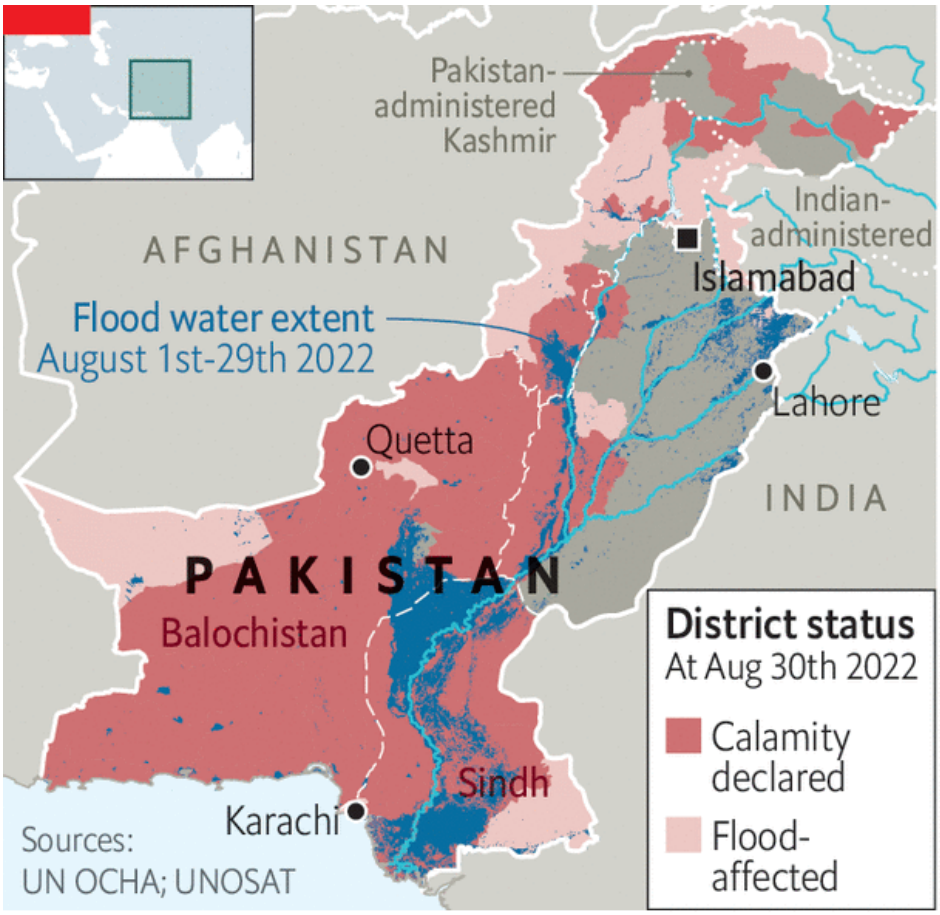
dear residents

After the Flood: Strategic Rebuilding **September 4, 2022**

Dear Residents,

Greetings from Karachi. I am in Pakistan for a short trip to visit family. It comes at a time where there is a crisis here with widespread flooding. I am sure you've seen the headlines. It has been an unusual summer here with a particularly heavy and prolonged monsoon season. Pakistan is an arid country with agriculture supported by the 5 rivers (that's how the Punjab region gets its name - *Panj* means 5 and *ab* means water). The rivers are fed by glacial melt in the Himalayan range. When it rains this much, it overwhelms the entire system.



The Economist

Our hospital systems have also been under stress lately. Both Parkland and Clements currently have a high census and resources are stretched. This also places stress on our education with an overflowing ED, waiting for beds to open and the pressure to discharge patients to create room for new patients. The faster turnover does pose the risk of work compression - even as the team census remains steady. This is not a new problem - since 1984, with the introduction of the prospective payment system, hospitals responded by increasing patient throughput - resulting in work compression. This only gets worse when the system gets further stressed. It becomes increasingly difficult to insulate the learning environment from the business needs of the healthcare system. Absolute team caps and strict adherence to permitted work hours act as a failsafe, but between optimal and maximal is a space that can be easily filled with high-volume low-educational activity.

As you know the service to education balance for the internal medicine, pediatrics, surgery, and the gynecology/obstetrics programs has tilted towards service as measured by the annual ACGME survey. Given that this has now become an institutional issue, it is one of the key priorities that is being addressed at the GME level. One of the first steps is to formally measure the workload being faced. While this seems straightforward to accomplish, the process has sufficient nuances that it needs a systematic approach.

The COVID emergency breached some of the firewalls between education and the overwhelming need to manage the exploding volume of patients. Now that we are in a more stable situation regarding COVID, there are other downstream forces stressing our educational mission. The rapid growth of the campus clinical enterprise as measured by the numbers of new beds, new faculty and new patients has the downstream effect of higher workloads for the teaching teams. This is being especially felt on critical care, cardiology, and consultation services. Over that last decade the number of faculty members has doubled, while residency and fellowship growth has been more modest. The numbers of advanced practice professionals (NPs and PAs) have partially filled the gap, but somewhat unevenly.

The imperative for residency redesign grows more urgent each day. I had a small epiphany when I listened to Dr. Shah's lecture on pancreatitis. He contrasted the management of pancreatitis in the recent past (NPO, IVF and pain management) to current management which involves many more decision points (what kinds of fluids, how fast, antibiotic choices, EUS-guided pseudocyst drainage, etc.). The training that you undergo now and the volume of evidence you must negotiate pales in comparison to my three years of training (1988-1991).

Over these next few months, I will focus on these questions and with your help, we will together advance the program.

Thank you for working so hard. Happy Labor Day,

Dino Kazi