

Understanding Why Residents May Inaccurately Log Their Role in Operations: A Look at the 2013 In-Training Examination Survey

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Background. With increased time and quality pressures, it may be more difficult for residents in cardiothoracic surgery residency programs to get independent operative experience. That may lead residents to inaccurately report their role as “surgeon” to meet American Board of Thoracic Surgery (ABTS) case requirements.

Methods. The 2013 In-Training Examination surveyed 312 cardiothoracic surgery residents and was used to contrast residents in traditional 2-year and 3-year cardiothoracic surgery residencies (traditional, $n = 216$) with those in 6-year integrated or 3+4-year programs (integrated, $n = 96$).

Results. Traditional program residents reported a higher percentage of cases that met the ABTS criteria of surgeon than did integrated program residents ($p = 0.05$) but were less likely to meet requirements if all cases were logged accurately ($p = 0.03$). The majority of residents in each program believed that their case log accurately reflected their experience as “surgeon.” Residents who

tended to log cases incorrectly had lower self-reported 2012 In-Training Examination percentiles, were less likely to meet case requirements if logged properly, and felt less prepared for board examinations and eventual practice compared with residents who logged cases correctly (all $p < 0.001$). Residents who believed they would not meet case requirements if logged correctly cited limited surgical opportunities, poor case diversity, and a compromised training environment but not the 80-hour work week, excessive simulation, or disproportionate number of complex cases as causes.

Conclusions. Overall cardiothoracic surgery residents appear to be satisfied with their training. There were specific subsets of trainees in both traditional and Integrated programs that are misrepresenting their role on cases because they otherwise may not meet the requirements.

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Changes in work hour rules, demanding case requirements, more complex and sicker patients, increasing use of minimally invasive procedures, and growing scrutiny on outcomes have put pressure on cardiothoracic surgery education [1, 2]. Each cardiothoracic surgery resident must meet the minimum operative requirements of 125 major cases per year to be eligible for American Board of Thoracic Surgery (ABTS) certification

[3]. To log an operation as “surgeon,” the resident must perform “technical manipulations that constitute the essential parts of the patients operation” [3, 4]. The interpretation of this definition is at the discretion of the trainee. Increasing constraints may lead residents to inaccurately log their role during operations they record as surgeon. Evidence is lacking regarding the prevalence of inaccurate case logging among present-day cardiothoracic surgery residents.

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The Appendix can be viewed in the online version of this article [<http://dx.doi.org/10.1016/j.athoracsur.2015.07.047>] on <http://www.annalsthoracicsurgery.org>.

The aim of this study is to begin to identify the prevalence of and reasons behind inaccurate case logs by cardiothoracic surgery trainees. We hope that by understanding this phenomenon we will be better able to address the issues that lead trainees to feel the need to misrepresent cases to meet requirements.

Material and Methods

We examined results from the 2013 Thoracic Surgery Directors Association In-Training Examination (ITE) survey (see [Appendix](#)), a compulsory annual appraisal of a number of issues regarding thoracic surgery resident education. The ITE survey profiles approximately 300 Accreditation Council for Graduate Medical Education cardiothoracic surgery residents every year on a variety of topics regarding their residency programs and careers. Given the recent increase in integrated and combined general surgery/cardiothoracic surgery residencies, the most recent 2013 survey data were used to contrast the evaluations from residents in traditional 2-year, 2.5-year, or 3-year cardiothoracic residencies with those in the newer integrated 6-year or combined 3+4-year programs. It should be noted that junior residents (postgraduate years 1 through 3) in integrated programs are required to take the general surgery American Board of Surgery ITE and are not required to take the thoracic surgery ITE. In this anonymous survey, several questions asked residents to report how often they inaccurately record cases as “surgeon” rather than as “first assistant.” We examined three subgroups of residents that were reporting answers that suggest they are having some difficulty in the training program.

A total of 312 Accreditation Council for Graduate Medical Education residents completed the 2013 ITE survey, with 216 in traditional programs and 96 in integrated programs. That represents a 100% response rate; and these responses constituted our study group. [Figure 1](#) shows the distribution based on training year and [Table 1](#) shows the trend in respondents over time. The data supplied to the investigators are deidentified as to resident name, program name, geographic location, and any other potential identifier (eg, birthdate, social security number).

The ITE survey consisted of structured rating questions with a 5-point Likert scale, open-ended questions, and requests for demographic information. All responses remained anonymous. Descriptive statistics were calculated for quantitative responses. Quantitative survey responses were compared between groups using *t* tests and Wilcoxon-Mann-Whitney tests for Likert scale responses. The χ^2 and Fisher exact tests were used to compare responses between groups. Statistical significance was defined as a two-sided *p* value of less than 0.05.

Results

First, we tried to examine whether residents believe they are being well trained and prepared for the boards and to enter practice. By understanding how residents feel about their training it is hoped that we will have a context to examine why they may inaccurately log cases.

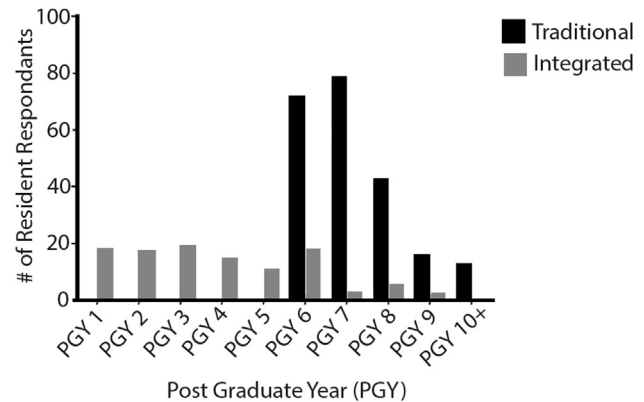


Fig 1. Distribution of residents based on training year. Traditional program (black bars) residents are those in 2-year and 3-year programs, whereas integrated programs (gray bars) are 6 years and 4+3 years. (PGY = postgraduate year.)

General Information

Most residents believed they would be adequately trained at the completion of the program (traditional 4.29 versus integrated 4.40, $p > 0.05$). Integrated residents were more likely to be interested in pursuing additional training compared with traditional residents (65% versus 39%, $p < 0.001$), and the most common reason for seeking additional training was to develop a specialized/niche practice (traditional 38% versus integrated 65%, $p = 0.05$). The most common area of interest for integrated residents was congenital heart surgery (22%), and for traditional residents, it was adult cardiac surgery (33%). More traditional residents (31%) than integrated residents (5%) were interested in general thoracic surgery.

Board Preparation

More trainees in integrated programs believed their program would adequately prepare them for the ABTS examination than traditional residents (4.21 ± 0.86 versus 3.97 ± 0.86 , respectively; $p = 0.01$). Similarly, traditional residents were more likely to pursue further educational activities (ie, review courses) to prepare for the ABTS

Table 1. Number of Trainees in Each Type of Training Program Over 4 Years^a

Training Program	2010	2011	2012	2013
Total	299	305	313	317
Traditional 2-year cardiothoracic residency	139	132	132	120
Traditional 3-year cardiothoracic residency	113	106	102	96
Combined 4+3 general/cardiothoracic	9	8	15	15
Integrated 6-year residency	28	45	51	81
Nonaccredited fellowship	4	11	8	3
Other	6	3	5	2

^a There has been a decrease in the number of traditional program residents and an increase in integrated program trainees; the year this study focuses on is 2013.

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