Teaching Anatomy: It’s Time for a Reality Check

To the Editor: In recent years the number of hours devoted to teaching anatomy in the undergraduate medical curriculum has been decreasing. Clinically relevant materials are being omitted as more topics are added to the curriculum. Residents are active in or among teams. We should be able to link data from our M&M discussions with data already collected for other hospital quality improvement initiatives, such as NSQIP. And we are working toward linking all of this information with objective data collected from the electronic medical record, such as vital signs and laboratory values. Comprehensive databases can show us how to do better.

The M&M process is no longer the only way for surgeons to improve patient outcomes, but this does not mean it is losing importance. Nothing beats honest discussion of patient cases that expose our weaknesses and inspire us to be better. In our new era of big data, let us not lose the personal approach to quality improvement through the tradition of the M&M conference. Comprehensive, multi-institutional databases can show us how we are doing—but the M&M process can show us how to do better.

Disclosures: None reported.

Jamie E. Anderson, MD, MPH
Resident physician, Department of Surgery, University of California Davis Medical Center, Sacramento, California; jeanderson@ucdavis.edu.

Diana L. Farmer, MD
Chair and professor, Department of Surgery, University of California Davis Medical Center, Sacramento, California.

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To the Editor: We are also developing a process to track complications and errors. We should be able to identify key areas of improvement from operating room efficiencies to resident education to communication between or among teams. We should also be able to link data from our M&M discussions with data already collected for other hospital quality improvement initiatives, such as NSQIP. And we are working toward linking all of this information with objective data collected from the electronic medical record, such as vital signs and laboratory values at various points of a patient’s hospitalization. Comprehensive data networks will inform quality improvement projects and allow for more nuanced surgical outcomes research.

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Jamie E. Anderson, MD, MPH
Resident physician, Department of Surgery, University of California Davis Medical Center, Sacramento, California; jeanderson@ucdavis.edu.

Diana L. Farmer, MD
Chair and professor, Department of Surgery, University of California Davis Medical Center, Sacramento, California.

To keep pace with modern medical curricula, the course material in anatomy could be divided into modules of short duration with each module comprising only clinically relevant materials carefully selected from the system- or region-based classification of human anatomy which is presently prevalent across the globe. Essentially, it would be curricular triage, where some areas are to be tagged as “must know” and differentiated from those of “should know” and “could know.” This process could be streamlined if clinicians, particularly from different fields of surgery, are brought onboard to provide valuable input. After all, these colleagues would be in the best position to identify the areas of anatomy that a medical student needs for successful medical practice. There should be the cushion of a sufficient time interval between each module, which would allow students to go through the study materials multiple times. This would possibly contribute to building baseline knowledge with respect to each module before the students move to the next one.

Instead of teaching too much anatomy within a short period of time, it would be more appropriate to provide selective but useful knowledge that students can actually imbibe and apply during clinical training. In a changing curricular environment, anatomists need to adapt and modify the teaching methods accordingly in order to withstand the test of time. The clock is ticking, and we need to act fast!

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Sanjib Kumar Ghosh, MD
Assistant professor, Department of Anatomy, ESIPGIMSR & ESIC Medical College, Joka, Kolkata, West Bengal, India; drsanjib79@gmail.com.

Professionalism Sans Humanism: A Body Without A Soul

To the Editor: Twenty minutes after his appointment time, the patient finally leaves the crowded waiting room to see the doctor. He mumbles, “It’s about time,” as a haggard and tired resident on the last hour of her 80-hour week walks in. Karen plops in front of the computer, wishing she had peed an hour ago. As she logs in, the electronic health record prompts her to ask about tobacco, a question whose relevance frustrates both patient and resident. Struggling to finish her chart while 15 minutes behind, she asks her patient all the other checkbox questions to achieve level 5 charting while staring intently at the computer screen, fielding inpatient calls as she goes. Recognizing a relatively straightforward presentation of the flu, she is about to examine her patient when the attending slips into the room and sees her engrossed in her screen with an exasperated look. “Where did you go to medical school?” he asks. “Didn’t they teach you professionalism?”

It is safe to say that no one begins medical training with the aim of wanting to treat patients poorly. Medical educators stress professionalism as a core competency, but it is still a problem in many settings.

In the scenario above, Karen is a good resident and a good physician. Like most of her peers, she came into medicine to help people, but, like 80% of her peers, has become burnt out by the system in which she learns and cares for patients. She does what she can to get her patients what they need, but in a broken system, doing so often means rushed, imperfect care. In our opinion, physicians have been reduced to automatons, spending hours arguing with insurance companies and doing clerical work. Residents put in 80 hours a week, the equivalent...
of two full-time jobs, while at home laundry goes unwashed and personal lives are forgotten. Payers dictate how many patients must be seen per hour, rewarding procedural work over meaningful communication.

The discussion of professionalism is incomplete without acknowledging the decline in empathy that occurs during medical school, the overworking of residents, burnout among attending physicians, and the huge numbers of doctors who commit suicide.1–3

If we want our health care practitioners to be more humanistic, perhaps we should begin by treating them as human beings.

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Abraham Khan, MS
Third-year student, Lewis Katz School of Medicine at Temple University, Philadelphia, Pennsylvania; AKhan@Temple.edu.

Sarab Sodhi, MD, MAUB
First-year emergency medicine resident, Cooper University Hospital, Camden, New Jersey.

References