

Protected Time vs Service Commitment



If there is one tip I can offer you, it would be—go post call. The long- and short-term perils of working with chronic fatigue have been proven by scientists.^{1,2} On the other hand, the rest of this essay is but a collection of observations and lessons gleaned from my personal experience in specialist training.³

Old Versus New

I am currently undergoing the final year of training to be a general surgeon. By any measure, I consider myself, and the rest of my cohort, to be products of the Old School training system—surgically competent, unfazed by most emergencies and overall—“Old School”. Why would we wish anything less for the juniors?

Truth be told, Old School is over-rated. In fact, it celebrates masochism. Many of us emerged from the training like Frodo⁴ at the end of his epic quest, triumphant (surgically competent) but scarred with battle wounds that may never heal (all the long-term ills of chronic fatigue, delayed marriage and family, and some even have reported personality changes).

What then should the New School be like? Should it get in touch with its inner feelings and recognise that surgeons need a warm and nurturing environment that pays full respect to their self esteem, psychological development and ethno-cultural background to produce a warm and caring individuals who recycle?⁵ Will we end up with a generation of namby-pamby surgeons?

On one extreme of the training philosophy spectrum—I have been there and done that—so must you. What doesn't kill you makes you stronger! The other extreme—New Age Sensitive Surgeons who might sob at the sight of a beautiful sunset. The ideal training environment should probably be somewhere in between. A surgeon who has never seen surgical carnage (30 admissions, 20 blue letters, 5 laparotomies, 20-hour operations, etc) may be somewhat

uninitiated. Yet, a surgeon who constantly functions in a life-and-death mode may be too callous and run the risk of professional burnout.

Culture

It is a good thing that the wind of change blows from a top-down approach. If it had been a ground-led initiative, things may move a little slower. But a top-down approach for change is only as effective as its enforcement. On the ground, age-old practices are still regarded favourably even if they contravene new policies or guidelines.

A blatant example of this is the flouting of protected time for residents to rest. It is common practice for residents to under-report their working hours so that their departments can pass the audits for training centre accreditation.⁶

Why do residents do that? Is it because of insufficient doctors? If it is, then, the employment of service staff should settle the problem. But this problem exists even in adequately staffed departments. This points to the source of the problem, which is probably more complex and ingrained in many surgical units.

Culture—surgical trainees are go-getters. A resident worth his salt is able to function despite having endured physical and psychological stresses for prolonged periods. My consultant once asked me if I was going post call. I was aghast at the thought of it. I had never heard of a surgical registrar going post call.

It is probably not explicit at the workplace, but a resident who does not go post call is regarded more highly by his peers and seniors than one who religiously follows the new guidelines.

Such an implicit system of appraisal at the workplace makes the protected-time guidelines difficult to implement and almost impossible to enforce.

The only way to change the culture is to lead a change in the mindset—to view the behaviour of not going post call as one that is irresponsible, one that places the resident's self-serving interests (training opportunity, masochism, image, appraisal) above the patient's safety.

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Protected Time to do What?

Rest. Adequate rest is important—it sounds almost too ridiculously simple but it is surprising how it is often ignored in real life. A surgeon should have enough rest so that he can reflect on his patients, his team members and his mistakes. He should have a clear mind, not one that is chronically fatigued so that he can ask questions that are not apparent in the hustle and bustle of the typical surgical day. He should have enough energy left at the end of the week, so that he is still keen to share his questions, findings and observations with his students (teach) and the larger surgical community (publish).

The concern is that surgeons who think, write and teach too much end up not being good operators. Nearing the end of my surgical training, I think the emphasis on surgical skills is important but should not be excessive. The skill set required for one to be a competent operator is probably achievable in a typical 5- to 6-year training program. And after a while, this skill set sort of stays the same with marginal improvement and refinement over a long period. Some of the sayings I have heard support this observation—“There are only so many times one can do a thyroidectomy without getting bored”, “80% of surgeons can do 80% of operations”, “There is no difficult operation—because it comprises repetitions of many simple steps—clamp clamp cut tie tie, traction counter-traction, exposure, etc”. This is true even for novel surgical skills like laparoscopic and robotic surgery. There is a learning curve and once it is overcome, it plateaus.

In contrast to motor skills, the other attributes of a good surgeon almost never plateau. These include sound decision-making, introspection, teamwork, collegiality, astute clinical observation skills, an insatiable curiosity and a critical mind. Unlike motor skills, acquiring these higher order cerebral functions requires one to be well rested, well fed and emptied of one's bladder and rectal contents. And to me, acquiring these attributes early in a surgeon's training years is more important than having a set of hands that can complete a gastrectomy in an hour.

Service Commitment

What is it that we need to protect the residents from? What exactly are the “service commitment” activities that the department needs to employ service staff to handle so that residents can receive good training?

Could they be ward rounds, clinics and speaking with families? These activities are often viewed as obstacles to operating time. Hence, if there are non-resident staff available, it is tempting to have them do the ward rounds and clinics while the residents go straight to operating theatre (OT) to operate.

Such a division of duties cannot be more disastrous. Good surgical training should ensure that the residents are competent with both inpatient and outpatient care.

In short, ward rounds, clinics and speaking with families are also training! Ward rounds train the resident in his inpatient management and postoperative and critical care skills. It also sharpens his leadership and resource management abilities. Clinics and speaking with families, whether it is counseling for surgery or breaking bad news, hone his communication skills—something lacking in most of us—brought up in traditional reticent Asian society where children are seen and not heard.

Training Opportunities

Protected time is not going to be the panacea for all our ills.⁶ It has to be complemented by supporting measures. One such measure could be to make up for the shorter training hours by increasing the learning at elective surgery settings. For that to happen, the teacher has to be one who is self-assured and has no further interest than to pass his skills and legacy on to the next generation. In most training hospitals, these “clinician educators” do not come by easily because of the brain drain to the private sector.

Another measure is to maximise learning opportunities with existing programs in the department. I am currently working in a unit where the junior residents are required to attend a “reflection” session after the weekly mortality and morbidity (M&M) round. I do not know what exactly happens at these reflection sessions, whether they play soft music and burn some aromatherapy oil to get everybody into a pensive mood. But I think the concept of this session is nothing short of visionary. This session recognises the limitations of the M&M as a teaching tool, especially for juniors—yes, we learn a lot from M&M, but it is also true that sometimes, emotions get in the way, sometimes, certain things are omitted, or padded, etc. To put it bluntly, some M&Ms have degenerated into useless shame and blame exercises that have probably driven thousands of eager medical students from this great discipline.⁷

The “reflection” sessions allow a senior clinician, usually the Head of Department, to impart the essence of the lessons to the juniors in a dispassionate way. To help them learn from other people's mistakes, so that one day, they will be equipped with the tools they need to learn from their own mistakes. These sessions may delay the residents' participation in other surgical activities for the day like OT or clinics, but it is time well spent.

There are softer approaches and measures, such as the playing down of the traditional hierarchy system that we hold dear in the fraternity. I do not mean addressing everyone by his first name. In the medical community, it

is considered acceptable for seniors to chasten, berate or even humiliate juniors. Many times, scolding juniors is done under the pretext of being “for their own good”. Really? A senior consultant once asked me—does scolding make the juniors learn better? I believe in “sparing the rod and spoiling the child” but we are talking about people in their mid twenties to early thirties. We may argue that there are a small population of residents with thick skulls, resistant to conventional rebukes and require a high-pitched voice and harsh language to get the message. Apart from these, perhaps, it is more powerful an education tool for a senior to simply state the mistake and leave it for the junior to internalize. In fact, not scolding does not mean condoning inferior standards. Some of the people who set the highest standards are those who never lose their temper or raise their voices.

Conclusion

Will the new training system create a better generation of surgeons? I suspect the next generation of surgeons will be better, regardless of the training system. That is the secular trend—each generation becomes better than its predecessor—and this is crucial not just for the medical world, but for the human race.

Hopefully, the new training system, with its protected time and other complementing measures, will help the next generation cope better with the challenges that the Old School never faced—an increasingly litigious population, information explosion, Google, Facebook, Youtube*, etc.

All the above are purely my personal viewpoints. But if there is one scientifically proven advice that I have for you, my fellow resident, it is to go post call.

* A patient came to the clinic asking about a surgery and said he already saw how it is done on Youtube!

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