

Must Surgeons in Training Programs Allow Residents to Operate on Their Patients to Satisfy Board Requirements?

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Introduction

Robert M. Sade, MD

Surgical trainees and their attending surgical instructors face a perennial question that is integral to our model of graduated participation in caring for patients: How can one accurately determine when a resident is ready to advance to the next level of responsibility? Those judgments depend on accurate evaluation of the trainee's developing judgment and increasing technical skills that become more refined with time and experience. Surgical educators have traditionally based their evaluations of residents on subjective observations, integrating those observations into practical judgments that they use to permit increasing levels of responsibility. The Thoracic Surgery Directors Association (TSDA) recently adopted the Accreditation Council on Graduate Medical Education (ACGME) milestone concept [1], which provides objective standards to use for determination of readiness to advance in training.

Surgeons have differing judgments of residents' capabilities, however, based on their variable personal experiences with trainees, different personal yardsticks of performance, and diverse philosophies of patient care and medical education. An implicit tension exists between the requirements of caring for patients and those of educating trainees, a tension that produces

quandaries for academic surgeons: What tradeoffs between doing one's absolute best for one's patients and fulfilling one's obligations as a teacher are acceptable? That question was addressed in a recent debate sponsored by the Cardiothoracic Ethics Forum at the Annual Meeting of The Society of Thoracic Surgeons. The discussion was based on a hypothetical scenario that illustrates a common problem of surgical education.

The Case of the Protective Surgeons

A highly respected residency program has a problem. The chief of cardiothoracic surgery believes that residents should complete the American Board of Thoracic Surgery (ABTS) operative requirements in the home institution if the service has a sufficient number of cases. He finds that several residents are at risk of failing to meet the ABTS requirement for congenital heart cases by the time they finish their residency, despite having a moderately busy pediatric cardiac surgery program. The program's two pediatric cardiac surgeons, Dr Smith and Dr Jones, have a reputation for not allowing residents to do more than assist in their operations, out of concern for the safety of their patients and for the increasing scrutiny of surgical results—the simple, straightforward cases that were once used for training residents are progressively less available because interventional cardiologists do those cases. Do Drs Smith and Jones have an obligation to allow thoracic surgery residents to operate on their patients so the residents can achieve their ABTS requirements?

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Pro

Richard G. Ohye, MD

Surgeons have an obligation to allow thoracic surgery residents to operate on their patients so the residents can achieve their ABTS requirements. Medical education is obviously a crucial part of maintaining a sustainable health care delivery system. Few physicians would argue against the idea that it is one of the responsibilities of our job, but should this be considered an obligation that we must carry out as a part of our covenant as a physician? This question is the root of the debate. Thus, perhaps it is useful to first define the word *obligation*. The Merriam-Webster Collegiate Dictionary defines *obligation* as “something that you must do because of a law, rule, promise, etc.” or “something that you must do because it is morally right” [2].

Is allowing residents to operate on our patients something we *must* do? My position is that, yes, it is something that we must do in our role as academic surgeons. It is an easy position for me to defend, as I feel strongly that as academic surgeons, we are duty bound to pass on our knowledge to the next generation of physicians. As we are all well aware, the traditional tripartite role of the academician is composed of patient care, research, and education. However, this simple stance does not really acknowledge the far more complex nature of the issue.

The vignette is helpful here. It draws out some of the issues that can affect our decision to allow residents to operate. The first is that “the simple, straightforward cases that were once used for training residents are progressively less available because interventional cardiologists do those cases.” The second is “a concern for the safety of their patients and for the increasing scrutiny of surgical results.” In addition to these local programmatic issues, there are the larger global ethical issues to consider, as well. Although these are certainly valid concerns, I hope to make the case that these concerns should not be seen as limiting, nor simply used as an excuse to not allow residents to operate.

“The interventionalists are doing all the easy cases!”

There is no doubt that many of the congenital cases that are traditionally seen as resident cases, such as atrial septal defects and pulmonary valve replacements, can now be done in the cardiac catheterization suite. Although I acknowledge that fewer of these specific cases are available, there are certainly still plenty of cases that the thoracic residents are perfectly capable of doing. We have a relatively large congenital program doing approximately 600 open heart and 900 to 1,000 total operations per year. I am proud of our faculty, who have a true commitment to educating residents and fellows; approximately half of all cases are performed by the thoracic resident or congenital cardiac fellow. Importantly, we do not count a case for the

resident or fellow unless they perform the case from the right side of the table, “skin-to-skin.”

For the purpose of this discussion, I pulled the case list from one of my recent congenital cardiac surgery fellows. During the course of 1 year, he did 252 cases, varying in complexity from atrial septal defects to Norwood operations. He did two atrial septal defect (ASD) repairs and one pulmonary valve replacement (PVR); however, we do many more than that in our program, and the reason they are not on the fellow’s list is that the thoracic resident is doing them! Many of the cases on the fellow’s list can be safely performed by a thoracic resident: seven incomplete atrioventricular septal defects, which are ideal cases for residents. In addition, he did 5 tricuspid valve, 11 mitral valve, and 7 aortic valve cases. Although some of these cases will be more suitable for a congenital cardiac fellow rather than a thoracic resident, some of these cases are appropriate for residents. The fact is, these are the types of procedures, in addition to the four heart transplantations, that the thoracic residents are doing every day on the adult cardiac service. The fellow did 27 right ventricle-to-pulmonary artery conduit changes, many of which are ideal cases for thoracic residents. I doubt anyone will argue that a thoracic resident should not be able to do a pulmonary artery band (n = 6), a vascular ring (n = 1), or a patent ductus arteriosus (PDA) ligation (n = 2). There were six coarctations of the aorta. Before anyone says that thoracic residents cannot do a coarctation of the aorta, I have personally taken a 3rd-year general surgery resident through such a case in a 3-year-old patient with a coarctation.

Thus, if one is waiting for only ASDs and PVRs, yes, it may be difficult to find 10 cases for the thoracic residents to complete. However, the fact is that these residents are amazingly capable and talented women and men, and there are many cases they can perform, if we are willing to let them. Even if in programs that perform half or a third of the volume of ours, there are still more than enough.

“It’s not safe and now the STS is starting public reporting!”

In regards to patient safety and public scrutiny, of course patient safety does need to come first. However, I would use my own program’s outcomes as evidence that the residents and fellows can be allowed to operate with excellent outcomes. We allow them to perform a high proportion of all cases and even complete the most complex cases “skin-to-skin,” including Norwood and arterial switch operations. The Society of Thoracic Surgeons—European Association for Cardio-Thoracic Surgery (STAT) Mortality Categories classify congenital heart operations into five levels of mortality risk (1 = lowest, 5 = highest).

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