I am supposedly a teacher

The university says I am. My job description, such as it is, insists I am. My CV documents the talks and seminars that I have given over the years. There are residents, fellows, and students who I have seen pass through my clinics theoretically learning what I have to offer. Lectures I have given have been directed toward satellites and spewed back to Earth far away from my lectern. It's not why I became a surgeon, but it does give me much more pleasure than I expected, and working with students of any level has a very humbling way of keeping one's ego well in check and one's knowledge up-to-date.

From the earliest days of medicine, teaching has been a person-to-person interaction, using knowledge, personal experience, and real patients to illustrate issues and pitfalls. The next generation was preceptored until they eventually realized their own preceptorship role. It was expected to take time and energy and personal, everyday commitment.

Are things changing?

Our medical school in BC has doubled in size over the past several years. Students have been physically ensconced in locations requiring technology and premeditation in teaching to a degree not seen before. Recruitment of local teachers has been undertaken with some difficulty and attempts to remunerate them for time and effort is either successful or not depending on your viewpoint. There will always be irresolvable arguments about funds for teaching, but I think that we also must recognize some other creeping changes in modern medical education. Some specialties are affected more than others, but I can speak for a few of the things I see happening in surgery; I'm betting there are corollaries in other fields.

There is a limit to the number of students who can be on a surgical rotation and get something out of it. We are at that limit in the so-called teaching hospitals, and students are now doing rotations in hospitals that are not necessarily prepared for the reality of a teaching environment. With the addition of trainees, things in the OR take longer, are less predictable, and are generally more stressful for staff. Overtime payments for OR staff are hard to justify even partly in the name of teaching when our resources are already stretched to breaking. The goal of our teaching is to make someone a safe and competent surgeon. This is a long, repetitive process that really cannot be at the whim of the system. It needs to be built in and expected. Some surgical divisions at busy teaching hospitals have contracts with their regions to provide clinical services. Clinical *academic* service contracts, however, have become endangered. The regions would prefer not to engage in discussions about teaching or academics on their dollar, though it affects the clinical deliverables and the hospital resources required. There is no unique value assigned to clinical teaching on its own in these contracts. And can the university afford to address it?

In the name of clinical efficiency we have become more divided in our hospital specialties with development of centres of excellence or efficiency such as we see with joint replacement. But students on nominally the same orthopedic rotation may not be exposed to the same type or variety of cases that a fellow student at another hospital may see. Objectives from the medical school and from the Royal College may not be fulfilled at either site. Students who might have expressed a desire to do a residency may not even get a rotation on the residency program sites. Students are shuffled around from surgeon to surgeon to fit the clinical sites enough that they have a hard time getting meaningful letters of reference for CaRMs. Our priorities in our public system are for patient care, not the ongoing hands-on education of our future doctors. Something will eventually give.

And then there is the possibility of a mandated work week. Surgery residents used to say that the worst part about being on 1-in-2 call was that they missed out on half the good cases. Of course, they were only half joking, but recent developments in Europe restricting every worker's week to 48 hours have been the subject of considerable distress in surgical training sectors. The exposure to the myriad presentations, subtleties, and actual technical practice required for competence is not a certainty in a 5-year residency of 48-hour weeks. What we have seen with the decreased operative exposure residents have in fiscally restricted OR time is that effort on the part of the teacher and the learner outside of the time spent with actual patients increases significantly. Preview, review, reteaching, technology, evaluation, and banks of accessible information need to be added so that the time actually spent in the clinic and OR is as efficient as possible. Impromptu teaching and learning, which comes from unscheduled interactions, will be a thing of the past.

A respected colleague said recently, "A surgeon can usually send the operation from his left brain to his right hand. But the challenge of teaching surgery is getting the information from the teacher's left brain to the resident's right hand." It still comes down to the basic unit of committed, time-consuming, person-to-person, patient-based preceptorship that is prioritized for just that purpose. In our ongoing efforts for fiscal and clinical responsibility and efficiency, I hope someone in charge will remember that.

—CV