Surgical residents as teachers

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The paper by Hutchison and colleagues in this issue (page 295) raises important issues that should stimulate wider discussion. First, we should accept that education and learning are not always the same thing. For a medical student, being shown how to perform a procedure by a resident may be an education for the student but may not be good structured learning. How can we be sure that the student is learning what we as teachers think is important?

This paper identifies the lack of structure surrounding educational teaching of clinical clerks by residents. We should explore the reasons why this occurs and then set goals to bring structure to this important educational activity.

Do we value the education of the medical student less because frequently as teachers we are not paid directly to teach and have therefore delegated many of our teaching responsibilities to residents? Are we ready to explore the idea that the role of the resident as teacher has not been an evolutionary process but rather an expeditious means of coping with increasing demands on the time of staff surgeons?

This study demonstrates the perception of the importance of teaching in that there was a uniform 60% response rate from students, residents and staff. The results indicate a gap between the residents and clerks mutually understanding the goals of teaching. This may be related to an inability to factor-in the needs and demands of residents and staff when clinical clerkship rotations are being planned.

The issue of teaching location is important. Clinical faculty are significantly constrained in the amount of formal on-call responsibility that we can give to clinical clerks — yet being on-call for the ward or the emergency room may be a much better education than working as a second or third assistant in the operating room. The ability of a clinical clerkship program to meet the needs of surgical training by such exposure should be emphasized; this may well make surgery a more attractive option for the student when selecting his or her future career.

Hutchison and colleagues discuss the need to enhance the education of residents as teachers. It is my opinion that the best teaching guide is a well-written curriculum, with core objectives and a method of assessing whether or not those objectives have been met. It is the recipient of teaching that needs to be tested to determine how much has been learned, and the results of those tests may well reflect on the teachers. Too often the assessment of teachers is seen as a popularity contest or who may be the most entertaining as a teacher. We should return to the basics where the results of teaching using well-defined end points are the objective means of assessing teaching competence. We need to structure educational experiences so we listen to both the student and the teacher when determining who should teach, what should be taught and where this teaching should take place. There are many procedures that medical students should be able to perform, such as venepuncture, arterial sampling and insertion of nasogastric tubes, that should be part of a teaching program with some form of objective methodology to determine competence. Since teaching defines us as individuals and as a profession it is too important an issue to be delegated without responsibility, reward or assessment. We should learn from Hutchison's paper how to assure that the appropriate resources are in place to maintain excellence through the use of teaching objectives and the determination of outcomes of teaching effectiveness. With the dramatic increase in tuition fees at medical schools across Canada, it may be that students see education as a commodity to be bought and evaluated like any other commodity. It is our responsibility to see that students get value for their money by insisting that monies are used to provide those necessary measures.■

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