A Critical Review of the Medical Education in S. Korea

“Resident Training”

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**S. Korean Medical Education**

General overview
- Heavy emphasis on lectures and book knowledge
- Expert-centered curriculum
- Ill defined general consensus on resident education
- Relatively passive clerkship—much less involvement in patient care than in West
- Strong emphasis on specialty rather than general training

**Postgraduate Medical Education**

<table>
<thead>
<tr>
<th>Year</th>
<th>Program</th>
</tr>
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<tbody>
<tr>
<td>2yr</td>
<td>Premed</td>
</tr>
<tr>
<td>4yr</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>4yr</td>
<td>General rotating internship</td>
</tr>
<tr>
<td>4yr</td>
<td>Residency</td>
</tr>
<tr>
<td>1-2 yr</td>
<td>Fellowship/Subspecialty</td>
</tr>
<tr>
<td>2yr</td>
<td>Master</td>
</tr>
<tr>
<td>4yr</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>39mo</td>
<td>Army duty</td>
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**Apprenticeship-based Residency Program**

- USA: 1889 William Halstead, John’s Hopkins
- Apprenticeship-based residency program
- Resident evaluation by attributes, not by academic achievement
- Haphazard resident evaluation
- Opportunistic learning
- Require long years of training
- Missing critical situation

**History of PGME: S. Korea**

- A chaos after the liberation of Japanese occupation
- Began by government initiative in 1951
- 10 specialties were the first recognized by the government
- Adapting American resident system
- Underlying traditional Japanese Ikoku system
- Fixed flat 4-year specialty training after 1 year internship
- Mandatory certifying examination at the end of the training
- No change for more than 50 years

**Current Status of PGME: S. Korea**

- 3200-3400 postgraduate trainees annually
- Over 97% of medical school graduates are in PGME
- Significant imbalance between generalist vs specialist
- Almost all doctors are specialists
- Dissociation in specialty between practicing vs training
- Education not integrated between hospital and Univ.
- Organized by Univ. Hospital without Univ. education
**Problems in Internship Training**
- Routine work/chores (I.V., ECG etc)
- No induction course
- No educational overview, not enough supervision
- Cheap labor force
- No sense of belonging, and marginalization
- Not an active care team member
- Equivalent to 3 months of clerkship in N. America
- Current debate for abolishing internship training

**Taiwanese Education**
*Overview: 1949-1997*
- Deficient basic generic clinical competence
- No direct patient responsibilities (5, 6th yr)
- Clinical education by observation
- Overwhelming routine work during internship e.g. I.V., medical documentation
- Immediate residency training right after graduation
- Lost chance of improving further generic competence
- Generic competence deficiency


**Dark Side of Korean Medicine**

*Overuse & Misuse of Technology*
- **Cause**
  - Inadequate generic clinical skill
  - Lacking the concept of primary care
  - Availability of state of the art technology
  - Fee schedule of national health insurance
- **Japan: Fragmented, episodic technical service provider**
- **Outcome**
  - Unnecessary increment of cost for care
  - Delayed medical decision making
  - Mechanical patient-doctor relationship

**Are we playing same game?**

*Globalization of medical education*
- May be same ball, but different rule
- Different output and outcome
- Excellent technologist
- Lacking founding generalism
- Not well-prepared for Western-style residency training
- Lacking big picture of PGME
- PGME operated by family affect

**Current Assessment in PGME**

*Are we doing this in S. Korea? None*
- 360 or Multi-Source Assessments
  - Peer assessment
  - Patient assessment
  - Self-assessment
  - Portfolio
- Clinical Simulation
  - OSCEs with standardized patients (SPs)
  - Incognito SPs
  - High-teach simulations
  - Virtual patients
  - Web cam

**Family as a Unit: Proximity**

*The Barrier to Assessment*
- Familial affective contact
- Proximity in professional life becomes profanity
- Unethical for social institutions: “Favoritism”
- Familial relationship in social institution lacks justice
- 3rd party intervention is needed (ethics and justice)
  *Levinas*
- Moral hazard in closed culture: Asian value
So what's STOPPING The CHANGE for more than 50 years?

Cultural Background
- Common to Korea, Japan and Taiwan
- Strong Uncertainty Avoidance
- Collectivism
- High Power Distance

Collectivism vs. Uncertainty Avoidance

How Did This Happen?

Power Distance in North Korea

Libertus Medicus (解放奴隸醫)
- Extreme hierarchy
- Extreme formality
- Structural violence
- One-way communication
- No constructive criticism allowed
- Conformity encouraged
- Collectivism
- Trans-generational legacy

Creativity & Personalities

Facilitating
- Non-conforming
- Independent
- Intrinsically motivated
- Risk taking
- Tolerance of ambiguity
- Above average intelligence
- Energy
- Self-confidence
- Cognitive flexibility

Far East
- Conforming
- Collective
- Externally motivated
- Risk avoiding
- Anxiety to ambiguity
- Above average intelligence
- Energy
- Family affect, not self
- Prescribed thinking
**Language and Motivation/Competence**

**Schwarz, Scheiman & Ryan**

**Autonomy supportive/Neutral**
- Identifies supervisee’s perspective and needs
- Vitalize inner motivational resources
- Interpersonal support
- Support supervisee’s capacity for self-direction and autonomous self-regulation

**Controlling**
- Neglects supervisee’s perspective and needs
- Frustrates/Thwarts inner motivational resources
- Interpersonal intrusion
- Pressure toward compliance & into a prescribed way of thinking, feeling, or behaving

**의국: Eukuk(韓): Ikoku(日)**
- System from old German “academic chair”
- Department led by a patriarchal chair
- Mixed Personal life, Family life, Professional life
- Family affect among members (faculty, resident)
- Fostering tubular vision: family affairs
- No big picture: Hospital, University, Society etc.

**Changes in educational environment**

Are we ready?
- Patient safety
- Physician well-being and balanced life
- Decreasing hands-on work experience
- New educational methods for new technology
- Quality education: efficiency
- Harvard: mandatory simulation training
- Competence before performance

**의국: Eukuk(韓): Ikoku(日)**
- Exercising educational autonomy
- Previously, education by rebate from ?
- Now, no departmental fund for education
- Familial institution vs Social institution
- No explicit educational objectives needed
- Passive identification of the chair
  “follow the leader!!!”

**Enlightened Administration**

- Term coined by F.D. Roosevelt
- Instead of individual state-run economic policy, federal government took initiative for the economic development plan to combat the Great Depression
- Factually well-informed, tolerant of alternative opinions, and guided by rational thought
Enlightened Administration

- Coalition of executive power for PGME
- Medical schools, Specialty Colleges, Q/A Agency
- Integration among the stakeholders for PGME
- National consensus on resident training
- Not departments’ own independent training
- Integrated training across specialties

Packaged Leadership Methods

- MBO (Management By Objectives)
- American invention
- Democratic governance
- Enlightened administration
- Good internal, external communication
- Consensus, Collaboration for PGME

Current Resident Education

<table>
<thead>
<tr>
<th>Specialty Training</th>
<th>Generic Training CPD CanMEDs Outcome Project</th>
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<tr>
<td>Generalism for Specialists</td>
<td>Core Training, General Internal Medicine, Surgery in General</td>
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<tr>
<td>Generalism for Generalists</td>
<td>Clerkship, Internship, Foundation Years General Clinical Education</td>
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</tbody>
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Korean Resident Education

- Having clinical competence is necessary condition! but not sufficient condition!
- No generic competence training yet (CPD)
  - Communication skill, ethics, management, teamwork, leadership, professionalism

UK Acute Medical Specialties

Core Training: Generalism for Specialist

- Level 1
  - 4-6 months rotation in acute medicine and medical specialties in 2 years
- Level 2
  - Min. 2 year specialist training in General Internal Medicine (Acute)
  - Acute care in hospital setting
  - Symptom-based
Core Training: Content of Learning

- Symptom competencies: Top 20
  E.g. Coma, Headache, Back pain etc
- System specific competencies
- Investigation competencies
- Procedural competencies

Generic competencies

- Professional, moral and legal framework
- GMC: Good Medical Practice
- Mandatory for specialty certification
- UK, Canada: CanMEDS
- USA: 6 competences, Outcome Project

CanMEDS Roles

- Accreditation standards
- Objectives of training
- Exam blueprints
- Final evaluations in training
- Maintenance of competence (CPD)

Surgical Training in S.Korea

- Residency day 1 to the end: strict specialty training within individual divisional unit.
- No basic, or core surgery training
- U.K. 3 YR basic core course
- Canada: Core surgery course >1950s
- 18 - 24 Months basic, or core surgery
But how to change from within?

Professional Self-Regulation

- Uniform standards and guidelines for training in each specialty, created both by doctors and other citizens
- Accreditation of PGME
  Resident program must be certified to have the resources, faculty and patients necessary for training
- Resident salaries, duty hours, time distribution, and vulnerability are closely monitored

PGME Accreditation

- Canada:
  - Royal College of Physicians and Surgeons of Canada CanMEDs 2005
- USA:
  - Accreditation Council of Graduate Medical Education (ACGME-6 competences)
- Australia:
  - Australian Medical Council: SEAC Specialist Education Accreditation Committee WFME PGME standard
- Singapore:
  - ACGME International office

U.K. Quality Assurance of PGME

- Multi-dimensional Quality Assurance
- General Medical Council (PMETB) Q/A Postgraduate Medical Education Training Board
- Deanery Quality Management
- Colleges’ /SACs’ Quality Management

BREAKING TRADITION

Tribalism within Collectivism

- Government (MOH) regulation of PGME
- Departmental boundaries in PGME
- Less collaboration among medical schools, teaching hospitals, specialty colleges in PGME
- Much less infusion of new methods of educational theory and practice in PGME
- Ignorance of professional standards abroad
Universal Principles for PGME

- Adult learning theory, not slave driving theory!
- Education for stimulating curiosity, discovery, teamwork, and responsibility
- Fair competition improves performance & outcomes
- Public consensus of good physicians in society
- Rigorous professional standards for residents & teachers
- Hybridization (globalization and indigenization)
- Active international exchange

Primum Non Tacere

An Ethics of Speaking Up in PGME
James Dwyer; Hastings Center Report 1994

- Learn how to speak up!
- Learn to respect trainees
- Learn to prevent power abuse in hierarchical system
- Confucian virtue: To remonstrate...
- Learning to "play the game" in extreme hierarchy
  Avoiding humiliation
  Putting up with (enduring), silence
  Recognition of the power differentials

Learning in Health and Social Care, 2, 213-222

Changing East Asian Culture in PGME

- Helping residents to develop means encouraging their goals, not the professor's
- Foster residents to support his/her own decisions by expressing their own reasoning
- Accept ambiguity and uncertainty
- Preventing residents' voluntary asylum into the passive slavery mentality
- Respect residents as future colleagues, not as intimate family members

Cultural Hybridization for PGME

West
- "Honor code:" individualism
  - Self-independent
  - Innovation
  - Cognitive flexible
  - Seeking different ways
  - Dialogue

East
- "Honor code:" collectivism
  - Authority dependent
  - Conformity
  - Prescribed thinking
  - Seeking right way
  - Monologue

Ideal PGME

Current PGME
- Patriarchal
- Authoritative, controlling
- Opportunistic
- Collectivism
- Hospital lead
- Implicit objectives
- Learning by identification
- Apprenticeship

Future PGME
- Democratic
- Autonomy supportive
- Systemic
- Individualism added
- Medical school-led
- Explicit objectives
- Adult learning
- Structured apprenticeship

Problems with S. Korean PGME

- Non-existent consensus on educational objectives
- Unstructured, non-systemic
- Ill-prepared for specialty training
- Power abuse in extreme hierarchy
- Vulnerability of resident status
- No government funds for resident education
- Hospital-oriented education
- Out-of-university education
Recommendation

- Less traditional familial affects
- Introducing MBO
- Enlightened administration
- Emphasizing generalism in BME, PGME
- Producing more than technology experts (醫匠)
- Hybridization, internationalization

Levels of learning

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Informative</td>
<td>Information, skills</td>
</tr>
<tr>
<td>Formative</td>
<td>Socialisation, values</td>
</tr>
<tr>
<td>Transformative</td>
<td>Leadership attributes</td>
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