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THE CURRENT STATUS OF TRAINING IN GYNECOLOGY

A PERSONAL VIEW

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A B S T R A C T

The practice of obstetrics and gynecology has changed dramatically in the last decade. Evidence exists for a marked increase in professional dissatisfaction, poor personal relationship and burnout. These conditions are now being seen in younger physicians and in training programmes. Physicians have thus stopped practicing obstetrics and gynecology at a much younger age and are increasingly quitting training programmes. These findings, along with the recent societal liability of the profession and medico-legal crisis, leave many communities with a shortage of physicians who practice gynecology in particular. A potential solution for alleviating some of these conditions is the introduction of a new paradigm of training in obstetrics and gynecology that produces a physician whose sole focus of practice is managing the gynecological patient as its end product. This purposive training will remove from the physician the need to be always available to the laboring patient that potentially may decrease stress, improve physician well being , increase length of professional practice and decrease burnout. The "gynecological" trainee will also devote more time to apprenticeship, coaching in communication and technical skills and in turn improve patent care and satisfaction because he or she will have no other distractions during training.

KEY WORDS: Education, Gynecology, Medicine, Obstetrics, Training.

The obstetrician and gynecologist's is evolving continuously in a process of negotiation between the medical profession and the society it serves. At different points in the history of the profession, the relative power of the profession and society has varied. In the recent past, scientific and technological advances, the consequent growth of the tertiary care teaching hospital and sub-specialist expertise have tended to place much of the power to define a physician's role in the hands of the profession. The medical community was thus able to understand the scientific aspects of that role. Some recent changes have, however, influenced the way in which health care and the obstetrician and gynecologist's role are viewed. The net effect of these changes is that the balance of power in the negotiation of his/her role is changing to give a more equal share to society and the profession. This negotiation of role has implications for postgraduate education and clinical training in obstetrics and gynecology.

Medical education performs a service for society in training doctors to meet the need for health care in that society. In many countries, the social context of medicine has however changed since the majority of obstetric and gynecological teachers were students. Increased biomedical knowledge and technological development now offers seemingly limitless health service potential for medical intervention in women aimed at cure or life support. Therefore, it is necessary for medical educational institutions to be able to recognize and interpret those changes and design appropriate educational

programmes in obstetrics and gynecology for medical students. Despite these limitations, a career in either obstetrics or gynecology remains one of the most gratifying of professions. Result of the recent postgraduate programmes for obstetric and gynecological training in many countries, however, indicate that the number of unfilled categorical positions has fallen significantly in comparison with previous years. This problem adversely affects the future of our speciality and reflects the deep-seated problems in our postgraduate education that are not difficult for bright and talented young medical students to identify. The prototype obstetric and gynecological trainee is thus perceived as a constantly overworked, chronically sleep-deprived health professional who has not seen his spouse or children for days and who manages to prioritize allocated duties and responsibilities with great difficulty. Public and government criticism of the treadmill. The prospects of this kind of lifestyles for years of training and possibly for more years of practice are thus diverting the best candidates to Surgery, Medicine, pediatrics or psychiatry. Does it need to be this way in order to be "trained in obstetrics or gynecology"?

For many reasons, gynecological trainees in particular are the recipients of an extremely poor educational experience compared to other medical specialities. First, the development of good clinical judgement in gynecological practice is based o the premise that the surgeon carries out a carefully executed history and physical examination on a patient on whom he or she is to operate. In practice, gynecological trainees actually do this in a minority of the patients with whom they are involved in the operating room because they are required to "cover" far too many patients. The major component of this patient population is laboring women since traditionally obstetrics and gynecology are perceived as one speciality and therefore training in both disciplines is usually combined. This approach has developed partly because administrators of teaching hospitals are unaccustomed or unwilling to leave patients uncovered by house staff in training and partly because directors of postgraduate education restrict the number of candidates admitted to obstetrics and gynecology training programmes. Hence, trainees are often required urgently to care for extremely sick gynecological patients of whose illnesses and operations they have the scantiest knowledge whilst on-call. Day-case surgery units further contribute significantly to this problem. As a result, residents and interns become mainly committed to set up cross-coverage coasters in an attempt to decrease hours on duty and to meet the on-call requirements of obstetric wards. The cross-coverage plans create a modus operandi amongst trainees of all-purpose algorithms rather than the intimate knowledge of a given patient. This results in sub-optimal patient care and gives support to the fallible paradigm that gynecological surgeons require only the most superficial knowledge of his or her patient.

Second, the attainment of good clinical judgment during training is impeded by the virtually total inability of the candidate to observe the course of disease postoperatively. Although most training authorities also require demonstration of this longitudinal experience with patient, this now seldom occurs as a result of the current cost-oriented health service culture promoting short hospital stays and less need for long-term outpatient follow-up.

Third, because of excessive clinical duties, the time for contemplative reading, diagnostic problem solving or reflective practice review has been replaced by a cautious and hurried search of the biomedical literature for information. Recent evidence nevertheless suggests that these professional activities are fundamental to both development and good quality medical care.

Last, but not least in significance, is the virtual disappearance of clinical ward rounds on gynecological patients conducted by senior physicians accompanied by trainees, staff and students, in lieu of labour ward rounds. Experienced consultants and departmental chairs thus cannot convey to the trainees their extensive gynecological experience because the "team" rounds, another recently introduced clinical governance approach, seem to prevail. The emergence of the team ideology has also contributed to a dilution of the responsibility of single individuals in patient care as well as mentioning, a situation that is detrimental to learning.

The solutions to these problems are not as difficult as some might be led to believe. Blaming health care administration and the socio-political climate is of no value. A few simple but innovative measures can address many of these issues. First, training directors and chairpersons must devise separate training programmes for either obstetrics or gynecology. The number of patients to be cared for by a gynecological education team should be curtailed in order to be able to truly provide excellent care in a learning mode. The upper limit of in-hospital patients to be cared for by a single team should

probably be limited to about 15. This implies that in most teaching hospitals, some health services in gynecological department will have no assigned trainees or students. Hospital physicians will be required to cover the latter services themselves, a common practice in non-teaching hospital. Residents and students will be assigned to teaching-clinical services and will have responsibilities for those patient only. The team should consist of a senior academic gynecologist as a team leader, a senior trainee or resident, an intern and a student. The entire team should make rounds together, at least once daily. Hospital physicians can be added to the team and should be selected for their interest and expertise in teaching. The trainees and students on each team will essentially become preceptors of the selected team leader and/or clinician-tutor and will attend all outpatient and operating room sessions with him or her providing continuity of care and longitudinal experience. Night and weekend coverage would be confined to the care of patients of the team eliminating cross-coverage with a reasonable arrangement divided among the trainees of such a team. In order for the pedagogic experience to be worthwhile, a given team should probably remain together for at least 2 months.

In conclusion, gynecologists now work in a context in which the old varieties about medicine and medical practice can no longer be taken for granted. The relentlessly rising volume of service demands particularly for obstetrics and continued restructuring of health care delivery furthermore leave inadequate time for establishing effective relationships with patients or for formal coaching. Hence, gynecological trainees are in a serious need of training and education if they are to adapt successfully to a different future. Although the proposal for a new model of postgraduate training in gynecology may seem to be a setback to pre-academic medicine days, in some respects this scheme reinforces the traditional apprenticeship structure that was very successful for so long. This offers few therapeutic solutions for improving recruitment and training in our speciality that was at its zenith just a few short years ago.

Hippocrates (460-375 BC) with remarkable ingenuity and prophecy, depicted such peculiar tutor-trainee relationship in simple terms.

To reckon him who taught me this art equally dear to me as my parents and teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction (The Oath).

Keep your face to the sunshine and you cannot see the shadow.

Helen Keller