

**Report to the Thoracic Surgery Directors Association
Activities of The Thoracic Surgery Residency Review Committee (RRC) 2011**

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The Thoracic Surgery RRC met at the Sanctuary at Camelback Mountain, Phoenix, Arizona on January 7-8, 2011. The meeting was led by Doug Wood (Chair), and attended by Chip Bolman (Vice-Chair), Michael Mill, Walter Merrill, Mark Orringer, Carolyn Reed, Tom Nguyen (resident representative), Bill Baumgartner (representing the ABTS), Peggy Simpson (Executive Director), Cathy Ruiz (ACGME), and Carl Backer (newly elected representative as observer status, officially beginning July 2011). Dr. Carolyn Reed was elected as the new Vice-Chair, to replace Dr. Chip Bolman, whose term expires June 30, 2011, and Drs. Michael Mill and Chip Bolman were thanked and congratulated for their stellar six years of service on the RRC.

Since the previous meeting two programs have withdrawn and five programs had submitted new Program Directors for approval. In this RRC meeting there were 34 program agenda items, 5 new applications for integrated programs, 4 approved and 1 new application for an independent program (not accepted). There were no new applications for Congenital Cardiac Surgery Fellowships. There are 2 thoracic programs on probation and no programs were removed from probationary status; 2 new programs received proposed probation. Currently there are 70 programs, with 14 integrated (Stanford, Penn, MUSC, Maryland, UT San Antonio, UNC Chapel Hill, Medical College of Wisconsin, Mount Sinai New York, University of Washington, Columbia, Northwestern, University of Rochester, University of Virginia, and Mayo), 12 programs approved for 4/3 combined Surgery/Thoracic Surgery programs (Brigham, Duke, Mayo, NYU, Maryland, Rochester, Virginia, Washington University, Mass General, University of Washington, UT-Southwestern, Indiana), and 10 Congenital Cardiac Programs (USC, Michigan, Penn, University of Washington, University of Colorado, Nationwide Children's (Ohio State), Texas Heart, Emory, Children's Memorial, Chicago, Children's Hospital, Boston). As of June 29, 2010, of the 70 traditional CT training programs, 47 are 2 year programs and 23 are 3 year programs, with approval for 124 PGY6 (97 filled), 123 PGY7 (104 filled) and 41 PGY8 (30 filled) positions. Eight of 10 Congenital Cardiac Surgery programs were filled with accredited fellows, and the integrated programs have 11PGY1, 8 PGY2, 4 PGY 3, and 2 PGY4 residents currently enrolled.

Conversion of resident case logs from CTSNet to ACGME

Resident case logs will convert from CTSNet system to the ACGME system (same as the residents have done for their surgery residencies) effective July 1, 2011, with an appropriate transition planned for residents who already have case logs entered in CTSNet. A Committee of individuals from the RRC and ABTS are working with the ACGME for CPT code conversion to allow automatic completion of resident case log summaries in the ABTS format, as well as to improve Program Director reports of individual residents and the overall program numbers.

New Duty Hours Standards to be implemented July 1, 2011

http://acgme-2010standards.org/pdf/Common_Program_Requirements_07012011.pdf

The most significant portions of the duty hours changes are noted here, with **highlighting of major changes:**

VI.G.4. Maximum Duty Period Length

VI.G.4.a) **Duty periods of PGY-1 residents must not exceed 16 hours in duration.**

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.b).(3) **In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient.** Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a) Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) **PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.**

VI.G.5.b) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

VI.G.5.c) Residents in the final years of education [as defined by the

Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. **While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

Integrated Residency

Application

The Review Committee reminds institutions that may be considering submitting an application for an integrated program format of the following:

1. An institution must sponsor an existing independent program and it must have a “Continued Accreditation” status and a cycle length of at least three years in order for the Review Committee to consider an institution’s request for an integrated program.
2. The institution must maintain both program formats after an integrated program is approved.
3. A completed application for initial application must be sent to the Review Committee administrative staff at the ACGME offices.
4. Institutions whose independent programs have a targeted site visit date within 24 months of the dated signatures on the Initial Accreditation Program Information Form for the integrated program will receive a site visit as part of the application process.
5. Integrated programs, when approved, receive a separate program number, distinct from their institution’s independent program number.

Index Case Requirements

The Thoracic RRC and the ABTS have agreed on a standard of index case requirements for residents entering integrated programs on or after July 1, 2011.

Core Surgical Years (PGY 1-3):

(375 operations averaged over 3 years, of which at least 125 must be cardiothoracic operations, up to 50 which may be “component cases” that include sternotomy and closure, thoracotomy and closure, LIMA takedown, saphenous vein harvest, aortic and venous cannulation, proximal and distal anastomosis, other vascular anastomosis, gastric/esophageal mobilization)

Advanced Surgical Years (PGY 4-6):

(125 major thoracic cases for each year for a minimum total of 375, with a distribution of index cases as defined by ABTS).

Over the course of the integrated residency the resident must also obtain a minimum of 150 index ABS cases with the following minimum distribution: Vascular 25, Skin/soft tissue/breast 10, Head/neck 5, Alimentary tract 20, Abdomen 30, Operative trauma 5, Pediatric 10, Plastic 5, Lap-basic 30, Lap-advanced 10.

Thoracic RRC clarification on the interrelationship of the resident complement in integrated cardiothoracic residencies combined with traditional independent (5/2 or 5/3) CT residencies

Institutions with an existing independent thoracic surgery residency, an accreditation status of Continuing Accreditation and a cycle length of three years or greater may apply for Initial Accreditation of an integrated program. Maintenance of both programs is required at least until such time that the integrated program has a minimum of one resident per year in training at the PGY 1, 2, 3, and 4 years. The independent program can then be phased out if desired as senior level integrated residents replace the independent resident positions. However, institutions are allowed to maintain simultaneous independent and integrated programs as long as the finishing Chief Resident complement does not exceed the number previously approved for the independent program. Institutions are also allowed to maintain an independent program without residents as long as the integrated program has filled all of the accredited senior resident positions. Institutions are limited to finishing only the number of Chief Residents for which they have accreditation in either the independent or the integrated program, whichever is greater. The independent program must necessarily “down size” as integrated residents reach the PGY-4 year (for 3 year independent programs) or the PGY-5 year (for 2-year independent programs), in order to maintain the appropriate complement of accredited resident positions. The accreditation provided by the ACGME for the independent and integrated programs is not summative and so Program Directors must manage their available independent positions in order to not exceed the Chief Resident graduating positions approved by the ACGME. To clarify, an example is given below of a 2-year independent residency approved for two residents per year (2-2) and how this would be managed with the addition of a new integrated residency approved for one resident per year (1-1-1-1-1). The maximum accreditation for graduating Chief Residents is two, and these are highlighted throughout. When the integrated program progresses to a resident in the PGY-5 year (one year before Chief Resident year), the independent program will need to decrease the entering number of residents from 2 to 1 in order to have two graduating residents as allowed by ACGME accreditation.

Year 1	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Independent						2	<u>2</u>
Integrated	1	0	0	0	0	0	

Year 2	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Independent						2	<u>2</u>
Integrated	1	1	0	0	0	0	

Year 3	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Independent						2	<u>2</u>
Integrated	1	1	1	0	0	0	

Year 4	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Independent						2	<u>2</u>
Integrated	1	1	1	1	0	0	

Year 5	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Independent						1	<u>2</u>
Integrated	1	1	1	1	1	0	

Year 6	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Independent						1	<u>1</u>
Integrated	1	1	1	1	1	<u>1</u>	