DOES GENERAL SURGERY RESIDENCY TRAINING PROVIDE COMPETENCE IN COMMUNITY-BASED PEDIATRIC SURGERY?

The Division of Pediatric General Surgery at the University of British Columbia has read with interest the article entitled: "Does general surgery residency prepare surgeons for community practice in British Columbia?" by Hwang.[1] This article correlates the surgical case logs of a contemporary general surgery resident's final 3 years of training with case volumes (by specialty area) encountered during his first year of practice. It is an important article that may have generalizable implications for all general surgery training programs, provided the author's conclusions are supported by the data presented.

What caught our attention was the author's unqualified statement: "The pediatric surgery experience during residency at UBC was relatively poor." This opinion was evidently based on the author performing 8 procedures in patients under the age of 16 during his first year of practice, having only performed a single hernia repair during residency, as shown in Table 2. We were surprised that the author did not elucidate the fact that UBC general surgical residents have a mandatory 2-month rotation in pediatric surgery in year 2 (this appears in Table 2, but is not otherwise clearly stated), and so the reported case log experience of his final 3 years of training did not include those cases performed during his dedicated pediatric surgical rotation.

The UBC Division of Pediatric General Surgery takes our educational mandate seriously. Our records show that general surgery residents rotating through our service at BC Children's Hospital perform, on average, between 30 and 45 operative cases during the 2-month rotation (average 34 for trainees rotating through in the past 6 months). They are mentored carefully through each and every case and are selectively video-taped to allow for replay surgical coaching. These cases reflect the surgical portfolio of a community general surgeon and include hernias, hydroceles, appendectomies, pyloromyotomies and pediatric vascular access. As 1 of 8 Canadian training programs for pediatric general surgery, the University of British Columbia has pediatric general surgery residents (who have completed training in general surgery) who do the majority of complex cases, including inguinal herniorrhaphy in premature infants, reconstruction of birth defects, surgical oncology and other cases, that a general surgeon is unlikely to encounter in a community hospital setting.

Our CanMEDS objectives for general surgery residents rotating in pediatric surgery include medical expert competencies beyond technical aptitude in community surgical procedures. Among these are a number of topics that require expertise in nonoperative management (e.g., intussusception, traumatic solid organ injury), intravenous fluid resuscititation (e.g., pyloric stenosis, complicated appendicitis) and an awareness of criteria for the transfer of a child to a specialized centre. It has been my experience that suboptimal outcomes in children managed for surgical conditions in the community are more likely to result from an error in judgment rather than a deficiency in technical aptitude.

The author reports that his operative confidence would have been higher if his residency experience in pediatric surgery had occurred closer to the end of training. Table 2 suggests that he performed a disproportionate number of hepatobiliary and thoracic cases during residency relative to the case numbers encountered in his first year of practice, so it is possible that a late residency rotation in pediatric surgery might have better prepared him for his first year of practice. Although we agree that general surgery residency programs need to be adaptable to the projected career needs of trainees, this author's experience needs to be validated with a larger sample size of community general surgeons before a curriculum change is proposed.

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References

1. Hwang H. Does general surgery residency prepare surgeons for community practice in British Columbia? *Can J Surg* 2009; 52:196-200.

THE AUTHOR REPLIES

I appreciate the opportunity to respond to the letter written by Dr. Erik Skarsgard, head of pediatric general surgery at the University of British Columbia, in response to my article.[1]

First, I would like to state that Dr. Skarsgard was one of my mentors during training, who I deeply respect, and I did not intend for the article to be a criticism of the UBC pediatric surgery rotation. As he has outlined, the rotation is a very well designed junior rotation and my personal experience on this rotation was excellent. However, my article is entitled "Does general surgery residency prepare surgeons for *community practice* in British Columbia?" (emphasis added) and it was the preparation for pediatric surgery cases in community practice that was poor in my experience and not the rotation. The main

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reason is because the experience, as comprehensive as it was, is so remote from the completion of the 6-year training program.

I fully accept the comment that this article is based on only 1 surgeon's experience and completely agree that the training needs of community surgeons early in their practices should be studied further. Community surgery is sometimes regarded as a default career for "failed" subspecialist candidates. In fact, it is a very challenging and rewarding job in its own right. I am glad that this paper has generated discussion and hope that not only UBC but all Canadian general surgery training programs refocus on community surgery and the needs of surgeons pursuing a career in community surgery.

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Competing interests: None declared.

Reference

1. Hwang H. Does general surgery residency prepare surgeons for community practice in British Columbia? *Can J Surg* 2009;52: 196-200.