Teaching and training in obstetrics and gynaecology

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According to my Concise Oxford Dictionary to teach usually means to give lessons on a certain subject by way of instruction.

On the contrary, to train means to bring a person to desired standards of efficiency by instruction and practice.

There are subjects, like philosophy, where teaching has the predominant role and others, like gynaecology, where training is as important as is teaching, or probably more.

I shall try to present here my own views on some aspects of these educational activities as I see them within the Italian framework of modern practice of health care.

As already defined, teaching has no particular connotation when applied to obstetrics and gynaecology. One person can teach a great number of students in a large classroom; using a good program on a computer, the person of the teacher can even be substituted by a television screen.

So, rather than discuss the methods I prefer to spend a few words on the contents of teaching.

At least in this country, the general practitioner is now almost completely excluded from the active practice of obstetrics; the only exception is some participation in pre- and post-natal care.

Also in the area of gynaecology his intervention is limited to what may be called " social gynaecology ".

In Italy the average general practitioner is not even expected to perform a bimanual pelvic examination or to take a Pap-smear. If he does it, he may even get into trouble.

Consequently, at the undergraduate level well-balanced teaching is all that is needed and training is really not necessary.

For similar reasons at the undergraduate level many traditional aspects of teaching can be given limited attention or be left out altogether from the teaching programs. For example, it is simply a waste of precious time to explain the details of the mechanism of labour or show the technicalities of the standard gynaecological operations.

On the contrary, other areas must be stressed like the impact of advances in technology, the problems to be expected from the ageing of the female population, the challenges originated by the new social and economic roles of women.

It maintains its emotional, if not didactic, importance that the undergraduate student be offered the opportunity to witness a few labours and deliveries but I am not inclined to call this a real " training ".

Training acquires a pre-eminent role at the level of postgraduate education; as a

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matter of fact specialist postgraduate education in obstetrics and gynaecology predominantly means to instruct the candidates in an environment where performance is possible on an adequate number of cases.

As was stressed for undergraduate teaching, also for postgraduate specialist training there has been a great change between what was needed 50 years ago and what is needed now. Moreover, what is needed now in the Western civilized world is very different from what is needed in the Third world. Therefore we must understand and accept the fact that postgraduate schools in different geographic areas should tailor their programs to the needs and expectations of their community.

If we remember the definition of training quoted at the beginning (to train means to bring a person to desired standards of efficiency by instruction and practice), it is mandatory that a sufficient number of cases be available within a reasonable time-span for every person in training. Therefore, the intake of new people into any training program should be proportional to the anticipated input of cases available for instruction. In this country such a rule is seldom enforced so that training opportunities are less than optimal already from the start.

The simple task of training people to perform bimanual pelvic examinations has many more limitations than training in most other diagnostic procedures.

In a few medical schools in the United States the experiment of hiring so called gynaecological teaching associates has been done with some success. This particular kind of associate is made up of ladies devoted to the cause of science who accept for a fee to submit themselves to pelvic examinations performed under supervision by the trainees.

In spite of the fact that this method of training may seem attractive and reasonable, I am certain that it could not even be mentioned in an Italian university. So we are left with the real patients. As it is almost impossible to obtain informed consent in this matter, the only way out is to disguise the trainees as real staff physicians and let them do at least a few unnecessary pelvic examinations.

Paradoxically things are easier in the operating room because when the patient is under general anaesthesia she does not see if her operation is used for training purposes or not.

Training in obstetrics is rather different from training in gynaecology, so that it must be examined separately.

As a matter of fact in most obstetric conditions, and even in normal labour and delivery, there is a special emotional tension that is usually absent among gynaecological patients.

Secondly, obstetric patients are usually awake or under local anaesthesia.

Finally there is a growing shortage of cases available for training. The reasons for this shortage are not always clearly perceived, so that it is appropriate to outline some of them in the last part of this presentation.

It is generally accepted that every patient has the right to be treated in the best possible way.

It is also well known (but is seldom stated loudly) that obstetric assistance by beginners is often unsatisfactory in spite of close supervision by an expert.

Thus, at the end, it is the patient who bears most of the cost for training new people. If the costs are usually negligible in the case of non-surgical specialities, they can be very high in surgery and even higher in obstetrics.

Therefore, the increasing consciousness and assertion of the rights of the patients has been a very powerful deterrent against the use of parturients as objects for training young physicians.

To this we must add, in the last ten to twenty years, the admission of fathers or other lay third parties into labour- and delivery rooms. The presence of these people is often perceived as a welcome addition to the scenery by the parturient; on the contrary, from the point of view of training efficiency, it is at least a disturbing intrusion.

As a result, the number of cases available for training becomes a small percentage of the total caseload.

Moreover, the very size of the total caseload has been greatly reduced by the declining birth rate, and the professional liability crisis is trimming what is left.

No wonder that under the present circumstances proper training in obstetrics has become a rather difficult task, both for the instructors and for the trainees.

As this condition has been going on for at least a quarter of a century, the transmission of dexterities and skills from one generation of obstetricians to the next has already been interrupted and is unlikely to be restored again in the future.

I do not see any way out that would not interfere with the basic rights of the patients, as they are perceived today.

What modern people often forget is that if they wish to have properly trained specialists, they must pay the price for this privilege; it is unfortunate that occasionally much more than money is at stake.

In spite of these pessimistic conclusions I feel very strongly that a reasonable compromise should be looked for by every sensible person interested to the health care of women. I shall try to explain my personal point of view using the example of caesarean sections.

According to a recent survey, at the beginning of 1987 Italy had a total of nearly 250.000 physicians (exactly: 245.116) for a population of close to 60 millions inhabitants; this means about one doctor every 240 people.

Of these physicians about 12.000 are obstetricians and gynaecologists in active practice, a proportion of roughly 5%, which corresponds to the proportion of 5,6% existing in the United States.

If we consider that the total number of births in 1987 was 560.265 babies, we can guess that the total number of caesarean sections has been around 10% of that figure, that is 56.000 cases.

56.000 cases of caesarean section for 12.000 obstetricians means an average of 4.7 operations per year per obstetrician. This number is barely sufficient to maintain an adequate dexterity for an already skilled obstetrician, but is certainly not enough for training a young house officer to become a specialist.

My own guess is that at least a total of 30 caesarean sections performed under supervision in the course of 2-3 years are necessary for that purpose. If this is true, for every specialist that we train, 6 or 7 practising obstetricians should give up their average share of caesarean sections for the benefit of the education of the younger colleague.

Actually, this is not a tragedy if we take into account the fact that more and more the Italian specialist in obstetrics and gynaecology has become the primary care physician for the female population; in other words, he becomes a sort of general practitioner who sees only women.

Things being as they are, the question is the following: do we really need to train these physicians to the level of surgical competence (I am afraid of saying excellence)?

Well, with due respect to different opinions, my answer is " no ".

More exactly, I would encourage the creation of an intermediate degree in obstetrics and gynaecology without requirements for surgical competence.

These people should be offered all the professional positions where there is no requirement to perform any kind of major surgery.

Only a limited and well selected number of these doctors should be encouraged to go on with further training in order to become competent pelvic surgeons. To these people all the available cases suitable for instruction should be reserved; but, once qualified, they should not be permitted to waste their capacity and time in jobs not requiring their skills. As I said before, the training of a surgeon costs much more than money.

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