

Surgical Training and Qualification in North America: Review and Comparison

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Abstract

Training and competency certification for the specialty of general surgery in North America have many similarities and some differences between the two countries (Canada & USA). The work and learning environment in both countries are very similar leading to many similarities in training and certification. Accreditation of the training centers and structured residency programs with carefully designed curriculum are the core requirements for specialization. The difference is in the accrediting and supervising institutions. Similarly, is the certification process. The Royal College of Physicians and Surgeons of Canada is responsible for both accrediting training centers and conducting the certification exams. While in the US, more than one organization is involved in the two processes. This variation may lead to different standards and quality of training. This difference is difficult to evaluate.

Keywords Surgery, Training, Qualification, North America

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List of abbreviation: ACGME = Accreditation Council for Graduate Medical Education, ABSITE = American Board of Surgery In-Training Examination, CE = Certifying Exam, QE = Qualifying Exam, MOC = Maintenance of Certification, RCPSC = The Royal College of Physicians and Surgeons of Canada

Surgical training and qualification in North America consists of training in an accredited surgery program and passing a board exam. In US, the Accreditation Council for Graduate Medical Education (ACGME) supervises the training programs. While the American Board of Surgery conducts the board exam process and certification. In Canada, both the accreditation and board certification are supervised and conducted by one entity, The Royal College of Physicians and Surgeons of Canada (RCPSC).

Training in accredited surgery program is essential for the board certification in both US and Canada. There are many residency

programs of variable sizes and capacity to train on surgery. In Canada, all surgery residency programs are affiliated with universities. In US, surgery programs can be either academic – affiliated with university – or community based. Each of the two setting (academic and community based training) has its own pros and cons.

In both Canada and the US, training generally follows a predesigned, structured, and approved curriculum in a residency program. In the US, there are 277 accredited general surgery residency programs and 8,102 on duty hours for the year 2017-2018 according to the official site of ACGME. While in Canada, there are 17 accredited general surgery programs. Six of these programs are in the province of Ontario, the most populated province in the country.

During the program, residents work and train in various blocks or rotations, both in the core general surgery and the related subspecialties. The duration of each block (rotation) is usually 1-3 months in length. In these blocks (rotations), residents work in teams of about 2-4 supervising surgeons and 1-3 residents. They are evaluated during and at the end of each block in addition to the evaluation at the end of each academic year. In the US, there is a yearly written examination as well. This is called the American Board of Surgery In-Training Examination (ABSITE). This exam includes both clinical and basic sciences. While in Canada, there is a primary written exam conducted by the RCPSC. It should be undertaken during the first 2-3 years of training. It is mostly for basic sciences.

In the US, the board exam process consists of two separate parts. The first part is the written exam – the Qualifying Exam (QE). This is conducted once a year, usually in August. Passing this exam allows entering the second part – the Certifying Exam (CE). CE is conducted multiple times during the year, usually around 5 times in various cities. Upon passing the CE successfully, the American Board of Surgery will issue the Board Certificate. This certificate is valid for 10 years. Re-examination every 10 years is a requirement to maintain certification. In Canada, the board exam consists of two parts but they are conducted independently of the result of each other. The written part is conducted during early June of each year; while the oral part is conducted during late June of each year independently of the written exam result. On passing both parts the RCPSC grants the board certificate.

The American College of Surgeons provides membership and educational services for its members. Board certification is not necessary for the membership. In Canada, the RCPSC provides educational, academic and maintenance of certification (MOC) services to its membership. Canadian Board certification is mandatory for the membership. MOC requires annual and five-yearly achievement of certain

credit points in continuous medical and professional education. The Canadian Board is therefore valid for life. The American Board of Surgery requires recertifying (taking the board exam) every 10 years to maintain certification.

The common question is which system of training and certification is better, the Canadian system or the US system? There is no definite answer for this question. The answer depends mainly on the program of training and the ultimate goal of the surgeon. Both sides have structured training programs of variable strengths to ensure training quality. The US side relies more on the ACGME strict criteria of training due to the diversity of quality and sizes of programs. In Canada, the RCPSC relies more on the academic affiliation of all the programs with universities. All Canadian programs and training are recognized by the American Board of Surgery. But not all US programs are recognized by the RCPSC. Diversity of training and subspecialties are wider in the US than in Canada.

Large programs, especially the academic, offer more scholar and academic training than hands on. The high number of residents and fellows increases competition on available procedures for training. While in community and smaller programs there is much less completion and more available operative procedures for residents. Academically, larger programs tend to have multiple subspecialties and expertise for the diverse surgical cases. This increases the exposure and spectrum of training if hands on maintained at an acceptable level.

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