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Original Research Paper

General Surgery

COMPETENCY BASED SURGICAL EDUCATION

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Educated, trained and competent all these words have some subtle differences. A resident may be trained to suture, educated about techniques and types of suture, but a competent resident would know when to suture, how to suture and when not to suture. This level of competency is achieved albeit late. The traditional approach to the postgraduate surgical training can be referred to as the "time-spent" model. Trainees are anticipated to spend a minimal length of time in the residency program, working on actual medical instances under supervision, with the assumption that the trainee would be transformed into a competent practitioner over this period. In our country the time spent is three year, in USA it is five years. Although this education model has existed for over a century, but there are certain problems with this age-old system. Most of us are benefitted from this system as we see, and perform certain number of cases, but have we ever realized that what about the other cases that we have not performed or seen. What about the other students who could not utilize this opportunity tom learn during his /her tenure. Can the supervisor/guide /teacher is cognizant about his student's capabilities in terms of performing surgical procedure.

Certainly the answer to these problems are-competency based surgical education.

Competency can be defined as "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (1)

In this system system, curriculum revolves around the expected outcomes expected of a resident, and their career progression is dependent on achievement of these competences. It also provides a new approach all together to teaching and evaluation with periodic and direct observations to ensure that residents are achieving Entrustable Professional Activities (EPAs) in real-life situations. EPAs is just an indicator for competencies, its a means to translate competencies into clinical practice.

Implementation of a competency-based surgical education is very difficult, as we need to robust mechanisms in place to ensure that every resident is undergoing the same amount of training to attain competency.

Proper logbook had to be handy all the time; consultant's supervision is the key to the developmental ladder. There are problems in our country, which are deterrent for this system to be implemented. In some places number and variety cases give to a particular resident is dictated by some personal choices, in some consultant are very busy in with their own work or practice. Even in teaching hospitals they forget that they are being paid to teach, to train - to make the future surgeons, who are not only trained, but competent.

Globally experts have agreed that the traditional time-based residency-training model is not up to the mark considering the need of the patients in this century. The age old model just allows residents to obtain degree from their respective universities following the completion of specific time-based requirements, summative assessment in the form of a knowledge-based examination is done. Skill and competency takes the back seat. Ever drivers are tested for their competency, but one can become a surgeon just by clearing the theoretical hurdles.

The Royal College of Physicians and Surgeons of Canada (RCPSC) as well as the Accreditation Council for Graduate Medical Education (ACGME) in the United States have increasingly emphasized the importance and necessity of training competent surgeons with a specific emphasis on assessing surgical skills. Of course every specialty or subspecialty is very vast and one cannot be competent for everything, but attaining competency can ensure that these residents can be most productive for the society if they are competent and gain experience by virtue of spending time in nurturing their skill and knowledge post residency.(2)

This system is outcome oriented -whether one is competent or not in a particular task.

The procedure in question once identified, the essential steps for these procedures are must be outlined in order to track residents skills acquisition using customized, objective assessment tools. To facilitate this process, an efficient methodology is required to identify these procedural steps, as it requires inputs from experts in the field.

India accommodates approximately one sixth of the world's population, there is heavy burden on the health system of our country. India produces a large number of postgraduates in surgery. Skill and knowledge acquisition varies among these residents as they belong to different Institutes with different institutional infrastructure, facilities, surgical expertise of the mentors, geographical variation of diseases, and socioeconomic status of the patients and trained different teachers, but end of three years all of them obtain - degree Master of surgery. (2)

Competence based training is in a general sense situated to graduate result skills and prepared around abilities got from an assessment of need of the general public. It deemphasizes time sensitive training and ensures bigger responsibility, adaptability, and student centeredness.

Of course there are certain limitations like- The competency-based approach not only reduces the role of teachers, it also often considers knowledge of a subject as secondary to mastering the skills—as some have put it, who cares what you know, it's what you can do that matters. (4). Frank *et al*. in their article "Competence-

based medical education: Theory to practice have also described the possible perils of CBME such as, in an attempt to define competencies and sub competencies, we may come up with a long list of abilities, and the essence of the subject may be lost.(5) The students, who are used to teacher-driven and time-based learning, may find it difficult to cope with CBME

Skills, however, are often the means, not the end.

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