PANEL III: EDUCATION OF THE PHYSICIAN

POSTGRADUATE

Reporter - DONALD POND

The first speaker was Dr. E. H. Botterell, dean of Medicine at Queen's University. He spoke of a changing society and advancing science which led to re-evaluation and re-organization of undergraduate medical education. It was his opinion that if a core curriculum of one or two years duration were introduced, then a student graduating with an M.D. degree would differ somewhat from a student graduating today. To be taught to practice is for the graduate and not the undergraduate student.

Because of the changing environment in which the physician is to work, the physician must learn to work with a team and must integrate the workings of this team.

Dr. Holden of Case-Western Reserve University talked on graduate surgical training and the administration of a surgical department. He maintained that postgraduate surgical training should be done at a university center and that the department of surgery in a university hospital should be represented to the university as a separate entity.

There is need for cohesiveness among the surgical sub-specialties in a university teaching hospital. To be cohesive, this department must be represented by a director and this director must represent the whole department. It is preferable that the director be a general surgeon because it is he who has a broader perspective of the whole field of surgery.

With respect to surgical training, he maintained that this training must be comprehensive. Some surgical residents are better off to have had general surgical education first; others, especially those in the surgical sub-specialties, do not need a full background in general surgery.

From the points of view of both surgical administration and surgical education the separate parts of surgery are to be organized for optimum benefit of the separate parts.

Dr. D. R. Wilson, professor of Medicine at the University of Alberta described postgraduate training from the internists point of view. He maintained that medicine required clear delineation of resident posts. He posed the question "Were these posts to be primarily for service to patients or primarily for resident training?" Today there has been a shift tc university-based programmes and this shift has created staffing problems in hospitals which are not university based or university affiliated.

As a result of a study which he described, he stated that there was a need to re-evaluate the performance of medical residents. He showed that there was not much difference in a medical resident's knowledge after two years of training when compared with his knowledge after four years. He felt that there should be an earlier evaluation, that is, at the end of two years. The graduate trainee could then further his depth of knowledge in his last two years of training.

There must be ways to shorten graduate medical education. He feels it should be possible to take a good clinician and have him define those qualities that have made him both a good clinician and a good teacher. These qualities could then be integrated into a computerized programme and given back to the residents. At present there is too much in the way of patient exposure and this could be decreased and more emphasis placed on the above.

Dr. John Stokes of University College Hospital, London, was the final speaker on this panel. He defined the position of the general internist and asked the question "Is there a need for the general internist?" He maintained that from the points of view of both undergraduate student and patient there is a need. He must deploy his time, that of his colleagues, and that of para-medical personnel to the best advantage. He thus plays a great part in total medical care.

Speaking in negative terms, he described well what an internist should or should not know. He suggested that there is no need for general internists to specialize, that there was no need for them to have formal psychiatric training and he resisted the view that they should be trained in a non-university atmosphere.

The overall conclusions of this panel with respect to postgraduate medical education were:

1. Postgraduate medical education should be at a university center.
2. Ways should be sought to shorten the postgraduate training period, but in such manner that the graduate will be able to cope with his changing environment.

PANEL V: INTERRELATION OF PARAMEDICAL PERSONNEL

Reporter - Lip Khai

CHAIRMAN: Dr. John Evans

PANELISTS: Dr. M. G. Fields
Dr. A. H. Shears
Dr. Gordon Thomas
Dr. Leonard Rubin
Miss Ruth Mey

Dr. Field who has made a study of the medical profession in Russia felt that with the expansion of medical knowledge and techniques and with an ever increasing demand by society for more and better medical services the inevitable trend in medical practice is towards greater specialization. As the physician limits the scope of his practice there is an increasing tendency for him to make use of allied personnel. This will free him from many routine tasks and enable him to spend more time with his patients.

Dr. Shears considered the role and responsibilities of the physician in this new setup. The physician must be the captain of the team, and to make the team work he must acquire a core knowledge of each of the paramedical disciplines and thus know their strengths and weaknesses.

Dr. Estes spoke of an experimental program for the training of Physician's Assistants at Duke University. These individuals are highly selected and trained. Their day begins at seven thirty in the morning when they come to the hospital to collect samples for tests. They accompany the physician on rounds and take notes. They do physical examinations on the patients (with the exception of rectal and pelvic examinations) and present the patient to the physician in a manner similar to that of the clinical clerk. Dr. Estes noted that the Physicians Assistants have been received well by the patients and they enable physicians to see up to 30 to 40% more patients daily.

Dr. Gordon Thomas spoke about the methods used to provide health care to Northern Newfoundland and Labrador where there is a small population scattered over thousands of miles of coastline. Up-to-date medical care is provided by having a center in Saint Anthony and outpost subcenters in the smaller communities. These are in contact with Saint Anthony by radiotelephone and staffed by specially trained nurses. Extensive use is made of aeroplanes to bring patients to the center for treatment.

In 1968 a course for Outpost Nurses was started at Dalhousie. Miss Ruth E. Mey who is directing the program explained that it was a two year course open to registered nurses. The course includes instruction in