Preface

Surgical Education in Colorectal Surgery

Judith L. Trudel, M.D.¹¹ Department of Surgery, Division of Colon and Rectal Surgery, University of Minnesota Medical School, Saint Paul, Minnesota

Clin Colon Rectal Surg 2012;25:125–126.

“The future ain’t what it used to be.”

Yogi Berra, 1925–

Former baseball catcher, outfielder, and manager

I trained in general surgery at a premier North American residency program in the late 1970s to early 1980s. Structured teaching consisted of one weekly hour of Surgical Grand Rounds and GI Rounds, and one monthly one-hour morbidity and mortality conference. The learned clinical opinion of senior surgeons was evidence enough of best surgical practice. Surgical simulation was tying knots at the bottom of a Campbell soup can. Learning technical skills, whether starting an intravenous line or doing a Whipple procedure was based on the time-honored “see one, do one, teach one” surgical curriculum. I took in-house calls every other night through my junior years (“The only downside of being 1:2 is that you miss half of the action”), and every night from home (when-ever I actually made it home) as a senior and chief resident. When I finished training, I became board certified for life in general surgery.

Although there was long-standing consensus that training future surgeons in the age-old Halstedian model had serious drawbacks, few would have predicted that the landscape of surgical education would change so dramatically and so rapidly. Fast-forward to 2012. This profound transformation can correctly be called a revolution: the way we educate medical students, residents, and fellows; the recognition of the need for lifelong acquisition of new skills and the maintenance of competence for graduated surgeons; the advent of sophisticated surgical simulation and evidence-based medicine; and the societal pressures for cost-effective, efficient, and lifelong quality surgical care have created a fluid new context for all aspects of surgical education.

The purpose of this issue of *Clinics* is to review those different aspects individually. I am deeply grateful to all the contributors to this issue. They were charged with the difficult task of concisely presenting the challenges we face as educators, lifelong learners, and practicing physicians. For many of these topics, there is little literature on which to

build, and they had to draw on their own expertise and experience to winnow the pearls I was looking for. I am certain that you will find these education experts’ opinions most enlightening.

The first three articles focus on our changing roles as surgical educators. The three stages of surgical education, namely medical students, general surgery residents, and colon and rectal surgery fellows present both common and separate challenges. Each level of training is reviewed individually. These articles are meant as a personal incentive to reflect on your own practice as a surgical educator. We expect that more questions than answers will be raised by these articles, and challenge you to rise up to the challenge of teaching surgical trainees in the current context.

Two very different educational tools have truly revolutionized surgical education: surgical simulation and evidence-based medicine. In response to multiple convergent pressures, deliberate practice has migrated from the operating room to the surgical skills lab. Open access to electronic information for the public, students, and practicing surgeons has increased the need for learning and maintaining critical appraisal skills. Trainees can (and do) access electronic resources in a just-in-time fashion to anchor their teaching on best practices, challenging their teachers. Although the role of surgical simulation and evidence-based medicine in educating trainees is intuitively obvious, using them for certification and maintenance of certification and competence is on the near horizon, thus making this a topic of high interest to all surgeons.

The American Board of Colon and Rectal Surgery was established in 1935 to promote the health and welfare of the American people through the development and maintenance of high standards for certification in the specialty of colon and rectal surgery. The numerous changes to surgical education have stimulated major changes in certification requirements. The current status of board certification and maintenance of certification, another constantly moving target, is presented.

Address for correspondence and reprint requests Judith L. Trudel, M.D., Department of Surgery, Division of Colon and Rectal Surgery, University of Minnesota Medical School, 1055 Westgate Dr., Ste. 190, Saint Paul, MN 55114 (e-mail: jtrudel@crs.org).

Issue Theme Surgical Education in Colorectal Surgery; Guest Editor, Judith L. Trudel, M.D.

Copyright © 2012 by Thieme Medical Publishers, Inc., 333 Seventh Avenue, New York, NY 10001, USA.
Tel: +1(212) 584-4662.

DOI <http://dx.doi.org/10.1055/s-0032-1322524>.
ISSN 1531-0043.

Funding for surgical education has always been tied closely to health care economics. In times of feast, little attention was paid to the mechanisms of funding for graduate medical education. The impact of a difficult economic environment has been increasingly felt in recent years. An overview of the current status is presented.

Finally, the American Society of Colon and Rectal Surgeons (ASCRS) has supported surgical education since its inception

in 1899. This last article reviews the tools ASCRS provides its constituents to obtain and maintain quality education in colon and rectal surgery, and provide superior patient care in a societal partnership.

I hope that you find this issue of *Clinics in Colon and Rectal Surgery* helpful in evaluating your educational activities, whether as an educator or a lifelong learner. I thank Dr. Beck for the invitation to serve as Guest Editor for this issue.