

## Curriculum for residents' education

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In his Editors' View in the October 2000 issue of the *Canadian Journal of Surgery* (page 326), Waddell eloquently described the dilemma of current academic surgeons and program chairs when establishing the curriculum for residents' education. However, he did not go far enough in his examination of the problem. It is necessary to revisit the historical underpinnings of the residency programs and to look at the value system of the different players in the residency training milieu.

Years ago residents were given subsistence wages for the privilege of becoming a surgeon. Over time there was a grudging acknowledgment that the work and learning environments were changing and that residents performed a job for which they should be paid. It also became apparent that a body was required to assume the responsibility for ensuring that resident education was of sufficient quality that the expectations of both the public and the medical profession would be met. The hospitals and universities assumed responsibility for the work environment and the Royal College of Physicians and Surgeons of Canada took responsibility for the educational program needs and definitions.

Part of the problem that Waddell defines relates to these split responsibilities and the apparent lack of consultation between these 2 groups, whose expectations from residents differ widely. The hospitals and universities see residents as expenses, and seek to recoup their costs through service work and charging educational "fees." The Royal College concerns itself with the educational expectations as seen from its more Olympian viewpoint and its interpretation of the public's needs. In the absence of any good methodologies for measuring the educational effectiveness of "apprenticeship" surgical training, formal didactic teaching sessions or routine clinical work, the debate over the educational value of these activities will be a battle of opinions; one in which the Royal College carries the most weight. Surgical educators have failed to institute a system that would augment or replace the highly subjective opinions that are delivered about resident activities and abilities. Training programs cannot even agree on a countrywide method of selecting residents that is fair to the residents and the training programs!

If we are to find a way out of this morass, we have to do a number of things. First, we must examine our

profession's work habits: Are they appropriate or are we operating on an outmoded understanding of what a surgeon should be? Our work habits appear to be driven by income goals and have not been assessed with the patient in mind: weekend call stretches of 72 hours, elective slates after being up all night fixing fractures, for example, and half-day clinics of 90 patients need to be revisited.

Second, if we examine our own work habits, we must also examine those of residents — with the goal of "normalizing" their work habits. The literature shows that sleep-deprived residents are more depressed, tense, confused and angry than others,<sup>1</sup> heavy resident workloads are difficult on marriages,<sup>2</sup> and female residents find balancing family and heavy work hours particularly stressful.<sup>3</sup> The "scut" work that residents do in hospital has nothing to do with education or patient care; it is a result of hospitals downloading work onto residents, who have minimal ability to change the situation. This must stop. We must work with our future colleagues, current residents, to ensure that they are being summoned appropriately at night when on call. We must also recognize that nobody is "safe" after being up all night,

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whether resident or staff person. The standard for the profession should include mandatory rest after call. Just because we currently have no pay schedule for that is not sufficient excuse to stop its institution.

Third, both the Royal College and residents must be involved in setting up a fair, valid system of assessing the educational value of residents' activities. This would likely include not only a count of how many operations residents perform and patients they see, but also how well they perform in all of these activities. Such an assessment would be bolstered by better research on the relationship between volume and proficiency, by the knowledge of what happens to residents after residency and the role of fellowship training and subspecialization. Perhaps we also need to debate the role of restricted licences, similar to the American system.

A large factor in the current state of affairs is that no one person or system has ultimate responsibility for the process of residency training. The program directors and residency training committees are the most logical people to have control over all aspects of the resident experience, but in reality they are subject to demands for routine ward and call coverage, Royal College requirements and of course, departmental policies. Proper funding for postgraduate medical training would help relieve some of these pressures by separating clinical work that generates funding from clinical work that provides mainly education. Sources for this funding already exist: the tuition that many residents are currently charged (rightly or wrongly) and the large difference between the value of a resident's work and the salary a resident is paid. If medical educators are to reduce income-generating activities in order to increase time spent on teaching, perhaps these resources should be aimed at better compensating teaching activities. Residents must keep in mind, however, that in-

creased wages narrow the gap between the value of their work and the value of their pay, thus lowering the amount of resources available for compensating their teachers.

Also, it is important to address Waddell's contention that values and communication are best learned in the clinical setting. To our knowledge no one has demonstrated that the clinical setting produces more change than formal didactic teaching in these areas. Certainly being up all night and working the following day can change (at least temporarily) how we feel about our own values, and certainly how we communicate with our patients.

This is only the beginning of a much needed debate about our professional standards and the training that is necessary to support them. There has to be change and we must make it happen. The public has to be educated about the reasons for change and why change is important. We will make a huge mistake if we retreat to the old ways, pointing to the fact that training was done a certain way in the past and there is no reason to change. A system that sacrifices its young is not one that deserves to survive. We all need to be able to work reasonable hours while being fairly compensated, without compromising those standards of practice that make us unique as a profession.

#### References

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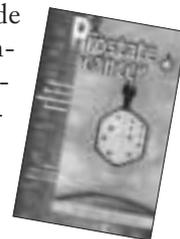
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