Alternative Considerations for Surgical Training and Funding

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KEYWORDS

• Surgical training • Funding • Graduate medical education • Alternatives

KEY POINTS

- The system of training we use is a minimally modified version of the training systems that were established in the United States in the 1880s.
- The current system of graduate medical education (GME) training we have is paid for largely by federal monies and subjected to oversight of the Accreditation Council for Graduate Medical Education in order to qualify for that financial support; general surgeons are certified by a monolithic certification system.
- Changes in clinical team structure and incorporation of our current GME system into a lifelong continuing medical education system within our clinical care environments could give us opportunities to greater diversify the surgical workforce and better distribute the costs of surgical training.

INTRODUCTION

Since the late 1880s surgical residency programs have existed in forms that are similar to our current models. Many important variations have been introduced over time including; transition from an open-ended to time based training models, transition from the pyramidal to the rectangular model, recognition as a national concern during the creation of Medicare including a shift to substantial federal funding, and the creation and modification of work hours regulations from 2003 to present, to name but a few. The distinct model of a medical student who transitions to resident or fellow as student/employee who then finally transitions to independent staff surgeon has been the standard model as well. We have assessed adequacy of training largely by national testing processes such as those offered by the American Board of Surgery

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Surg Clin N Am 96 (2016) 35–46
http://dx.doi.org/10.1016/j.suc.2015.09.002 surgical.theclinics.com
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since its creation in 1937. On aggregate this system has worked remarkably well though as economic, demographic, and cultural changes continue to evolve, one must wonder if we were to change our models how might we do that and what reasoning could we use. This article's focus will be to take a stratospheric view of what could be done, particularly in the United States, rather than characterize what happens in other countries with other health economic systems.

DISCLAIMERS

By way of full disclosure, I have made my living for the past nine years as a program director of a categorical general surgery training program. My salary during that time was largely, though not entirely, supported by funds paid to our sponsoring institutions by the Center for Medicare and Medicaid Services (CMS). I am board certified and re-certified in surgery by the American Board of Surgery (ABS). I have served as an Associate Examiner for the Certifying Exam (CE) for the ABS on multiple occasions and serve as an examination consultant question writer for American Board of Surgery In-Training Exam (ABSITE). I have been a member of multiple state and national committees of the American College of Surgeons (ACS) including the joint group on Transition to Practice jointly sponsored by the ACS and Accreditation Council for Graduate Medical Education (ACGME). I have also served as the Designated Institutional Officer (DIO) for our institution as well as Chairman of the Graduate Medical Education Committee (GMEC). Lastly, I served as Associate Dean for the Medical School (an Association of American Medical Colleges (AAMC) approved school) with which we are affiliated. I greatly respect and admire those with whom I have worked and in no way question their qualifications, ethics, or dedication to what they have done. The views expressed in this article, except where directly attributed to a specific source, are solely my own and do not necessarily reflect the views of any of the organizations listed above or otherwise described within the context of this document nor do my views necessarily represent the views of the United States Army, Department of Defense, or United States Government.

FURTHER DISCLAIMER AND EDITORIAL NOTE

The *Surgical Clinics of North America* nearly exclusively publishes material that reviews the existing literature and adds expert perspective and context to our understanding of that body of knowledge. In this issue we are attempting to review issues that span the arc of a surgeon's career from medical school through to retirement. From an editorial standpoint for this issue we felt compelled to also consider ideas that might be outside of current experience to at least stimulate a discussion of paths we might regard that are not simply tweaks of the system we already use. The ideas that are expressed in this article represent considerations that to the best of our knowledge have not been tried. The basis for these proposals come from identifying limitations of our current models encountered during decades of experience in having to solve typical and atypical problems involving both the training of resident and staff surgeons, as well as addressing labor and business issues of small and large medical corporations and/or developing medical capability in austere wartime environments. The concepts given for consideration are speculative by their very nature.

Much of what will follow in this article may be interpreted as a suggestion for complete change in process for the development of surgeons. It is meant to provide alternative constructs to what we are currently doing rather than list condemnations of what we have done. These ideas are not delivered as "tested methods" of what would

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