

The trouble with technical competence: Defining it, measuring it and achieving it!

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Zakaria and colleagues have provided us with a report that is both timely and provocative.¹ It is timely because it raises the issue of competence of our graduates at the same time that the (or your) Royal College has mandated a shift towards a competency-based model of postgraduate medical education (CBME). This will place more emphasis on assessing competence and less on time-in-training. It is provocative because they have thrown down the gauntlet. They have challenged training programs to demonstrate if, how, and when they decide a graduate is ready to be unleashed on the public. They should be congratulated for possessing the courage to poke a skunk and provoke us to think more deeply about what the goals and objectives of urology residency training really should be. For at least 20 years that I have been involved in postgraduate education, we have followed the same recipe: committed, knowledgeable and well-meaning educators review the objectives, debate what is and what is not possible for trainees to achieve, worry about what happens if we set the bar too high or too low with respect to accreditation, submit revisions to the Royal College, revise the edits received, meet again the next year and do it all over again. Not exactly a timely and provocative process.

That said, we are not alone in the struggle to define core surgical competencies. General surgical programs have also examined the issue of technical competence upon graduation. In a recent report from over 1500 residents in the United States, 38% of graduates said that they were not confident with their skills upon graduation.² In a similar vein, a task force on the future of General Surgery just released their report on that discipline's future in Canada.³ After a

2-year in-depth review, the report outlined a series of recommendations to ensure a strong relationship between training and eventual practice. One key recommendation was the creation of "enhanced areas of expertise." This may take the form of tailored training during senior residency based on one's projected field of practice, or with additional fellowship training and subsequent Areas of Focused Competence (AFC) diplomas. We are already seeing this "tailoring" with over 90% of our graduates pursuing fellowship training for many complex reasons.⁴

Should we re-align the objectives of training based upon this publication? No; at least not yet. For starters, we need to stop talking to ourselves: this survey received responses from 44% of university-based urologists which equates to about only 13% of all practicing urologists in Canada. Remember that 70% of CUA members self-identify as community-based. We need input from the majority. We need to extend the survey to canvas all community and university urologists to find out what it is that they *need* from newly-minted urology grads. The question should be "what surgeries do new urologists *need* to be able to perform safely without further training when they graduate?" If practice groups (and their patients) need proficiency in areas that we are not teaching, the problem lies not with the objectives of training, it is the training itself. Maybe our residents need to have a significant mandatory rotation in the community so that "bread and butter cases" (whatever that means) are taught properly. The act of sequestering our residents in centres with experts (like me) who know more and more about less and less does not further the mission of training competent general urologists.

I am embarrassed to say that Canadian orthopedic surgery is ahead of us in dealing with this existential crisis. They have already canvassed their community surgeons regarding what they need from new graduates to serve their patients competently. This information has been rolled up into a proposal for a national curriculum in orthopedic surgery.⁵ The Specialty Committee in Urology is in the process of

launching a similar comprehensive, bilingual e-survey of our entire membership as a first step towards developing a national curriculum for postgraduate urological training. When this survey is launched, *please don't press delete*. Please respond. This is your chance to influence the training of the next generation of Canadian urologists!

Competing interests: Dr. MacNeily is Chair of the Royal College Specialty Committee in Urology.

References

1. Zakaria AS, Haddad R, Dragomir A, et al. Royal College surgical objectives of urologic training: A survey of faculty members from Canadian training programs. *Can Urol Assoc J* 2014;8:167-72. <http://dx.doi.org/10.5489/cuaj.1720>
2. Coleman JJ, Esposito TJ, Rozycki GS, et al. Early subspecialisation and perceived competence in training: Are residents ready? *J Am Coll Surg* 2013;216:764-73. <http://dx.doi.org/10.1016/j.jamcollsurg.2012.12.045>
3. Task Force on the Future of General Surgery. 2014. The Future of General Surgery: Evolving to meet a changing practice. Ottawa, Ontario: The Royal College of Physicians and Surgeons of Canada. http://www.royalcollege.ca/portal/page/portal/rc/common/documents/educational_initiatives/future_of_general_surgery_report_e.pdf. Accessed May 27, 2014.
4. Welk BK, Kodama R, MacNeily AE. The newly graduated Canadian urologist: Overtrained and underemployed? *Can Urol Assoc J* 2013;7:E10-E15.
5. Wadey VM, Dev P, Buckley R, et al. Competencies for a Canadian orthopaedic surgical core curriculum. *J Bone Joint Surg Br* 2009;91:1618-22.

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