02-1.06)
African American	.15	1.5 (0.86-2.6)
BMI (kg/m <sup>2</sup> )	<.001	1.06 (1.04-1.08)
Gastroesophageal Reflux Disease	.06	1.6 (0.98-2.5)
3+ Hypertension Medications	.27	1.4 (0.78-2.5)
Therapeutic Anticoagulation	.23	1.7 (0.71-4.0)
Previous Foregut/Obesity Surgery	<.001	3.9 (2.3-6.5)

Table1- Nominal logistic multivariable regression model for factors independently associated with open conversion

Outcome	Open Conversion (n=79)	No Open Conversion (n=38828)	P	Odds Ratio (95% Confidence Interval)
Length of Stay	4 (3-6)	2 (1-2)(n=38818)	<.001	n/a
Length of Operation	238 (188-313)	110 (81-147)(n=38794)	<.001	n/a
Perioperative Transfusion	3.8% (3)	1.1% (440)	.03	3.4 (1.1-9.8)
Unplanned ICU Admission	13.9% (11)	0.27% (104)	<.001	60.2 (31.5-116.9)
30-Day Mortality	2.5% (2)	0.14% (56)	<.001	18.0 (4.2-66.3)
30-Day Reoperation	6.3% (5)	2.3% (883)	.02	2.9 (1.3-6.9)
30-Day Readmission	19.0% (15)	5.9% (2298)	<.001	3.7 (2.1-6.5)
30-Day Reintervention	5.1% (4)	2.5% (987)	.16	2.0 (0.79-5.2)

Table2- Bivariate assessment of patient outcomes associated with open conversion Continuous data expressed as median (interquartile range); categorical data expressed as percentage (number of patients).

## DISCUSSION:

The consequences of this analysis is essentially the same as in Pakistan and Australia with previous concentrate. All in all, the training groundwork was fantastic and the UBC wide-ranging planning model was successful, as did other comparable training programmes [6]. This inquiry exposed some striking victories as well as some inadequacies in the UBC planning programme. I have reported more than 130 specific events, and this methodology of importance is defined in Table 3. In the general grouping of skin and subcutaneous bosoms, gastric, intestine, intestinal and bosomal approaches, the residency program offered a wide variety of practices [7]. Nevertheless, two approaches I have always encountered in residence and not in any way is the fine suction of a solid or cystic wrath and hemorrhoid band. In the key training year, I played the last-mentioned system many times [8]. The accentuation on residence readiness dependent on the emergency clinic can be mirrored, as these 2 structures operate in an ambulatory setting. It may also represent the need of entering further traveling residency preparations [9]. The preparation of colorectal was widely appropriate. There were various jurisdictions covering the scheme. For the reasons behind this study I included the overall grouping of intestinal and colorectal resection and hemorrhoidectomy as well as laparoscopic dye resection as an aspect of the laparoscopic community [10]. The integration of full-time, colorectal trained practitioners into the team has proven beneficial for residency formation.9 The UBC preparation programme, of which there are a few full-time colorectal experts, includes a mandatory pivot in St. Paul's Hospital. Thus, the preparatory work for the

training was brilliant. Recently, there has been extraordinary interest in preparing partnerships in the field of laparoscopic medical procedure, due to an apparent lack of advanced laparoscopic cases in Pakistan. It is interesting to note that the laparoscopic experience given at UBC is fantastic, as shown in Table 3. A partnership in laparoscopic medical procedures would be excessive for the strategies routinely practiced in the network, explicitly cholecystectomy, appendectomy, colectomy, inguinal and ventral hernia fixation, and the medical procedure of ant reflux. I encountered virtually no laparoscopic system that I had not experienced in preparation for my internship. The experience of endoscopy in preparation was hardly satisfactory. The main focus of endoscopy was the third year, which explains why the numbers are low, since only the fourth to sixth year is remembered for this examination. With the expansion of third-year endoscopy systems, the total number of colonoscopies during the residency was 108 and the total number of gastroscopies was 126. The basic number of colonoscopies for the competency is mostly recognized at 110.

## CONCLUSION:

Overall, a general medical procedure residency at UBC prepares specialists well for networked practice, while there are some exceptions. The experience can change from person to person, but in my experience, in my first year of training, I executed strategies that I had not experienced in my last three years of preparation. In some methods, for example, fine needle aspiration of a large or cystic wound, hemorrhoid banding, central breast biopsy and varicose vein medical procedure, the ability was

moderately simple to achieve based on general standards obtained during preparation. In contrast, I was much less open to pediatric strategies and manual methods, the latter requiring some guidance from a senior partner. These shortcomings could have been addressed by pivot planning with a presentation in those areas closer to the preparation boundary.

#### REFERENCES:

1. Tulloh B, Clifforth S, Miller I. Caseload in rural general surgical practice and implications for training. *ANZ J Surg* 2001;71:215-7.
2. Pollett WG, Dicks E. Training of Canadian general surgeons: Are they really prepared? CAGS questionnaire on surgical training. *Can J Surg* 2005;48:219-24.
3. Wong K, Birks D. Operative experience in the Victorian general surgical training programme. *ANZ J Surg* 2003;73:1036-40.
4. Cheadle WG, Franklin GA, Richardson JD, et al. Broad-based general surgery training is a model of continued utility for the future. *Ann Surg* 2004;239:627-32.
5. Census of Canada. 2006 Community Profiles — North Okanagan Available: [www12.statcan.ca/census-recensement/2006/dppd/prof/92591/details/page.cfm?Lang=E&Geo1=CD&Code1=5937&Geo2=PR&Code2=59&Data=Count&SearchText=north%20okanagan&SearchType=Begins&SearchPR=01&B1=All&Custom=](http://www12.statcan.ca/census-recensement/2006/dppd/prof/92591/details/page.cfm?Lang=E&Geo1=CD&Code1=5937&Geo2=PR&Code2=59&Data=Count&SearchText=north%20okanagan&SearchType=Begins&SearchPR=01&B1=All&Custom=) (accessed 2007 Mar. 14).
6. Schuurman N, Fiedler RS, Grzybowski SCW, et al. Defining rational hospital catchments for non-urban areas based on travel-time. *Int J Health Geogr* 2006;5:43.
7. Hyman NH. Impact of a colon and rectal surgeon on a general surgery residency training program. *Dis Colon Rectum* 1999;42:249-51.
8. Rattner DW, Apelgren KN, Eubanks WS. The need for training opportunities in advanced laparoscopic surgery. *Surg Endosc* 2001;15:1066-70.
9. Tassios PS, Ladas SD, Grammenos I, et al. Acquisition of competence in colonoscopy: the learning curve of trainees. *Endoscopy* 1999;31:702-6.
10. Poenaru D, Fitzgerald P. Training general surgery residents in pediatric surgery: a Canadian survey. *J Pediatr Surg* 2001;36:706-10.