Medical School Training for the Surgeon

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KEYWORDS

- Medical education • Surgery resident prep curriculum
- Entrustable professional activities

KEY POINTS

- Currently, there is heterogeneity among graduating medical students in terms of their preparation for a surgery residency.
- Within undergraduate medical education, there is an ongoing paradigm shift from a broad-based, one-size-fits-all curriculum, to more focused preparation for future practice and residency specialty.
- Surgeons and medical educators must invest in developing integrated longitudinal programs to develop surgical trainees, beginning with medical school.

Surgery training is typically viewed as beginning July 1st, when new interns begin their surgery residency. The July intern is considered relatively undifferentiated, and attention within the surgical community has focused most often on the eventual development of that intern into a fully capable, trained surgeon over the course of a surgery residency. However, this traditional paradigm of focusing primarily on training during residency requires that medical school graduates enter residency training with adequate background medical knowledge, rudimentary but sound fundamental technical skills, and an understanding of the field and their role as junior residents. Recently, concerns have been raised regarding the heterogeneity of graduating students' readiness to take on these tasks, and a feeling that the first months of residency are often spent preparing newly minted residents to safely take the reins as a postgraduate year (PGY)1 resident. Moving forward, greater attention is needed to ensure our medical school graduates are optimally equipped to succeed, and that they enter

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residency with a more cohesive skills set focused on the foundational abilities needed on the first day of their postgraduate training program.

This article outlines the current state of surgery training in undergraduate medical education. We also highlight ongoing efforts to improve the preparation of graduating students for Surgery residency, and to better incorporate specialty-specific surgery training within medical school. Finally, we focus on future directions in undergraduate surgical education, particularly taking into consideration ongoing curricular initiatives in medical schools across the United States.

SURGERY TRAINING IN THE TRADITIONAL MEDICAL SCHOOL CURRICULUM

The majority of students' surgery-specific training has traditionally occurred within the third year core clerkship and fourth year elective or subinternship rotations. However, surgery educators have raised concerns that these experiences are variable in terms of quality and duration of exposure, and that as a result, new interns are not prepared uniformly to begin their surgical residencies.[1–3]

A number of factors contribute to the variability in graduates' readiness for surgery training. Within the third year clerkship, medical schools vary widely in terms of how well students are incorporated into patient care and decision making. Further heterogeneity is introduced based on the clinical rotations to which students are assigned, with some medical schools having rotations predominantly in tertiary referral centers on services directed by highly specialized practitioners with focused practices, and other schools' rotations using community-based preceptors with broader general surgery practices. Beyond this variability within the third year clerkship rotations, schools and students vary widely in their approach to the fourth year of medical school. Rotations include electives of various rigor, subinternships, and the increasingly common visiting audition rotations at outside institutions.[4]

In addition to this variation in exposure, concerns have been raised that medical students are increasingly marginalized during their clinical rotations, and clinical clerkships more closely resemble "observerships" with less active roles for students. Although the electronic medical record has a number of advantages for patient care and ease of accessing information, the implementation of many of these systems have limited students' ability to participate in clinical documentation.[5] Many graduates have little experience writing traditional history and physical examinations, brief operative notes, daily progress notes, and discharge summaries. The loss of this active experience negatively impacts their efficiency with these tasks as they enter residency. A number of invested parties, including the Association of American Medical Colleges (AAMC), the American Medical Association, and the Carnegie Foundation, have recognized these changes in undergraduate medical education and have expressed serious concern regarding the marginalization of medical students, which has occurred in recent years.[6,7] The AAMC has launched the Project on the Clinical Education of Medical Students in an attempt to combat this trend, and the Carnegie Foundation has called for better standardization of outcomes across medical schools with a focus on tailoring learning needs to students' future residency and career choices.

ENTRUSTABLE PROFESSIONAL ACTIVITIES

In recognition of this variation in preparation across medical schools, the AAMC has outlined 13 entrustable professional activities (EPAs) expected of all medical graduates I the United States (**Box 1**).[8] The EPAs are defined as "tasks or responsibilities that trainees are entrusted to perform unsupervised once they have attained sufficient

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