

## **INTERNAL DISCUSSIONS WITHIN YOUR DIVISION OF CARDIOTHORACIC SURGERY**

**Change is difficult and moving from the classic 5 year GS core curriculum followed by a 2 or 3 year “fellowship residency in cardiothoracic surgery to a comprehensive integrated 6 year curriculum required “buy in” from every member of your current Division of Cardiothoracic Surgery, In addition, new teaching skills will be required as most current members of Divisions teach at the post graduate level...ie they are used to training surgeons who already have 5 years of surgical training under their belt before being exposed to cardiothoracic surgery. The basic competencies of patients care, medical knowledge, practice based learning and improvement, professionalism , interpersonal and communication skills, and system based practice will have to be introduced into the curriculum at the most basic levels, not just the advanced refinement skills we are presently accountable for. Teaching junior residents the basic skills of instrument handling, tissue handling, practice efficiency, etc will be necessary from the first year out of medical school till graduation at year 6.**

**If faculty consensus is lacking within a division, this task is doomed to failure as such a radical change requires a change in every faculty for this effort to succeed. The new program effort can not simply be led by the Program Director; all faculty must be involved and a new distribution of responsibility and labor must be determined....faculty must oversee a much more robust curriculum both didactic and in the operating room, faculty must become involved in simulation as an adjunct to the operating room, faculty must work to develop new evaluation tools, new performance metrics, new accountability dashboards both in and out of the operating room, faculty must learn to become involved in other outside rotations to determine quality and relevancy, faculty must take on new roles with local ACGME efforts, faculty must develop new mentoring skills, faculty must make this new educational responsibility as a very high, maybe highest priority, in an already overcrowded set of potential conflicting responsibilities. All faculty must participate in the development of the Program Information Form (PIF) and understand its content in detail, especially the goals and objectives of every rotation.**

**There was a recent retreat of the ABTS where they invited Doris Stoll, PhD, who for many years was the ACGME coordinator for the Thoracic Surgery RRC. She presented the following observations:**

# **AMERICAN BOARD OF THORACIC SURGERY RETREAT ON INTEGRATED PATHWAYS SEPTEMBER 24, 2008**

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**SCHEDULE OF EVENTS American Board of Thoracic Surgery Fall Retreat  
The Inn on the Biltmore Estate Vanderbilt B Room September 24, 2008**  
**TIME AGENDA PAGES** 2:45 pm - 6:00 pm Retreat on Integrated Pathway 2:45  
– 3:00 pm Opening Remarks and Overview *Richard H. Feins, MD* 3:00 – 3:45  
pm Running an Integrated Residency Program  
*Guest: Culley Carson, MD* 3:45 – 4:30 pm Financing Resident Education  
*Guest: Jamie Padmore* 4:30-5:15 pm Education Basis of the Integrated 5-8  
Cardiothoracic Training Program  
*Guest: Doris Stoll, PhD* 5:15-6:00 pm Creating a Comprehensive Integrated  
Cardiothoracic Training Program  
*Guest: George J. Magovern, Jr., MD* 6:00-6:30 pm Questions and Discussion

To: Richard Feins, MD, President Members and staff of the American Board of  
Thoracic Surgery From: Doris Stoll [dorisstoll@nycap.rr.com](mailto:dorisstoll@nycap.rr.com) Date: September 4,  
2008 Re:  
Confidential Report Comments requested for the ABTS Meeting on September  
24, 2008

Dr Feins asked if I would submit a summary of the practical matters and national  
policies affecting any proposal for the revision of thoracic surgery residency  
programs. The outline of issues is attached for your review prior to that meeting. 5

## **DISCUSSION MATTERS**

### **1. National standard setting matters**

A. Outlining a plan that includes the specialty's projections for physician  
skills in the specialty for the next 10 years While understanding that some  
rules are needed, keep the rules sparse Develop the broad strokes for the  
curriculum, but leave the details to each program, e.g., the total length of  
the program and the length of the core elements Allow program flexibility  
within tolerances, but agree on the tolerances Determine the requisite  
core of knowledge and skills by objectives, not length of rotation Increase  
resident admission criteria Be mindful of the impact of these changes  
upon the residents' practice Develop formative tests for sections of  
knowledge and skills, not by year.

B. If you wish, consider how to transfer residents into and out of a new  
program and similarly consider how to back-load resident positions Use  
the resident admission criteria you have developed for transfer as you  
would for admission Develop a mechanism for a small external body to  
evaluate resident experiences (both clinical, didactic, formative test  
scores) NB: I did not include faculty or dean letters. Treat this process as  
college transfer credits, except make the criteria tougher, i.e., do not  
accept resident time for credit because someone came from an accredited  
program, but rather truly evaluate the clinical experiences, didactic  
knowledge, and the resident evaluations. Never permit admission carte

blanche, i.e., put all such admissions on six-month probation and a tight evaluation leash by contract.

**2. Policy issues relating to education Gain consensus among leadership and membership that a change in education is needed**

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**Acknowledge the lack of time for leadership to monitor national educational changes across medical specialties Understand well the size of the project and identify the possible political implications Change how you think about your programs: can you retain the three or 5-year core and then add blocks for bona fide certificates? In this way you “tap dance” around the ACGME procedures attached that will sideline this project for years. In other words, change content perhaps, but not the length of the Program and if needed, make minor changes to the Requirements Acknowledge the tendency to believe that the way we were trained was the best way, but do not let this dominate the discussion Work through how a block vs. an integrated format can be developed intelligently (this statement also relates to the information suggested in 1B transfers and back fills) Work through the historical difficulties experienced by many during the completion of their surgery prerequisites, but then drop the subject Particularly know that relations across departments, within institutions, national relationships may not permit development in some institutions Understand that any curricular change may not necessarily improve your recruitment efforts, but it should attract residents who want good education**

**3. Outline efficiencies Share expensive resources, i.e., the simulation lab, staff, computer-driven education models Provide common didactic education among specialties, e.g., pulmonary medicine, interventional radiology, cardiology, vascular surgery Accept that other MD specialists will provide parts of the curriculum appropriate to their area of expertise Consider alternative methods for “covering the house,” i.e., can pulmonary medicine fellows, PAs and NPs take call?**

**4. Change how you think about the educational delivery methods Give program leadership the flexibility to develop a curriculum for their program that may differ from current ones, but can meet terminal objectives and outcomes**

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**Think about the longitudinal curriculum based upon the individual resident meeting milestones before moving forward as compared with rote movement Develop the clinical curriculum by sequencing skills and didactic experiences from easy to moderate to difficult as compared with scheduling by service obligations and always blocking long sequences of time in one department Assure that residents (generally) receive skills practice with return skills demonstration consistent with appropriate the didactics, both prior to clinical experience Build in remediation time for any resident at various times within the program Include more frequent testing, both skills and didactics, throughout the program Necessary attachments from the RRC and ACGME follow Proposal for Program Experimentation and Innovation (from ACGME website) Instructions**

The program director should complete the Program Experimentation and Innovative Projects Proposal Form and supply all of the requested information. The DIO must sign the proposal indicating review and approval of the sponsoring institution's Graduate Medical Education Committee. Proposals should not exceed five pages in length. Attach additional documents as numbered appendices. One copy of the proposal should be sent via standard mail to the Executive Director of the appropriate ACGME Residency Review Committee. **Residency Review Committee (RRC) Approval** Proposals which include requests for a waiver/variation/suspension of Common Program or Institutional Requirements require ACGME approval; the proposal will be reviewed by ACGME prior to consideration by the RRC. This process may delay the response time from the RRC. Program Directors should estimate 6-9 months for a decision from the RRC. The RRC Executive Director will provide official notification to the Program Director and DIO of the RRC's decision to include: 1. if approved, the duration of the approval, which will not exceed the next accreditation review, and 2. the method of monitoring (e.g., progress reports, updates) by the RRC. **Thoracic Surgery PRs: Experimentation and Innovation (from the RRC Common Requirements)** Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project. \*\*\*

ACGME Approved: June 12, 2007 Effective: January 1, 2008 **ACGME Procedures for Approving Proposals for Experimentation or Innovative Projects** Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific requirements must be approved in advance by the Review Committee. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

1. Eligibility Criteria a) The sponsoring institution must hold a status of Accreditation or Continued Accreditation. b) The program must hold a status of Accreditation or Continued Accreditation.

2. Proposal Content The program director submits the proposal using the ACGME form, "Proposal for Program Experimentation and Innovation" to the Review Committee Executive Director. The institution's and program's responsibilities are to clearly demonstrate that the project will improve resident education and/or patient care. The proposal must include the following:

- a) description of the project,
- b) rationale for the project,
- c) method of evaluation,
- d) accreditation requirements from which the program/institution will deviate,
- e) description of any new, missing or variant on-line submission of information through the Accreditation Data System (ADS) that would require Review Committee approval,

f) approval by the institutional Graduate Medical Education Committee g)  
signature of the designated institutional official.

### 3. Approval Process a) Institutional Endorsement

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(1) The sponsoring institution's Graduate Medical Education Committee, or its equivalent in single residency institutions, must review and approve the proposal. The designated institutional official's signature indicates approval.

(2) The proposal is sent to the Executive Director of the appropriate ACGME Review Committee. b) ACGME review

(1) Upon receipt of the proposal and prior to review by the Review Committee, the Executive Director will notify the ACGME if the proposal contains a variance to the common program and/or institutional requirements. The ACGME will judge whether the proposal justifies granting a variance to the common program and/or institutional requirements.

(2) Upon receipt of the proposal and prior to review by the Review Committee, the executive Director will notify the Vice President, Applications and Data Analysis to review ADS issues related to the proposal. These issues must be addressed prior to review by the Review Committee. c) Review Committee Appraisal The Review Committee will: (1) formally review such proposals at its regular meetings and will retain documentation of its actions in the program's history; (2) determine whether the request justifies granting approval of the project; (3) stipulate the duration of the approval, which will be no longer than the next review; (4) inform the program and/or institution of the form of monitoring by the Review Committee; (5) enter information regarding the approved Innovative Projects in the Accreditation Data System. In the event that the Review Committee denies a request, the action cannot be appealed. 4. Monitoring a) The form of the monitoring is determined by the Review Committee, e.g., a progress report, a time study, a resident survey, a site visit, or other method. Upon review of the results of the monitoring, the Review Committee will reevaluate the rationale for the deviations from the requirements and may continue, deny, or modify approval of the project. b) The Review Committees will report the status of Innovative Projects, including waiver of requirements (common, institutional and specialty specific) to the Monitoring Committee at the Review Committee's next scheduled review. ACGME Policies and Procedures June 2008, pages 104-05 8