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Case Report

CASE REPORT

A patient reads the medical literature

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Abstract

A 45-year-old male with no significant past medical history presented with a lump in his right groin. Outpatient computed tomography imaging ordered by his primary care physician demonstrated moderate right inguinal hernia containing nonobstructed distal descending/proximal sigmoid colon. Surgical repair of the hernia was recommended and the patient was referred for consultation with a general surgeon. The patient then conducted a search of current medical literature and, upon reflection, refused to let the consulted surgeon operate upon him. After identifying a significantly more experienced surgeon, the patient underwent office consultation and, later, uneventful surgical repair of his inguinal hernia. To follow is a case description with a review of the relevant literature read by the patient that informed his decision to be operated upon only by a more senior general surgeon.

INTRODUCTION

In 2012, the ACGME implemented the Clinical Learning Environment Review [1] as part of its accreditation system. While the stated goal of the CLER process 'recognizes the public's need for a physician workforce capable of meeting the challenges of a rapidly evolving health care environment' [1], a consequence of the ACGME's work since over the past several years is a new physician workforce whose members are unable to work competently at tasks they were ostensibly trained to perform.

CASE PRESENTATION

The patient is a 45-year-old male with no significant past medical history who has worked in the pharmaceutical and health care industry for >20 years. After noticing a lump in his right groin, he reached out to this author, who informed him that it was likely an inguinal hernia and, if not painful, was best evaluated in an outpatient setting by his internist. Within a week, outpatient computed tomography imaging was ordered by his primary care physician, which demonstrated a moderate right inguinal hernia containing nonobstructed distal descending/proximal sigmoid colon. Surgical repair of the hernia was recommended and the patient was referred for consultation with a general surgeon. The patient then conducted a search of current medical literature and, upon discovering significant evidence that new graduates of surgical residency programs often lack basic surgical skills, the ability to identify tissue planes or confidence in their surgical abilities [2, 3], the patient opted to seek out a surgeon who he believed had obtained the experience necessary to instill enough confidence in the patient that the patient was willing to let the surgeon engage in acts which, if performed by a person without a medical license, constitute the crimes of battery and aggravated assault. After identification of and consultation with a suitable mid-career surgeon, the patient allowed himself to be schedule for an inguinal herniorrhaphy. This was then performed without event, and the patient recovered free of adverse sequelae.

DISCUSSION

The medical literature has long been widely available. The growth of telecommunications technologies in the late 20th and 21st centuries has made it accessible to more people, and few things focus the interests of a person on medical topics so much as being told they need surgery. Our patient quickly discovered several disconcerting things, which we discuss here.

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One of the six ACGME CLER survey focus areas is supervision [1]. The guidelines are quite clear that at no point during a surgical residency should a surgeon in training operate without an attending surgeon in the room. While residencies continue to provide graduated increases in responsibility over time, the lack of training in independence has led to new surgical graduates not completing the training necessary to truly be independent practicing surgeons. Indeed, 1 year after the implementation of the CLER survey, a significant number of surgical residents (27%) 'worried that they would not feel confident to perform surgery by themselves when they finished training'. In response to this, the American College of Surgeons established a 'Transition to Practice' fellowship [4] which is, essentially, the completion of surgical training that the ACGME has *de facto* removed from the general surgical residency curriculum.

Thus, our patient faced the question of 'how' to identify those surgeons who did not feel they could operate independently. As the boards do not test operative skill, the patient quickly determined that board certification is not a marker for surgical competence. Nonetheless, it is worth noting that our patient learned that residency training in an area with high malpractice payments is independently correlated with lesser resident autonomy, compromises to resident education and a higher failure rate on the American Board of Surgery examinations [5]. Living in the largest metropolitan area in the USA, with its attendant high rates of malpractice payments, this concerned him.

He further learned that since the implementation of duty hours' restriction on surgical residents, the failure rates on certifying oral examinations have doubled from 15 to 30% [6]. This statistic too pushed our patient to seek out a more experienced surgeon.

Indeed, our patient was astonished to note that, despite the ACGME assertion of a 'rapidly evolving healthcare environment' [7], a review of the case logs of surgical residents over the past 20 years shows that the breadth and variety of cases has narrowed significantly.

Our patient was further dismayed to learn that identification of this problem has not helped with finding a solution. While, in 2013, Mattar *et al.* noted that 'general surgery residency inadequately prepares trainees for fellowship', 4 years later, George and Fryer noted that [8], 'US General Surgery residents are not universally ready to independently perform Core procedures by the time they complete residency training. Progressive resident autonomy is also limited. It is unknown if the amount of autonomy residents do achieve is sufficient to ensure readiness for the entire spectrum of independent practice'. This problem continues to this day—and drove our patient to conduct his own search for a surgeon he felt comfortable allowing to operate on him.

CONCLUSIONS

With a focus on wellness, resident work hour limits, faculty supervision, minimization of litigation risk and other concerns, a modern residency in any discipline, particularly surgery, is quite different than in years past. There is an abundance of literature suggesting that new graduates are not capable of operating independently, and that many of them know this. This does not instill confidence in patients who are seeking to be an active part of their own journey through our health care system. In the absence of a change in residency training, or more formal programs for postgraduation mentorship that are 'completion of training' in all but name, we expect to see more and more information savvy patients learning this and declining to be cared for by novice attending physicians.

CONFLICT OF INTEREST STATEMENT

The author has received 'no support from any organization for the submitted work; has no financial relationships with any organizations that might have an interest in the submitted work in the previous three years and has no other relationships or activities that could appear to have influenced the submitted work'.

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TRANSPARENCY DECLARATION

The author (the manuscript's guarantor) affirms that the manuscript is an honest, accurate and transparent account of the study being reported.

PATIENT INVOLVEMENT

The patient is aware that we are publishing a case report and has signed consent.

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