Privilege

Privilege is defined as a right or benefit enjoyed by a person beyond the advantages of most, which is often a source of pleasure to that individual.

Lately I've been thinking a lot about hospital privileges. When I decided to set up my medical practice I applied for privileges at my local hospital. I filled out an application and met with the hospital privileges committee who determined my fate. They asked me questions about my scope of practice and whether I planned to deliver babies and how many shifts I would do in emergency. My success on acceptance was based on my answer to these questions and the general feel of the interview. Securing privileges allowed me to build my practice and gain favor with the local medical community. Not applying wasn't an option, and without these privileges it would have been a tough slog indeed.

Well, let's see what my privileges allow me to enjoy in 2011. I have the benefit of coming to the hospital on a daily basis to see my admitted patients and helping to coordinate their care. I am then available during the day if any other problems arise with these patients. If they require surgery I will cancel my office and assist during their operation. If the operating room runs late or my patient is bumped for a more emergent case, I will have to cancel more office patients. I also get the pleasure of sharing rounds with my office colleagues on weekends.

I am then privileged to be available after hours as part of a call schedule so that I can get woken up at 3 a.m. because someone has just noticed that Mrs Smith's urea is less than it was yesterday (I'm not making this up). Admittedly, this "call" is only monthly as there are around 30 of us family doctors still working in the hospital, but on a weekend you are available for 24 hours and handle numerous pages for the privilege of no remuneration.

Another benefit that brings me pleasure is renting a pager for the sole purpose of being available to my hospital. I also fork out an ever-increasing amount of money for the privilege of parking at my hospital. The parking rates are controlled by Impark and set at a regional level. The hospital remains the only place in my large community where you have to pay to park.

The most poignant benefit I get to enjoy beyond the advantages of most is watching my hospital deteriorate to a shadow of its former self. Patient care has deteriorated to the point where I would not want to be admitted there anymore. Let me be clear: I admire and respect so many of the dedicated staff that work at my hospital. They truly are unsung heroes struggling with an ever-increasing workload. My hospital is overcrowded, and its occupants are served often unrecognizable rethermalized nutrition. Vulnerable, frail elderly patients of different genders are separated by thin curtains. There is a shortage of nursing coverage and auxiliary personnel such as physiotherapists, occupational therapists, social workers, and more. There appears to be a lack of basic patient care, and sadly the focus has become on getting patients out whether they are really ready or not. The majority of people making the decisions don't have a vested interest in our community and it has become more about dollars and cents. Frankly, I am embarrassed about what I can offer my patients when they are admitted to the institution I am associated with.

What a privilege.

—DRR

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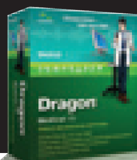

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Choosing the right resident

I recently spent hours scrutinizing and trying to objectively rate CaRMS applicant dossiers as a member of our residency training committee. Then I shared and sorted my impressions among those of my five other committee colleagues and sat together a dozen hours the last Saturday of January interviewing and reviewing our short-listed candidates. It's brutal. For us and for the candidates. And it's unimaginably more brutal for those who didn't get an interview who must recognize the finality of a career door closing.

We on the committee are uncomfortably aware of how important and life changing the application process is for each candidate. We in turn want to use the best, fairest, most inclusive method of choosing the right resident. Our selection process starts with a scored objective dossier evaluation and ends with structured interviews created by an industrial psychologist who designed the template of questions to tease out qualities we feel are important in our field. It flirts with "objectivity" in an otherwise subjective gestalt evaluation. We have a record of selecting good residents in our field, but I'm not sure the process allows us to do the best job.

The national fourth-year CaRMS match was mandated in 1993. In my opinion, the old way had definite advantages. Applicants could be more mature in their exposure to specialties to make real choices. They could apply any year after graduation and more than once if need be. Letters of reference were more meaningful to committees as applicants usually participated at a higher, more critically observable level. If they didn't match to a desired residency, their rotating internship allowed them to get a general licence to do locums or open a practice. At the end of medical school and internship, they were relatively well-rounded, fully trained general doctors with doors open to most options of practice or training.

There are problems with requiring medical students to apply for their one chance at a residency in the midst of their final year. First, they spend much less time and energy in their fourth year actually learning to be a doctor. In competitive specialties they are doing "audition" electives all over the country, flying week to week to put their faces in the minds of selection committee members in as many schools as possible, positioning themselves for good letters of reference, and becoming proficient in only one small part of medicine. Some do five or six electives in the same specialty. If the residency they want is in a highly competitive field, they must also do electives and get letters for a backup specialty. Then, if they are lucky, they spend January of their fourth year again blowing their carbon credits to fly all over the country to do interviews. It's a huge commitment. The experiences and breadth of knowledge they give up during a critical time of medical education must detract from their ability to become the best doctor they can be. The prequel is that in order to get those desired electives lined up in the fall of fourth year, they have to guess what specialties into which they want to "book" by early third year. How realistic is it to think that students with 2 years of mostly nonclinical medical school under their belt really know what they want to do for the rest of their career? How will they otherwise get exposed to the fields they neglect in order to concentrate on one or two specialties? How do we know if we want to train them? Every year our applicant pool unveils a number of students who have had what we call "a late epiphany." They

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did what they thought might be a throwaway elective late in October of final year, and fall in love with that specialty. They are at a decided disadvantage in the application process as all of their letters, research projects, and previous leanings are what show up on their CaRMS dossier. We still take these candidates very seriously, but they have to be especially good to rise to the top. And what about the great candidates who don't make a match to their beloved field in that particular year just because there was one slightly more competitive candidate? They really can't ever reapply to the main match. And if they choose not to match at all, they can't even work as a physician. If they match to a program that was a distant second or third place backup, how great will they be for that specialty? Most brutally, there are some amazing candidates who come *this close* to matching into a highly competitive residency who have put too many of their CaRMS eggs into one basket and don't match at all. They are hooped.

From the perspective of a residency selection committee member, and from what I hear from the medical students we train, I don't see the advantages of the currently required residency match out of fourth year. There are people smarter than I am who are in charge of evaluating these things, but I think the short- and long-term consequences are not especially favorable: to an individual's undergraduate medical education, to the student's ability to try a few specialties on for size before committing to a match, and to a specialty's ability to consistently pick the best candidates. The finality of the one-match one-chance decision is also troubling because only if the stars are perfectly aligned can post-CaRMS changes be made.

It seems to me that the option of the rotating internship should be objectively and seriously re-evaluated. Rotating internships contribute significantly and positively to the practice of medicine, confidence, maturity, exposure to new medical fields or concepts, cementing of specialty preferences, and development of close lifelong relationships with colleagues in unrelated fields. For me it was a formative, necessary year. Medicine has changed in the last two decades, including how specialists and family medicine-trained practitioners practise. We should re-evaluate this forced early differentiation into specialties. There still may be some students who choose to match to a specialty right out of medical school. But perhaps we should revive the option of applying to a 1-year rotating internship match without prejudicing the student from later entering the specialty or family medicine CaRMS match. It wouldn't surprise me to see some specialty programs openly state a preference for trainees with a rotating internship. I see many students being more prepared to commit to a specialty they know they really want or would be good at, and would be more able to demonstrate to selection committees that they are the best candidates. And last but not least, they would spend the last undergraduate year in medicine, actually learning medicine.

—CV

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