Additional Thoughts on Orthopedic Residency and Fellowships

Augusto Sarmiento, MD

In the guest editorial “The Education of Orthopedic Residents and Fellows” (http://www.orthosupersite.com/view.aspx?rid=60341) in the February 2010 issue of ORTHOPEDICS, my co-author and I expressed concerns over the perceived impact of the increasing popularity of fellowships on residency programs, while making suggestions on how to prevent harmful, unintended consequences.

In that article, we attempted to study the genesis of fellowships, and particularly their rapid spread. We speculated that the initial interest in them was the residents’ desire to overcome perceived deficiencies in specific areas of the discipline that may have resulted from the proliferation of subspecialties services that brought about a shortening in the length of rotations over the 5 years of structured education.1

I had long suspected that such an explanation was not necessarily accurate, since within a short time most residents pursuing an additional year of fellowship were not choosing training in areas of perceived deficiencies but in areas where greater opportunities for lucrative practices were more likely to exist.

The rapid growth in interest in fellowships, however, came with obstacles for many since saturation with newly graduated fellowship-trained orthopedists wishing to limit their practice to the subspecialty of their fellowships is already taking place in many cities. The number of super-specialized orthopedists that a given community can afford to have is based on the size of the population in the area to be served. A city of any size may provide an adequate number of patients to satisfy the emotional, professional, and financial needs of only a certain number of such specialized surgeons. If their numbers exceed those criteria, they begin either to increase the indications for surgery (which has a limit) or to broaden the scope of their practices into areas where they had previously felt insufficiently trained to perform well.

As the number of fellows in orthopedic programs affiliated with medical schools has increased exponentially in recent years, several programs now have with more fellows than residents. This has resulted in unhappiness among residents who perceive, and rightly so, that surgical material they expected to serve as opportunities to enhance their surgical skills is now, to a high degree, the fellows’ territory.

According to some, the underlying factor explaining the growth in fellowships is the realization that the structured 5-year period of residency is not sufficiently long and therefore should be extended. I disagree with this premise. What is needed is not additional time but a reassessment of the current situating and the placement of fellowships in the proper perspective. The more fellows added to residency programs, the more severe the problem will become, aggravating the existing unhappiness among the residents. This unhappiness may soon turn into anger and demands for a resolution of the problem.

Since frustration with the failure to obtain sufficient surgical experience in several areas is a major cause of the dilemma, it is likely that in the near future, 1 year of fellowship, which

Residents should be the ones performing the procedure, while fellows should serve as assistants.
may have corrected the deficiency in 1 specific area, will not be enough, and another year will be sought for another area where a similar problem existed.

Our guest editorial suggested that it is imperative for directors of residency programs to give the highest priority to resident education, not to fellowship education. Resident education is their first responsibility, and the emphasis on fellowships should be tempered. We proposed that in those instances when surgery is to be performed by people other than the faculty, the residents should be the ones performing the procedure, while the fellows, seeking additional exposure to a given subject, should serve as assistants, unless the volume of surgical material is so large that both groups can be appropriately accommodated. This suggestion, “as illogical as it may appear to many, should not be dismissed too cavalierly,” since “the fellows we are considering under this scenario will be individuals who, according to our suggested plan, would have received during their residency sufficient exposure to their subsequently chosen subspecialty.”

It is my suspicion that we had not sufficiently studied the issue at hand when we wrote the guest editorial, and this prompted my desire to look in greater depth at the growing trend of pharmaceutical and implant manufacturing companies subsidizing orthopedic fellowships. This feature is not being openly acknowledged by directors of residency programs but has not escaped residents, particularly those who had failed to receive acceptance for fellowship training.

The fact that the subsidizing of fellowships by industry is becoming widespread suggests that the same will soon happen to fellowships not affiliated with medical schools, if it is not already the case. Community surgeons with busy and successful private practices have fellows, and others wish to have them. It is logical to anticipate that some of these practitioners, aware that the financing of fellowships can be obtained from industry, will seek approval of their own programs from those responsible for their accreditation. They could justify their requests based on the fact that they have a large volume of patients and will be able to add didactic conferences and research activities to their fellows.

I recently learned from a young orthopedist that his fellowship had been subsidized by a certain implant manufacturing company, and, in addition, the expenses incurred by attending 2 major hands-on courses held in distant cities had been covered by another industrial concern.

Although the issue of industry subsidizing orthopedic fellowships has not as yet reached critical levels, I suspect it will reach the point where official intervention by the appropriate accrediting bodies will become urgent.

Industry’s reach has proven powerful and will continue to grow longer and stronger. To assume this not to be the case is dangerous naïveté. Industry, we must recognize, is not interested in education for its own sake, but because by subsidizing it they exponentially increase the number of physicians who in a quid pro quo fashion will use the products manufactured by their generous sponsors and/or serve their marketing agenda.

There is no longer room for complacency and pusillanimous responses. We owe future generations a major effort to solve a situation rich with potentially serious and unanticipated consequences.

REFERENCES