

Back to the Future

Can. J. Neurol. Sci. 2001; 28: 281-282

“Those about to study medicine and the young physicians should light their torches at the fire of the Ancients.” Rokitansky.

In reading the comments of the article in this issue, *Current Educational Issues in the Clinical Neurosciences*, by J. Max Findlay, et al (page 299-308), I am moved to consider the issues which I considered fundamental in my own training. I was privileged as a “foreign medical graduate” to come to this country and light my torch at the fires of the Canadian giants. The experience that I and many others enjoyed went far beyond “the mandatory requirements”, “call schedules”, “morning-after regulations” and “guidelines”. We enjoyed Canadian neurology/neurosurgery at its best. For a century it has provided the young with outstanding mentors, many of whom founded and contributed to this journal. They ministered to the sick and, by inferential observation, drove a fledgling field of clinical neurological science forward. Residents and fellows were entrusted with looking after the sick while teaching the young that were to follow. We were stimulated to do research and explore the unknown. Most, if not all of the current specialists in this country were privileged to learn from the Canadian Greats in world class centres dedicated to patient care, teaching and research.

Yes, it is now the 21st century and times have and should change. Clearly, regulation and protection are required in order to lead a balanced Oslerian life, while at the same time a certain intensity of training is paramount. Dr. Findlay and colleagues’ article clearly enunciates some of those principles but perhaps disregards some of the more exciting prospects that attend clinical neurosciences in the 21st century.

Brain imaging has removed much of the mystique and the fear that went into looking after patients when these specialties were most often diagnostic and non-therapeutic specialties. Unlocking the human genome opens the way to potential therapeutic intervention where nihilism has previously reigned. Molecular imaging heralds a new golden age. This will happen, but only if we can excite and mentor the young to carry the torch forward.

To be critical of training programs may be inflammatory, but a grave mistake that is made, and is eluded to in this article, is a move towards protectionism. The isolation of Canadian medicine forgets the strengths that were drawn by many of the greats receiving training in the best clinics and laboratories throughout the world and then coming back to Canada. Many of Canada’s best neuro-training programs attracted residents and fellows from all over the world. This geno- and phenotypic mixing is essential if these specialties are to evolve. Isolationism will lead to extinction. These hothouses in Canada were the place to be. Regulation and protectionism will kill what was one of Canada’s strongest international cards. The suggestion that foreign medical graduates will fill call schedules, is a dead end solution. To propose “training international medical graduates as hospitalists able to take first night call exactly like a resident and

working with the residents during the day” makes depressing reading. This solution is more retrogressive than the problems that the residency program committees and directors faced in the first place, i.e. how to improve the environment of the young. Foreign medical graduates are here to excel and, in return, our best graduates and residents must travel abroad. Foreigners are not here to keep Canadian residents in their beds.

Stroke care, like neurology budding off from internal medicine thirty years ago, has very special needs. At least for those who take stroke call and provide immediate care, it is a form of “extreme neurology” and the experiences, while fulfilling, are demanding. One in one call schedules for staff stroke neurologists are a fact of life for pioneers, particularly in smaller centres. Until the specialty grows, this will be the reality, as it was for Canadian neurologists and neurosurgeons when the specialty was separating from its parent medicine and surgical specialties. While neurology and neurosurgery were initially thought of as subspecialties we now are subspecializing again. Further evolution will require more teaching and research but the rewards of effective patient care and satisfied inquiry will compensate.

Sir David Weatherall, the recently retired Regius Professor and holder of Osler’s Chair in Oxford has always maintained that medical students turn their back on science when they pull on their white coats and go to the wards.¹ Good residency training must be combined with research exposure and accomplishment. Research is not listed in this article’s “hallmarks of an excellent program”. The ancients are remembered, not just for their quiet art, but also for their science. We are training young minds so that they can be engaged in the difficulties that made us vulnerable as humans. We therefore have a very special role in the lives of our patients. We are also privileged to be the teachers of residents whom we must inspire. To quote Goethe “start and the mind grows heated”, if we fail to ignite the imagination of the young, the way forward for clinical neurosciences will be dimly lit.

The residency program committees in this country wish to be “admired around the world”. To do this, they must take a more progressive international look. They must stimulate research excellence and compassionate care and not provide more bureaucratic regulation. Good teachers and research mentors will always protect and look after their young, otherwise they will face extinction. Yes, it is important to combine life style demands with the pressures of the job, but this is not a job, this is a calling, and if we dismiss our history, we will be all the poorer.

Alastair Buchan

1. Weatherall DJ. Science and the Quiet Art: Medical Research and Patient Care. Oxford: Oxford University Press, 1995.

EDITORIAL NOTE

In this issue of CJNS, Dr. J. Max Findlay and colleagues have

nicely amassed and condensed ideas developed during a symposium on Clinical Neurosciences education at the CCNS meeting in Ottawa, June 2000. We think it extremely important and timely that such issues be highlighted in our journal.

In adding some editorial comment with Dr. Buchan to these ideas, I raise the issue of neurological training by residents in internal medicine. In recent years, there has been concern about a perception, not systematically studied, that neurology rotations during internal medicine residency training programs in acute care hospitals are difficult, time consuming and worth avoiding. To prepare for Royal College examinations, and to fulfill Royal College requirements of a rotation in neurology, alternative approaches have been chosen, such as exclusive outpatient rotations, extra time in outpatient neurology clinics before exam time, or rotations away from the site of the primary internal medicine program, where scrutiny, standards and responsibility may differ. In contacting the Royal College about neurology training requirements in internal medicine programs, I was surprised that there are, in fact, no guidelines as to what a neurology rotation should comprise. Most program directors (in Neurology and Medicine) design such rotations to ensure enough exposure to acute care neurology (read the emergency room) but some rotations are as short as one month or are not done. While

a preliminary survey of some programs across Canada indicates that “off service” or “out of town” rotations are relatively uncommon, the question arises as to whether more specific College guidelines are required. In prior years, stroke care was handled in large measure by internists (still the case in many places in Canada). In most Canadian hospitals, acute stroke care by neurologists is not available. Given this concern, yet possible shrinking acute neurology training by internal medicine residents, a serious gap in expert stroke care may widen. The concern is not confined to stroke care but includes the acute care of such conditions as myasthenic crisis, Guillain-Barré syndrome and acute myelopathy, none of which are dealt with in exclusive outpatient neurology training programs. It is also likely that neurosurgery has similar challenges, with fewer general surgeons training in such procedures as acute burr hole drainage of hematomas and other emergencies. It may be that the clinical neurosciences community in Canada will need to be more proactive in determining what level of training is required by non-neurologists and non-neurosurgeons in Canada who nonetheless look after neurosciences patients. Before too long, the patients themselves may demand to know how much time their internist spent learning about stroke!

Douglas Zochodne