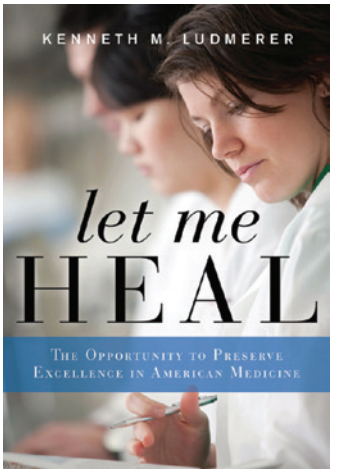
*LET ME HEAL: THE OPPORTUNITY TO PRESERVE EXCELLENCE IN AMERICAN MEDICINE*

# The history of residency programs is still being written

BY CHARLES R. MEYER, MD




1973 marked the Watergate hearings with North Carolina Sen. Sam Ervin's slow drawl interrogating one White House miscreant after another and every day revealing another one of Richard Nixon's deceptions. Although the hearings were on my radar screen, my biggest blip that year was applying to internal medicine residency programs. In my peregrinations to visit seven or so programs, Ervin-like, I investigated what was important—call schedule, attending physician involvement in teaching and degree of responsibility granted to residents. Over the next three years I gradually acknowledged the wisdom of my match and exited residency grateful for what I had learned and how I had learned it. Medical school lit the fire for medical practice but residency launched me.

Residency is still a large blip on the screen of medical students but the blip has changed since 1973. The magic day in March when the results of the residency match are announced is still a breath-holder for fourth-year medical students but the road to the match is tougher. Rigorous competition for prize residency spots can spawn 60 or more applications and multiple expensive trips for interviews. A disappointing match can lead to depression and a frantic scramble to find a position outside the match.

Residency in 2018 is the end result of an evolution in the training of doctors that began in the 19th century. Kenneth Ludmerer, MD, professor of history at Washington University, traces that evolution in his latest book *Let Me Heal: The opportunity to preserve excellence in American medicine* and reminds us that the training of physicians was originally haphazard at best. After completing medical school, a poorly disciplined program of two winter sessions of lectures and book learning followed by a test, physicians had to scramble to "learn the trade," hopefully to gain hands-on experience with patients. Their primary option was an apprenticeship during which they contracted with a practicing physician to spend time in his practice. Unfortunately, that time might involve only menial tasks such as cleaning glassware or keeping the books. According to Ludmerer, "many preceptors made little effort to provide systematic instruction, keep up-to-date with recent medical developments, or offer trainees sufficient clinical opportunities." In 1867, the AMA proclaimed such training "worse than useless."

During the late 19th century, a fortunate few who fulfilled the requirements for "subordination, capacity for labor and conduct" landed "house physician" positions in which they followed attending physicians on their rounds at a general hospital. House physicians traded the valuable clinical exposure for an unpaid indentured existence that included a ban on marriage and a requirement to stay in the hospital at all times.

Post-graduate medical education advanced in the late 19th century as specialization began to escape its reputation as the haunt of itinerant quacks and charlatans; American physicians seeking clinical experience in their specialty initially had to travel to France or Germany. Prompted by doctors who had this European experience, Johns Hopkins started the first residency program that promised physicians-in-training patient responsibility, faculty supervision and teaching of medical students with the goal of producing "clinical scientists." These same themes recurred as post-graduate education matured.

Residency programs in the early 1900s burgeoned with their own peculiar variations, while incorporating those same principles. Ludmerer chronicles residency programs' response over the ensuing years to the challenges of DRGs which he says initiated the era of "high throughput" of patients, government funding with the advent of Medicare and Medicaid, changing lifestyle demands and needs of entering residents, the demise of the pyramid system that had tapered available residency slots as residents progressed through the system, the advent of the 80-hour work week requirements, and doctor burnout. Ludmerer's analysis of the history of residency is exhaustive and at times exhausting as he reiterates the themes of residency programs—sometimes to the point of tedium.

What Ludmerer does make clear is that the evolution of post-graduate medical education is not finished. As tectonic shifts in medicine and medical economics continue, residency programs will again have to adapt and medical students and residents will have to refocus their radar and rekindle their fire. MM

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