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MEDICAL RESIDENCY MODELS

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In medical residency models, there are basically two approaches: the first is called the temporal model, and the second is known as the staged model (EPAS').

The first approach, the temporal model, is based on a fixed timeline: after passing the selection process, the medical resident follows a predetermined duration to complete the program. If the program is three years long, they complete those three years, neither finishing earlier nor later. There is no variation in key stages that certify them as specialists. At the end of those three years, regardless of whether they performed more, fewer, or even no procedures in their field of study, they graduate with a specialist title issued by the Ministry of Education and Culture and endorsed by the local Medical Council, with final approval by the Federal Medical Council. They are then released into the population to practice as specialists. This model is a failed one because it lacks control over the essential stages required for true specialization. For example, if a gynecology program defines that a gynecologist must perform at least fifty hysterectomies to be deemed competent in gynecologic surgery, under the temporal model in Brazil, a resident who performs just one, fifty, or even two hundred hysterectomies graduates as a specialist. The completion of the necessary steps to achieve expertise in that area is not required. This is the model used in Brazil and throughout Latin America.

The complication with this model is that, as a general rule, medical residents complete their three years—or more or less, depending on the program—based solely on time, and nearly 100% of them are approved. Removal from the program or transferring a resident to an area where they might be better suited does not occur. Therefore, this is a model that urgently needs reform, as it is detrimental to the Brazilian population.

The second model, known as the staged model (EPAS), is based on tested competencies. Each program establishes specific requirements that the medical resident must meet. For instance, if a resident does not complete the required fifty hysterectomies, they cannot progress to the next stage. This model is superior for several reasons. First, it ensures that residents are not stuck in areas where they lack aptitude. Surgeons are surgeons, and clinicians are clinicians. It allows for the transfer from one area to another. For example, if a resident aspires to be a surgeon but lacks the necessary skills, they can transition to a clinical area, and vice versa.

If, after three years, the resident has not completed the required stages for their chosen specialty, they do not graduate or receive their title. This model emphasizes clear and defined

competency, requiring the completion of all outlined stages. The EPAS model, practiced by the Royal College in Canada, does not have a fixed timeline for residency completion. A resident may finish in three, four, five, or even ten years, but only upon fulfilling all pre-established requirements. This approach is superior because it ensures that what is promised in the program's documentation is delivered to the public: a true specialist. Consequently, the population can trust the certification issued by the Ministry of Education and Culture (MEC) and the endorsement of the Federal Medical Council. Unfortunately, under the current system, this trust is not justified.

Therefore, the Federal Council of Medicine must look a little more into this, and in our view, we must transport and defend the model in stages and abandon the temporal model, because this model is not the right one for the population.

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