

Surgeons and trainees often refer to the 1960s and 1970s as the “days of the giants.” It was an era of extraordinary surgical progress, including the development of parenteral nutrition, transplantation, and cardiac surgery. Training programs were also in their heyday, and chief residents were looked on as gods by their juniors. I trained during this golden age, and I recognized that it was a real privilege. However, despite the remarkable talent of my attending physicians and the strength of the resident corps, many things were wrong with residency programs in that period. Salaries were at the poverty level, and we all had desperate financial problems; imagine supporting a wife and child on \$100 a month. The pyramidal system kept residents on their toes, but we were afraid to err not because it might harm a patient but because we might not make the cut. The work hours were appalling, and call schedules generally ranged from every other day to 2 out of 3 days. There was certainly no time for family life or play. Although the conferences were great because the attending surgeons were brilliant, there was no structured educational program, and we had to learn everything on our own. Scut work was a constant source of harassment.

It is interesting to read Dr Komenaka’s evaluation of the surgical residency at the turn of the millennium. Times have certainly changed, but surely not all for the worse. Even though abolition of the pyramid may have decreased interresident competition, this competition was far from healthy. Pyramidal systems were unreasonable, often cutting residents who satisfactorily completed 4 or more years of training. Today’s salaries are hardly generous, but they are livable. Scut work is mostly gone from the resident job description, there are great teachers and physicians to learn from, approved programs offer full curricula and basic science lectures, and the work level has become more reasonable. Despite Dr Komenaka’s concerns, today’s residency programs are hardly by comparison the “days of the pygmies.”

Because we always strive for perfection, my interpretation is that the pendulum has swung a little too far from the oppressive nature of the old-time residency programs. What is needed now is fine-tuning so that the recent gains are not converted to future losses. Unless they become a habit, personal days are important as long as they do not directly interfere with patient care. Work hours need to be shortened but certainly not legislated or counted. If we do not provide a reasonable (as opposed to soft or cushy) lifestyle for today’s surgical residents, there will not be any residents to train in the near future.

If, after realistic attempts at role modeling and education have failed, trainees are negligent, complacent, or disinterested—so much so that the quality of their clinical work is not excellent—they should be dismissed even if it creates a personnel shortage. Contrary to Dr Komenaka’s opinion, no one has a lock on a chief residency position. Standards must be maintained, and residents (and attending physicians) need to be held accountable, but only to ensure the highest quality of patient care.

The framework is in place for this to be the decade of the giants. It is up to all of us to make sure that it happens.

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Clostridial Myonecrosis Cluster Among Injection Drug Users: A Molecular Epidemiology Investigation

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A molecular epidemiologic investigation was performed on a cluster of severe necrotizing *Clostridium* infections in 5 injection drug users admitted to an urban community hospital. Interviews with survivors suggested a point source of infection. Pulsed-field gel electrophoresis of *Sma*I restriction digests was performed to determine the molecular relatedness of clinically obtained isolates and isolates obtained from heroin samples and the home environment. A common clonal strain was found in *Clostridium sordellii* isolates from 2 socially unrelated patients and from drug paraphernalia. Clonality of a *Clostridium perfringens* strain from another patient isolate was identical to an isolate from a syringe found in her home. Other *C perfringens* isolates from patients, heroin, and the environment were determined to be polyclonal. We postulate that rapid recognition and public health notification led to rapid resolution of the outbreak. (2002;162:517-522)

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