



## Thoracic Surgery Director's Association Newsletter July 2005

### Yet One More Match ?

Jeffrey P. Gold, MD

By the time of this writing the sobering results of the 2005 Thoracic Surgery Resident Match are known to all. The summary data reveals that 39/139 positions (28%) were not filled and 31 of 95 programs (33%) did not fill completely. There were 100 active applicants for 139 positions of which all of the 100 residents matched. Of the 31 unmatched programs for first year resident positions 25 (27%) of all United States programs did not match a single resident, with most successful matches occurring in larger programs, in larger cities, in academic healthcare centers. Indeed, even our traditionally 'highly respected' programs were cast into this group as well. The ramifications of these results while truly devastating on a programmatic level, are equally alarming on a specialty-wide and national policy level as well. What happened? What went wrong?

I can't help but wonder how much "surprise" there actually was upon checking the programmatic match results. Clearly, the applicant pool has been changing for the last decade and changing even more dramatically over the last 3-5 years. Last year's match produced approximately a 1:1 ratio of candidates to positions, filling approximately 17 (12%) of programs only in the post match "scramble days." Even more clearly, our residents have increasingly struggled long and hard to secure a job over the past years. Alas, while the magnitude of the match data, shocking as it was, is to a large extent predictable, if indeed history teaches us, this pattern will be sustained or even more severe in future years unless dramatic changes occur.

What are we to think? What are we to do? While there are no easy answers,

the words of Admiral James Stockdale describing his experiences at the "Hanoi Hilton" as a prisoner of a war camp during the Viet Nam War are quite instructive. In his descriptions of this time period entitled "In Love and War," Admiral Stockdale and his wife chronicled their experiences during the 8 years of captivity there. He writes "I never lost faith in the end of the story." This is a very important lesson. You must never confuse the faith that you will prevail in the end; which you can never afford to lose, with the discipline to confront the most brutal facts of your current reality." For us to face the "brutal facts" and to remain highly focused on our desired goal to educate the appropriate number of superbly training residents is what we are all about.

For sure, lowering admission standards to secure a resident-based work force will be self defeating. We will certainly produce a generation of borderline, weakly skilled practitioners who will at some time be asked, without ability, to carry forward the skills and traditions of our thoracic surgical specialty. Yes, there are too many positions and yes, until the supply/demand considerations of the applicant pool or job pool change, it will be our obligation to maintain stellar selection standards and matriculate the appropriate number of highly qualified residents.

This is also a time to be surer that the ethical standards of our recruitment and educational processes are "pristine". Isolated stories regarding recruitment, training, board preparation, etc. while surely exaggerated, are to some extent based in fact, and do not flatter our specialty and those who have dedicated their careers to our residency process.

At the same time, we must recognize that much of the future of our specialty



rests in our hands, those of the Residency Program Directors. This is a time to meticulously critique our own programs and to be sure that we are optimally educating our residents. I would suggest that many, possibly all programs can be improved somewhat and that more than a handful of programs are in need of considerable improvement. Yes, some of the programs will cease to exist in the current form. This is a time to finally and completely separate service from education, this is a time to make sure that every case and every bedside interaction is a high quality learning opportunity, and this is a time that resident learning activities are scheduled to optimize the educational value for our residents and not the convenience of the faculty or the exigencies of the operating schedule or ICU coverage.

In short, this is a time to ask brutally honest questions regarding the mission of your department (or your division), of your healthcare center, of your faculty and indeed of each other. If your answer is yes, you truly want to insure future generations of high quality thoracic surgeons, then we together, have much work to do.

The following is an incomplete list of activities that should be considered as high priorities in focusing on our horizons while confronting the realities of today.

- 1) Work with the American Board of Thoracic Surgery to insure optimal case numbers and diversity.
- 2) Work with the Residency Review Committee/ACGME to insure the highest quality of residency program standards.
- 3) Ensure that all considerations of the 80 hour work week are fully met.
- 4) Separate all service (non-educational) activities

- 5) definitively from truly educational activities.
- 5) Ensure that surgical care experiences begin early with meaningful progression of technical and judgmental roles.
- 6) Facilitate experiences in innovative thoracic including catheter-based therapy, thoracic organ transplantation, arrhythmia management, video assisted procedures, etc..
- 7) Start early and work diligently to help secure durable and quality post-residency jobs.
- 8) Work to maintain a high quality of life environment for our residents and for their families.
- 9) Work with general surgery program directors to identify the cadre of high quality residents that may be interested in thoracic surgical careers and foster their interest.

Above all, we must embrace a non-defeatist atmosphere permeating all aspects of the thoracic residency education experience. As a specialty we continually face the most complex and daunting clinical challenges. As a specialty we have been responsible for an unending stream of superb, highly technical innovations and the ongoing understanding of our field down to the molecular level. All of this has been done with great enthusiasm and tremendous confidence. This is **our** time, our time to raise our standards, to continue to redefine our specialty, and to continue to take great pride in our educational system. "Face the blatant truth and never lose sight of the desired goal." It is critical for the Thoracic Surgery Director's Association to remain equally strong and resolute, highly organized and always highly focused on the quality of our educational process.



## Report from the Secretary

The TSDA is under many pressures at this time from the difficulties and realities of our most recent match, the job situation resident's face and reimbursement issues we all deal with these days. Our efforts to address these issues and others have led us to adopt the use of ERAS which some 80 of our approximately 90 programs now are enrolled in. We envision this service to greatly facilitate the ability to screen and track resident applicants in the future. For those not using this service, you may find yourselves at a disadvantage when it comes to resident recruitment. The rollout of this thus far seems to be well received and we believe the enrollment of applicants as they begin to apply late this fall and early next year will be smooth as well. Thank you to all of you, coordinators and directors alike that have helped make this transition occur.

Our finances are in good shape overall, but we will continue to have real challenges if this kind of resident interest persists and positions again go unfilled next year. Concern in the TSDA leadership exists over whether or not more programs will choose to close and our dues support will dwindle further. In order to support our current operations it takes around 200,000 dollars a year to make our costs. This supports an executive director and administrative support working for us to keep our Director lists current, dues paid, associate program director, faculty, and resident lists up to date. In addition, we support the services of a full time technology support person who over the last few years has implemented and distributed the prerequisite curriculum to our programs and residents, helped maintain and develop our website, and most of all has worked with Dr. Gold and others to enhance and further expand our web curriculum now available to every program. Our dues structure supports now under half of this cost. The rest has been made up from industry

support. We are in negotiations with the TSFRE for ongoing support that would allow for the maintenance of our current programs and development of others further. Those of you that would like to know more about this can certainly ask any of the executive committee members for more background and information to continue to advance the goals of the TSDA.

All in all, optimistic we must remain as challenges are faced and conquered. Thoracic Surgery education remains a very satisfying and important part of our medical community even as it changes in ways never before so dynamic.

*Thanks, John Calhoon  
Program Director  
UTHSCSA*

## Request for Newly Matched Residents

With Match Day having passed, the TSDA again needs the names and contact information for your new residents so that we can get them set up in the Education Universe system.

Please email Bill Begg at [bbegg@tsda.org](mailto:bbegg@tsda.org) with the name, email address and phone number of the residents who will start your program in July of 2006.

If we do not have an email address for the new residents, they will not be able to receive their information, so it is imperative that we have that information quickly.

## New Security Logon

Each user has received an email informing them of the changes to the logon procedures, as well as a reminder as to their User ID and Password, along with a default PIN. Upon logging in for the first time, each user will be asked to



change their PIN to something other than the default.

Other than the log in system, there are no outward changes to the interface. Users will be able to access this system from anywhere that has an internet connection (home, work, libraries, Kinko's, etc). There is no additional software that needs to be installed.

### **Evaluation System**

The TSDA Education Universe contains what could be called Version 3 of the Evaluations Utility. You may remember the TSDA releasing the first two versions as an Access database. This version has the advantage of working across computer platform (PC or Mac) as well as working across browsers (IE, Netscape, Firefox, etc).

The design of the system is to have an evaluation filled out on each Resident and Faculty member, and the program every three months (each Quarter). This system will meet all the RRC requirements for reviewing you residents and program.

The real prize with the system is the full granularity of the reports. The Director can pull all the resident evaluations for a particular period, or pull a report specific to a resident, filled out by a particular faculty member for a particular time period. The Program and Faculty evaluations also have fully granular reports, though names are not attached to the evaluations as they are for a resident evaluation.

### **Resident Review Module**

With the addition of the Resident Review module, the TSDA has now made managing a program's contact list easier than it has been. A fully developed Program Staff Management system will be in place by July 1, 2005. it will allow a Director or Coordinator (who has administrative rights) to edit or add

residents and staff directly into the TSDA system. This will improve our ability to communicate with users.

### **TSRACS**

*Carla MacLean, President TSRACS*

The Administrator/Coordinator Section currently plans to meet at the STS meeting in New Orleans on Sunday, January 29, 2006. Potential topics for discussion / presentation include ERAS, coordinator certification, site visit preparation and resident portfolios. If you have suggestions or requests for topics to be presented, please feel free to contact any member of the TS-RACS Executive Committee listed below.

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### **ABTS Update for the TSDA**

*Timothy J. Gardner, MD Chair ABTS*

At its October, 2004, Meeting, the Board of Directors of the American Board of Thoracic Surgery unanimously passed the following resolution:

In response to current practice patterns in Thoracic Surgery and to insure adequate preparation for contemporary Thoracic Surgery practice, the Board (of Thoracic Surgery) intends to revise the standards required of individuals to qualify for entrance into its certification process. The Board will establish 2 primary paths to certification, a Cardiothoracic Surgery Track and a General Thoracic Surgery Track. An additional special certificate pathway will be established for candidates who complete the



Cardiothoracic Surgery Track and plan to perform Congenital Heart Surgery.

The case requirements that were proposed for both primary paths to certification at that time increased the index case requirements in some categories (Adult Cardiac, Lung, Pleura and Chest Wall, etc.) for both pathways, but the total number of required cases was lower in the General Thoracic Surgery Track. *(Please see the chart at the back of this newsletter.)*

The Board published the resolution and announced its intention to increase the case requirements to the RRC-TS, the TSDA and to the Thoracic Surgery community in subsequent months. We asked for comments and suggestions and received excellent feedback from many sources. One particularly important response was received from the General Thoracic Surgery Club after its meeting in March, 2005. The members of this group, almost all of whom are principally engaged in the practice of General Thoracic Surgery, recommended that the total number of cases required in each primary pathway to certification be identical, despite a different subspecialty emphasis in the two pathways. This group also recommended that there be no reduction in the current Adult Cardiac surgery case numbers for the General Thoracic Surgery track and recommended against elimination of the requirement for some congenital heart surgery experience in this track.

At the Board's next Directors meeting held recently in Chicago at the time of the Oral Examinations, the Directors approved the modifications for required index cases suggested by the General Thoracic Surgery group. The Directors also agreed that regardless of which primary pathway, or track, a Thoracic Surgery resident completes, the same examinations will be administered, both written and oral,

for all Thoracic Surgeons. This policy will insure that each certified Thoracic Surgeon will have successfully passed the identical examination process.

It is expected that at the next meeting of the Board of Directors, on October 1, 2005, the Directors will finalize the requirement for increased index cases in both primary pathways, as summarized in the attached table. It is also likely that the Directors will recommend specific training and operative case requirements for special certification in Congenital Heart Surgery.

#### **Update From the RRC**

*David A. Fullerton, M.D.*

The RRC has recently addressed several important issues related to Thoracic Surgical Education.

1. Joint Surgery/Thoracic Surgery Residency Program.

After several years of dialogue between the American Board of Surgery (ABS) and the American Board of Thoracic Surgery (ABTS), a joint Surgery/Thoracic Surgery Residency Program is now available for interested institutions. This educational pathway will provide eligibility for both ABS and ABTS certification. The RRC-Thoracic Surgery, along with the RRC-Surgery recently approved these plans.

The application process for these programs is now available through the ACGME. In summary, the programs will be structured as follows: Sixty months of residency will continue to be required for ABS certification. The change in the residency program will come in the clinical assignments during



the last 24 months of Surgery residency (PG4 and PG5 years). During the last 24 months of Surgery Residency, up to 12 months of clinical rotations may be devoted to Thoracic Surgery. The cases done by the resident in Thoracic Surgery during these last 24 months may be counted toward ABTS certification provided the clinical rotations meet the program requirements for Thoracic Surgery.

During the PG1 through PG 4 years, the program director in Surgery will be responsible for the resident.

During the PG5 year, the responsibility for the resident will be shared by program directors in Surgery and Thoracic Surgery.

During the PG6 and 7 years, the Thoracic Surgery program director will be responsible for the resident.

2. Residency in Congenital Heart Surgery.  
The RRC has approved the paradigm, including case volumes, for an ACGME-accredited residency in congenital heart surgery. Interested program directors may obtain the specific details, including case volumes and the application process, from the ACGME.

3. Case Volumes for ABTS Certification.  
The RRC approved the proposed changes in case volumes for ABTS certification. The specifics of the proposed changes were discussed at the recent TSDA meeting in San Francisco. Final approval of these proposed changes must await discussion by the ABTS this fall.

**Board Preparation Course.**

At the upcoming annual meeting of the American College of Surgeons, the Advisory Council for Cardiothoracic Surgery will host a Board Preparation Course in lieu of the Postgraduate Courses in Cardiac and Thoracic Surgery. The course will be held on October 18 and 19, 2005, in San Francisco. One day will be devoted to General Thoracic Surgery, and the next to Cardiac Surgery.

The course is designed to prepare those taking the written ABTS examination either for certification or re-certification. Attendance is expected to be high, and early registration is therefore encouraged. See you in SF!

**Future TSDA Meetings & Locations**

*Dates are subject to change; notice will be given*

October 17, 2006

American College of Surgeons  
San Francisco, CA

TSDA Plenary Session	None
TSDA Executive Council	10/17/05
TSDA Committees	10/17/05
TSRA Session	None
TSRACS Session	None

January 28-31,2006

Society of Thoracic Surgeons  
New Orleans, LA

TSDA Plenary Session	1/28/2006
TSDA Executive Council	1/30/2006
TSDA Committees	1/30-31/06
TSRA Session	None
TSRACS Session	1/29/2006

April 29 – May 3, 2006

American Assoc of Thoracic Surgeons  
Philadelphia, PA

TSDA Plenary Session	4/29/2006
TSDA Executive Council	5/1/2006
TSDA Committees	5/2-3/2006
TSRA Session	None
TSRACS Session	None



*Proposed New Case Requirements v. Current Index Case Requirements*

	<u>Current Cases</u>	<u>General Thoracic Track</u>	<u>Cardiothoracic Track</u>
<u>Congenital</u>			
Primary	10	0	10
Assistant	10	10	10
<u>Adult Cardiac</u>			
Valvular	20	20	50
CABG	40	40	80
Reops	5	5	15
Aortic	0	0	5
Other	15	15	15
<u>Lungs/Pleura/Chest</u>			
Lobe, pneumonectomy segment	50	100	50
Other	30	50	30
Other	20	50	20
<u>Mediastinal</u>			
	0	5	5
<u>Esophageal</u>			
Resection	4	30	15
Benign		20	10
Other	4	5	5
<u>VATS</u>			
	10	30	15
<u>Endoscopic</u>			
Bronchoscopy	10	50	25
Esophagoscopy	10	25	10
Mediastinoscopy		25	10
<u>Consultative</u>			
New patients	0	50	50
Follow ups	0	50	50
	# Cases	270	270
	1st Assistant	10	10