EDITORIAL

# Surgical training in Sri Lanka - where next?

The establishment of the postgraduate institute of medicine (PGIM) in 1980 was a watershed in postgraduate medical education in this country. It saw the birth of a new breed of specialists trained and certified locally taking the reins of their respective specialities throughout the country. It also marked a break, albeit partial, from a post-colonial mind-set that was largely reliant on and accepting of systems and labels originating from the UK. Undoubtedly, giant strides have been achieved in Sri Lankan postgraduate medical training in the last three decades and the PGIM has become an established landmark in the medical history of this country.

The structure of postgraduate surgical training and assessment has evolved over the years. From their beginnings under the umbrella of general surgery, subspecialties have emerged with their own boards of study, curricula and assessment systems. Restrictions on numbers entering the training program have come into place for the first time this year. Records of in-training assessments (RITAs), portfolio based formative assessments and research has been introduced to the training program and soon, higher surgical trainees will face a pre-board certification assessment (PBCA) or exit examination.

Whilst these changes have inherent merits and the convergent objective of producing a better surgeon, it is worth taking a step back to reflect on the process. Once too often, despite the best of intentions, the ad hoc adoption of new models without due appraisal has proven to be unsustainable and unpopular, as with some of the revised undergraduate medical curricula in this country. The initiation of change is not always easy. But harder still is to address the fundamental questions pertaining to it: Is there a need for this change? What shortcomings of the existing program are being addressed? Are they relevant to the needs of the country in the foreseeable future? What are the projected outcomes of the effected change and are they measurable? However desirable, do we possess the infrastructure, the manpower and the will to implement this change? Are these being effected for the sake of change itself or to appear impressive on paper?

Within the context of the caveats expressed above it is vital to recognize in principle that training programs are continuously evolving, dynamic processes. Consensus building among the key stakeholders is a challenging but essential process for their successful implementation and sustainability. Here, the College has a key role to play; to foster a lively, healthy and mature debate between the PGIM and the Ministries of Health and Higher Education and the surgeons on the priorities and objectives in terms of the surgical needs of the country in the coming decades. Projected populations and population structure, anticipated disease burden, economic growth and the projected state and non-state expenditure on health and education need to be factored in. Improved but sensible surgeon to population ratios need to be determined within local economic realities rather than simply derived from developed economies. Recognition that subspecialisation and the establishment of recognised high volume tertiary centres in surgical subspecialties is the logical way forward for better outcomes and quality of care is imperative.

A few fundamental issues related to surgical training and assessment that could benefit from reappraisal come to mind. Currently, except for orthopaedic surgery, other subspecialty trainees begin formal training in their particular speciality only after the MD part II examination. They meander through a multitude of appointments that, with the exception of general surgery, could at most have provided only a flavour of that subspecialty, to the extent that the designation of senior registrar may be considered a misnomer. A shift towards a residency type of program similar to the US with the commencement of subspecialty training after a year of basic or general surgical skills needs to be explored. Formative assessments at different stages of subspecialty training with a final PBCA removes the reliance on a single summative assessment that may not reflect the true competency of the trainee and leaves little room for remedial action in-training. Replacing the current long essay and structured essay question (SEQ) paper with a combination of multiple choice questions that include single best answer (SBA) and extended matching item (EMI) type questions combined with a series of SEQs promises to be a more objective tool of assessment.

To maintain our stature and competitiveness globally the College in conjunction with the PGIM should work towards international accreditation, a process that requires demonstration of a training program and assessment process that is robust, fair, consistent and transparent. One potential benefit of this could be the easing of the difficulties senior registrars currently encounter trying to obtain appropriate training placements or fellowships abroad. While the loss of locally trained surgeons to greener pastures is of concern, adopting a positive approach towards this issue by nurturing links with them opens the door to a source of expertise, resources and training opportunities.

Of course, it would be naïve to assume that all decisions will be based solely on cold, hard facts and projections. Issues of ownership, territorial fidelities, strategic factors and that much maligned yet inextricable elephant in the room, private practice, will inevitably exert their influence on this process. Yet again, these too are real life issues not peculiar to our country that need to be accommodated and dealt with as such to work towards the betterment of surgical training.

Challenging yet promising times ahead as we move into a new year.

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