



MINI-REVIEW

Urology training in the developing world: The trainers' perspective



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Residency training;
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ABBREVIATIONS

EBM, Evidence-based
medicine;
CPSP, College of Phy-
sicians and Surgeons

Abstract Context: Despite producing some of the leading urologists in the world, urological training in the developing world is marred by inconsistency, and a lack of structure and focus on evidence-based practice. In this review we address these issues from the trainers' perspective.

Introduction: Teaching the art and science of urological practice is a demanding task. It not only involves helping the resident to develop the depth of cognitive knowledge, but also to have an appropriate surgical judgement, and an ability to act quickly but thoughtfully and, when necessary, decisively.

Discussion: The surgeon must have compassion, communication skills, be perceptive and dedicated. Most importantly, however, he or she should have the ability to *cut and suture*. Not all of these can be inculcated in the training programme, even with the best of efforts. The selection of an appropriate candidate therefore becomes an issue of pivotal importance. The changing focus of urological training incorporates research and evidence-based practice as essential components. It is particularly important in the developing world, as there is a dearth of standardised practice models across the healthcare system. Encouraging female residents can be done by improving and tailoring the working conditions. The 'brain drain' is a major

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problem in the developing world, and bureaucracy and government need to take appropriate measures to provide high-quality healthcare facilities with room for professional growth.

Conclusions: The future of urology will depend on improved education and training, leading to high-quality urological care, and to developing a service that is patient focused.

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Introduction

Historically, surgical training has followed the Halstedian tradition of a defined apprenticeship. The apprenticeship model involves observation, modelling and graded participation. The trainee starts with internship and continues through residency training, with increasing responsibility until the trainee has the same abilities as the teacher. However, the apprenticeship system is characterised by long hours of work, with poorly defined goals, a lack of focus on research and evidence-based medicine (EBM), and that is limited to case presentations, and haphazard, random experiences that depend on patient flow and disease presentation.

Within the older system the assessment and evaluation are outmoded and have significant subjectivity. Standards for accreditation are ill-defined and not uniformly applied. By contrast, the modern training models have an appraisal-based evaluation, the assessment tools are more objective and there is a significant emphasis on external review of the programme and internal quality control. Training in research, ethical issues, concepts of teamwork and management are also part of the training model.

Recruitment

The training of a urological resident starts with induction and concludes upon graduation. The selection of urological residents is a difficult task, and programme directors are interested in identifying the best candidates. The selection of a high-quality resident is hampered both by the dearth of good-quality candidates, because surgical specialties are losing their attraction and trainers are struggling to appoint the right candidate for limited training places. The primary objective of the recruitment process for surgical residents is to identify those candidates who will perform well both as residents [1] and subsequently as independent surgeons [2]. However, the most appropriate strategy for achieving this objective has not been clearly established [3] and there is a significant variability in the ranking and selection systems or philosophies used by individual programmes. The use of psychometrics has been advocated in the recruitment process. This involves an 'ability test', which assesses general cognitive abilities, and

specific aptitude and personality tests, which assess the personality and behaviour, interests and motivation of the candidate. Knowledge, judgement and good technical abilities are the three fundamental requirements, but other skills, e.g., psychomotor skills, visual-spatial ability and depth perception are also critically important. They are particularly relevant in the face of the change in urological practice from open surgery to complex endourology, laparoscopy and robot-assisted surgery [4] (Table 1). The assessment of these qualities is therefore considered important during the selection of potential urological trainees. In developing countries these tools are particularly important, as constrained resources mandate the investment of time and energy in the right candidate. The selection processes in the developing world are mostly ill-defined and subjective. Knowledge is assessed by a general and specific examination, followed by short-listing the candidate for interview, with associated significant subjectivity. Female residents can be encouraged by providing tailor-made and flexible training programmes with provision to take time off to fulfil domestic obligations.

Training

Unlike in the developed world, urological training in the developing world is mostly unstructured. There is a significant variation in the standard of graduates from various programmes. Degree and exit examination qualifications reflect poorly on the standard of postgraduates [5]. Not surprisingly, the performance of the graduates is extremely variable. Some of them take leading posts even in highly competitive positions in the western world, but the standard of other graduates is extremely poor. The 'brain drain' is another major issue confronting the healthcare industry in the developing world, resulting from several factors, like a poor health infrastructure, poor financial remuneration and limited professional growth.

The training of a urological resident in Pakistan is typically on a 2 + 4- or 2 + 3-year model. In this model 2 years are spent in surgery in general, and 3 or 4 years in urology. The College of Physicians and Surgeons (CPSP, www.cpsp.edu.pk) is the principal body involved in the certification of postgraduates and in monitoring training. The exit examination for urological graduates

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