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Surgical Skills as Resident-Selection Criterion

Bertrand P. Kaper, Adam D. Bernstein and Joseph D. Zuckerman
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S. Toh, K. Tsubo, S. Nishikawa, S. Inoue,
R. Nakamura, and S. Harata reply:

Dr. A. Sharma, Dr. R. Singh, and Dr. S. Sharma raised two questions: one regarding the size of the fragment and the other regarding comparison of the two nonunion groups according to the Milch classification of the lateral humeral condyle fracture. As to the first question, they stated that the size of the fragment in a long-standing nonunion is difficult to measure and that they would like to know the definite yardstick for small and large fragments. As described in our article, on page 596 in the Radiographic Findings section, a fragment of the lateral condyle is considered to be small when its articular surface is not larger than the length of the articular surface of the facing (opposite) radial head on the anteroposterior radiograph. In contrast, a large fragment has an articular surface that is larger than the articular surface of the radial head.

Their next question is whether a Milch type-II fracture will ever culminate in a group-I nonunion. Milch type-II fractures involve either the entire capitellum and the lateral part of the trochlea laterally or the entire trochlea medially. The radiocapitellar joint maintained its normal relationship in all of these fractures that we have seen. Thus, we would say that all cases are clearly seen to fit into either group 1 or group 2.

—Satoshi Toh, MD
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Surgical Skills as Resident- Selection Criterion

To The Editor:

I read with interest the Orthopaedic Forum "Orthopaedic Resident-Selection Criteria" (2002;84:2090-6), by Bernstein et al. Each selection criterion reviewed in this study has merit in the ultimate selection of our future

residents and colleagues. I would argue, however, that the criteria identified and reviewed place little or no importance on manual skills and surgical dexterity. How well medical students can perform on a written examination, such as the United States Medical Licensing Examination (USMLE); how well they do during an "audition" clerkship; or how polite they may seem during the interview process has very little or no bearing on their ability to acquire and hone surgical skills. The fact that only sixty-six respondents identified "testing of manual skills as part of the interview process" as a selection criterion suggests that at least 40% of programs do not require such screening.

While there has been much interest in viewing ourselves as "orthopaedists" rather than "orthopaedic surgeons," the bottom line in clinical practice is still our surgical skills. Errors in judgment in the operating room or technical errors during surgical procedures can result in devastating consequences for our patients.

I agree strongly that the selection process is a difficult one. Many variables need to be evaluated and weighed. Since we are ultimately training surgeons, however, I see the need for a better and more thorough evaluation of the manual skills of each applicant in the entire selection process.

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A.D. Bernstein, and

J.D. Zuckerman reply:

We welcome the interest in our work on the orthopaedic selection process. Dr. Kaper's observations regarding the relative lack of weight placed on manual skills evaluation in the resident-selection process are interesting. In our study, program directors were given the opportunity to evaluate the importance of manual skills. The results of our survey indicated that only five (5%) of the 107 responding programs utilized manual skills testing during the interview process¹. The program directors' responses in our study suggest that they do not place significant importance on the evaluation of manual skills during resident selection.

Few reports evaluate the relationship between manual skills and resident performance. Hoffer and Hsu reported a positive

correlation between the results of specific manual dexterity tests performed by orthopaedic residents and subjective resident evaluations by faculty members². However, we have not been able to identify any reports that specifically correlated manual skills testing during the selection process to performance during residency or in practice. On the basis of our senior author's experience with over 140 graduating residents, we think that manual dexterity in the operating room represents a learned skill gleaned from experiences obtained during residency training. It is extremely unusual, in our experience, to have a resident exhibit grossly inadequate surgical skill at the time of completion of a five or six-year training program. The "errors in judgment in the operating room" described by Dr. Kaper are more than likely to be an issue of indications, fund of knowledge, and experience, none of which would be assessed by a skills evaluation during the selection process.

The value of screening candidates for surgical dexterity during the resident selection process is uncertain. While technical skills are undoubtedly critical for a surgeon, there are little, if any, data to support the predictive value of dexterity screening tests in the resident selection process. We think, however, that the didactic operative and ethical training that a resident receives will ultimately have the greatest impact on the type of physician and surgeon that he or she will become.

—Adam D. Bernstein, MD
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2. Hoffer MM, Hsu SC. Hand function in selection of orthopedics residents. *Acad Med*. 1990; 65:661.

Surgical Treatment of Adult Idiopathic Cavus Foot

To The Editor:

We are writing in regard to "Surgical Treatment of Adult Idiopathic Cavus Foot with Plantar Fasciotomy, Naviculocuneiform Arthrodesis, and Cuboid Osteotomy. A Re-