Blending Community and Big Hospital Experiences for Residents—Does It Add Value?

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My first visit to North America was last century when I was a youngish family physician on sabbatical in Canada. I spent a wonderful year reading and thinking about education. One of the articles I read was the interesting study on the ecology of medical care by White and colleagues,[1] which told us what we all suspected, that most patient interactions with the health care system did not happen in the hospital. During that sabbatical, my Canadian colleagues reminded me that "you can't teach forestry in the lumber yard." This metaphor was somewhat lost on me, coming from Scotland, where centuries of felling, burning, and overgrazing had reduced the native forest to a few forlorn fragments. This metaphor makes more sense now that I live in British Columbia near pulp and saw mills and surrounded by forest. During this time we taught medical students and residents primarily in the hospital and in tertiary care settings—tantamount to the lumberyard in our analogy—which meant they were largely missing experiences in the community settings, where illness arises and is often managed, and from where some patients are sent to the tertiary institutions, often for very specific services. Even though the study of White and colleagues[1] was conducted more than 50 years ago, it was repeated by Green et al[2] more recently with similar results. If I ask myself whether things have changed much with respect to how and where we train our future physicians, my thoughts would be "maybe, a bit."

From my observations there are 2 contemporary, and somewhat opposing, themes that influence how we think about educating residents. One theme is that modern health care relies heavily on advances in technology and techniques both to investigate and treat illnesses and conditions, while also helping to reduce patient stay times. This means that patients are in the hospital for shorter periods of time, and when they are there, they frequently are having things done to them, and thus are not available to help with resident education. The patients may also not truly reflect the practice of community-based physicians. These factors have led to an increased emphasis on broadening residents' experiences to include more time in ambulatory and community settings. This makes good sense, as long as residents also provide patient care in tertiary care environments, with the sickest and most complex patients, to learn investigations and treatments they may not see in smaller centers.

The other theme, almost in contrast, is an increased attempt to rationalize and control the educational experiences of residents. This increased control is seen in terms of fulfilling defined elements of rotations so that residents have had all the "required" experiences to allow them to develop the competencies thought to be needed for safe independent practice. While most residency programs have embraced competency-based education, in many ways some of the rotations seem time based, as residents are required to spend defined periods of time in various subspecialty experiences, which often means they have to spend much of their time in tertiary care hospitals.

For example, many of the current Royal College of Physicians and Surgeons of Canada Specialty Training Requirements in Pediatrics[3] are time-based experiences and often happen only in a tertiary care center. This may mean that some residents might be exposed to as much as 10 months in community and ambulatory care rotations, while others as little as 2 months in total. The rigid constraints of required experiences and defined competencies may actually keep young residents from experiencing the very contexts most relevant to their future practice. Is the way we do things now preparing young physicians for the complexity and uncertainty of practice where learning wise judgment and honing the art of medicine is as important as demonstrating defined competencies? There are a number of voices beginning to question our reliance on competency demonstration as a true indicator of readiness to practice.[4,5]

Another aspect of this discussion is the notion that learners learn better if there is continuity of care and continuity of preceptor. There is evidence that continuity of setting and preceptor does make a difference in terms of the richness of learning for

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residents: it provides an important opportunity for residents to be "apprentices."[6] However, large modern hospitals often promote fragmented care.

In this issue of the *Journal of Graduate Medical Education*, Topps and colleagues[7] describe a qualitative study looking at resident experiences in a training model where pediatrics residents split their time between community settings in Northern Ontario and tertiary care settings in Ottawa. Their conclusions are interesting and may have lessons for all of us, particularly faculties of medicine that have distributed arrangements[8] or partnerships in different contexts. The new insight I took away from reading this article was that of complementarity: residents' education is enhanced by exposure to different contexts. Not surprisingly, tertiary care hospitals were seen as more hierarchical with increased competition among learners. However, these sites were also seen as providing formal education opportunities and allowing residents to learn to care for patients with the most complex conditions. There was little difference in access to teaching from specialists in either setting. Neither community nor tertiary care experience was perceived as better than the other; they were viewed as different, with the type of learning and exposure to cases varied at every site depending on season, staff, other learners, and preceptors. These findings underline the fact that effective education is socially constructed and highly dependent on relationships. Unique to the community sites was the potential for continuity of patients over time and the opportunity to look after many aspects of a patient's condition.

For me, the primary message in this research was that ensuring residents have a variety of experiences in different contexts may well enhance their education. This is supported by the solid analysis in the article's discussion that suggests that exposure to both community and tertiary care settings may be a better way to ensure the various CanMEDS[9] or Accreditation Council for Graduate Medical Education competencies are covered in a training period. In this regard, the authors conclude that tertiary care centers provided more opportunities to develop the CanMEDS Collaborator, Manager, and Scholar roles, while community experiences provided more opportunities to develop the Communicator, Professional, and Health Advocate roles.

While the study by Topps and colleagues[7] is small in numbers and focuses on pediatrics residents, it is rich in description. Perhaps more programs from different disciplines should consider enhancing the variety of settings in which residents learn. A blend of tertiary care and community experiences can enrich residents' experiences. Carefully constructed rotations will allow the different contexts to augment each other.

This blend makes excellent sense: Why are we not doing this routinely?

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