

Safety Measures, But What About Measures to Assure Education/Training/Experience?

To the Editor:

Patient safety should be paramount in resident education. As noted by Iglehart¹, mindful action by the Accreditation Council for Graduate Medical Education (ACGME) has led to substantial reduction in and limitation of resident service and education activities. That group has now made further recommendations² to reduce fatigue and increase safety. The major impediments to past implementation of ACGME recommendations have been resident replacement costs and even finding qualified replacements².

In their very appropriate attention to one aspect of patient safety, the ACGME has apparently failed to consider other portions of the equation. Iglehart¹ reminds us that the original training time was required “in order to gain the experience necessary to become well-qualified physicians.”

Residency training programs, however, have generally been inadequate even prior to the current reduction in resident hours. The current limitations have precluded meaningful attention to these residency program deficiencies. While inadequate experience has been documented in many areas important to the primary care physician, I will limit my comments to musculoskeletal disease. Less than 3% of curriculum in medical school is devoted to musculoskeletal disease, and even less in residency^{3,4}. This contrasts with recognition that 14%–28% of primary care visits relate to musculoskeletal issues^{3,4}.

Musculoskeletal disease can be divided at least into rheumatologic, orthopedic, and rehabilitation medicine specialties. Each has its own database and pertinent experience. One study revealed that 3 months of rotation were required if the participant were to demonstrate at least minimum skills in care for/management of individuals with just the rheumatologic component of musculoskeletal disease⁵.

Given the increase in medical knowledge and development of new (often expensive) diagnostic modalities, there has been an exponential increase in the knowledge base. Current training seems to concentrate on technique utilization⁶, rather than developing clinical expertise, and does not seem cost-effective. Without adequate clinical training, there is dependency on expensive technologies (e.g., MRI scans), when a trained clinician could resolve the problem without resorting to unnecessary testing.

If the goal of a clinical training experience is to enable the successful participant to assess and at least initially care for patients with the diseases/problems inherent in that discipline, it is essential that the training

exposure be adequate to that task. Anything less would not seem to safeguard patient safety.

Realizing the increase in pertinent medical knowledge, expansion of diagnostic technologies, and the spectrum of additional training/experience essential to the primary care physician, the adequacy of a 3-year residency must be questioned. Augmenting family and internal medicine residency training to create a 5-year program would seem a necessary step to address the education/training requirements and would have the ancillary effect of solving the current problem of staffing facility service needs.

As one of the “short-changed” fields, should not rheumatology be raising the clarion? Should the primary care training programs be augmented or should a new field of primary care training be created — one that solely trains outpatient clinicians?

BRUCE ROTHSCHILD, MD, Department of Medicine, Northeastern Ohio Universities College of Medicine and Arthritis Center, Biodiversity Research Institute, University of Kansas, Lawrence, Kansas 66045, USA. Address correspondence to Dr. Rothschild; E-mail: bmr@neoucom.edu

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