

Training Residents in the United States: Past, Present, and What's Next

GEERT BLIJHAM, MD, PhD

In 1979, I became hematology/oncology fellow in the Department of Developmental Therapeutics at the world-famous MD Anderson Cancer Center in Houston, Texas. I had almost finished my residency in internal medicine at the Academic Hospital Maastricht in the Netherlands, and with curiosity and anxiety I looked forward to my new working and training environment. It turned out to be a once-in-a-lifetime experience. There were 6 patients per fellow (rather than 12 as a resident in Holland), daily rounds by the attending physician (rather than once a week), rounds on Saturday and Sunday (rather than having the weekend off), and patients calling 7 days a week, 24 hours a day (rather than “out of the hospital” meaning “no patient contact”). And, most important to me, a department chair with a never-ending ability to ask difficult questions, to address the “why” more than the “what.” After all, in 1965 Emil J. Freireich was the coinventor of the first curative treatment for children with acute leukemia. For him, and consequently for all faculty in the department, today’s patient care was the laboratory for the patient care of tomorrow. This fellowship experience has stayed with me for all my professional life.

Where was I in the succession of “tectonic shifts” in residency training that Kenneth Ludmerer describes in his fascinating book *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine*? In short, I benefited from the profound changes in working conditions that, as he describes, characterized the 1960s and 1970s. Residents and fellows did not have to be monks anymore; I received a salary and was entitled to a private life, albeit with less privacy than I was accustomed to. Moreover, I did not suffer from the upcoming shift toward what Ludmerer calls “the high throughput era,” in which the day of admission was in fact the first day of discharge. The patient load was actually rather low, and there was enough time for reflection and study. Within 1 year I had submitted an abstract on prognostic factors in chronic myeloid leukemia blast crisis and had presented at the Annual Meeting of the American Society of Clinical Oncology about the first patients with testicular cancer treated with stem cell transplantation. Training and science were still in balance, at least in the fellowship phase, on the way toward Board

eligibility, which, as Ludmerer points out, was the phase most resistant to the pressures of production.

This brief summary of my own experience resonates with a major theme of *Let Me Heal*: the constant drift away from the early “Hopkins” days, where “students” rather than “employees” were taught by eminent clinicians how to think rather than how to act, and toward the “9-to-5” house officers for whom the mastery of skills and techniques is most important.

Ludmerer certainly recognizes there are problems associated with working more than 100 hours a week, and having an educational system that looks inward rather than taking aspects of society into account. But his word processor becomes enthusiastic when he writes about Osler and Halsted, Stead and Beeson, the full dedication of residents to the well-being of their patients, and residents becoming not only expert medical specialists but also clinical scientists.

Let Me Heal is very well written and touches on virtually every aspect of the graduate training of physicians in the United States. But it is not applicable only to the United States: almost all of these aspects are recognizable to those engaged in the education of medical specialists in Western Europe, albeit with some differences. In the Netherlands, in the early 1990s we reduced the working hours of residents to 48 hours per week and did so, I believe, without any deterioration to the quality of training or patient care. We even introduced part-time training programs, which allow female residents to combine starting a family with continuing medical training. To me, Ludmerer’s fascination with the 80-hour workweek, or with the resident being allowed to stay 4 or more hours after a busy night shift, seems to be inspired more by romanticism and nostalgia than by facts. In contrast to his opinion, I would assert that neither professionalism (that is, serving the interests of the profession) nor the interests of patients are at risk when residents are treated as normal human beings.

About 20 years ago in the Netherlands we embarked on a system in which the resident spends time in both an academic hospital and a community hospital. Before that time, academic hospitals and community hospitals offered separate programs. On paper these programs may look very much alike (duration, rotations through inpatient and

outpatient departments, a required number of procedures), but in reality there were considerable differences in the number of patients per resident, the intensity of supervision, and, most importantly, patient mix. Academic and community hospitals are different working places, yet both offer valuable training experiences.

Being only trained in an academic setting may sound more attractive, but it may leave the resident with the erroneous impression that rare diseases are the most common ones in the world. The resident may lack typical practice experiences that form the daily life of most medical specialists. *Let Me Heal* does not delve into this issue of exposure to both academic and nonacademic institutions.

Let Me Heal is the book of a historian describing the rise and fall of the very successful American residency system. In the last chapter, Ludmerer introduces interesting thoughts about how to adapt this system to the realities of today's health care without losing its inherent good qualities. Here I sense that a thorough discussion about the relationship between generalist and superspecialist educations, both in terms of competencies and regulation of numbers, would add to his work. Ludmerer makes the point that changes in residency training and changes in health care are closely related. Part of the problem with the

current residency system in the United States is due to general problems in health care: the emphasis on *more* rather than *less*, the persisting view that a patient's death is a medical failure, and confusion about what professionalism really means. I sense that Ludmerer is concerned that such messages are reinforced through residency training. In a way, the health care system and the residency system hold each other hostage.

When I left MD Anderson to return to the Netherlands, I asked my attending physician about his experience supervising me. He said, "We said so often *no*." I took that as a compliment, knowing that some of my cancer patients, after honestly and openly discussing the pros and cons of a new treatment in the final stage of their disease, ultimately declined treatment. I was fortunate to get my education in hematology and oncology in an environment that allowed me independence, and at the same time let me be inspired by excellent clinicians and scientists. *Let Me Heal* provides us with a deep insight in how this successful residency system has been developed and maintained, despite threats from the world around it.

Geert Blijham, MD, PhD

Professor of Medicine Emeritus and Former President,
University Medical Center Utrecht, the Netherlands