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Education of surgical house staff and medical students – opportunities and problems

There is a growing realization in educational circles of the importance of all forms of education in ambulatory settings. As ambulatory medicine begins to receive greater emphasis in our medical schools, the nature and degree of exposure of medical students to ambulatory surgery will undoubtedly change. At the moment, medical students are rarely exposed to ambulatory surgery in an explicit and organized way. Ambulatory surgery, if it is offered at all to the medical student, is usually offered as an appendage to the inpatient surgical activities. Students are generally not taught the basic principles of ambulatory surgical procedures. Students should be exposed in an organized fashion to the principles and techniques of ambulatory surgery, including the principles of local and regional anaesthesia. The basic elements of planning and performing an operative procedure and the basic elements of tissue handling techniques can be taught in an ambulatory setting. Students should be taught and should have experience in the care of injuries requiring surgical repair, such as lacerations and soft tissue injuries. Opportunities should be presented for the students to have sufficient follow-up on patients so that they can become familiar with the management of complications that may occur. A curriculum, with clearly stated educational objectives, is also essential.

At the resident level, the educational issues become somewhat more complex. Residents also need to have a basic grounding in fundamental elements of ambulatory surgery. These principles are at the present time not well taught in many medical schools and they are not well taught in many surgical residencies. There is a tendency for surgical residents to focus on the inpatient surgical procedures, and the ambulatory activities are often given a position of secondary importance. The academic structure of each residency programme should provide the opportunity for residents to be exposed to and involved in ambulatory surgical procedures in an organized fashion under adequate and appropriate supervision. Surgical faculty should be assigned to the ambulatory surgical centre as well as to the inpatient units. Surgical residents generally get experience in ambulatory surgery in one of two organizational frameworks. One system is to assign the resident to a team which is responsible both for inpatient and outpatient activities. The drawback of this system is that the pressure of the inpatient activities often dominates the residents' activities. Another system is to assign the residents directly to an ambulatory centre in which they have no inpatient responsibilities. That system has the advantage of providing appropriate emphasis on ambulatory surgical activities, but participation of residents in preoperative and postoperative care may be more difficult to achieve in this setting. Whichever assignment system is used, residents should have protected time to participate in the ambulatory surgery programme.

From an educational standpoint, residents should be involved not only in the performance of an operative procedure, but also in preoperative care so that they may participate in establishing a diagnosis and in planning an appropriate operative procedure. They should be responsible for significant portions of the operative procedure itself and should also be involved in the postoperative care of the patient so that they may become familiar with outcomes of the operation as well as with complications. Continuity of care is just as important in ambulatory surgery as it is in inpatient surgery. Facilities should be made available to the residents so that the continuity of care is maintained.

We are still at a relatively rudimentary level of development of educational programmes in ambulatory settings. Excellence in ambulatory surgical education will require organization and the commitment and dedication of surgical faculty as well as residents and students, but there is no reason it cannot be achieved.

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References

1 Kambouris AA. Ambulatory Surgery. Its impact on general surgical practice. *Am Surgeon* 1986; **52**: 347–50
2 Levy M. An ambulatory program for surgical residents and medical students. *J Med Ed* 1988; **63**: 386–91
3 O'Hollaren MT, Romm CL, Cooney TG, Bardana EJ,

Walker J, Martin C. A model for faculty practice teaching clinics developed at the Oregon Health Sciences University. *Acad Med* 1992; **67**: 51–3
4 Ravitch MM. The education and training of surgeons. *Pharos Alpha Omega Alpha Hon Med Soc* 1988; **51**: 22–4
5 Ward RE. Extrinsic factors affecting surgical training. *J Surg Res* 1988; **44**: 309–13
6 Zones JS, Schroeder SA. Evolving residency requirements for ambulatory care training for five medical specialties, 1961 to 1989. *West J Med* 1989; **151**: 676–8

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