



Evolving Perceptions of the Plastic Surgery Integrated Residency Training Program

Elizabeth Pace, BS, Bruce Mast, MD, FACS,¹ Justine M. Pierson, MS, Adam Leavitt, BS, and Christian Reintgen, BS

Department of Plastic Surgery, University of Florida College of Medicine, Gainesville, Florida

OBJECTIVE: In recent years, there has been a transition in plastic surgery residency training. Many programs across the country are now using integrated training modalities vs. independent training programs. This change in residency training has brought into question the effectiveness of integrated residency programs, in which medical students immediately enter the plastic surgery specialty upon graduation. This study assessed plastic surgery residency program directors and faculty members' viewpoints on the transition to integrated training programs and the effect this transition has had on the training of plastic surgery residents.

DESIGN: An anonymous 13-question survey was formulated using a pilot survey sent to members of the plastic surgery department at the University of Florida. The final survey was then electronically sent via SurveyMonkey.com to 92 current plastic surgery residency program directors. Program directors were identified via program lists provided by the American Council of Academic Surgeons. Program directors were then asked to forward the survey to faculty members of their respective institutions. Responses collected were analyzed via SurveyMonkey.com and Microsoft Excel.

SETTING: University of Florida College of Medicine, Department of Plastic Surgery.

PARTICIPANTS: Plastic surgery residency program directors as identified by the American Council of Academic Surgeons.

RESULTS: A response rate of 40.2% was achieved via 37 of the 92 plastic surgery program directors responding to the electronic survey. An additional 6 anonymous faculty members also responded to the survey, 13.9% of all responses. Institutions indicated that the majority was using

integrated residency programs, with some institutions using both integrated and independent training programs simultaneously. Most respondents indicated that they supported the transition to the integrated residency program at their respective institutions. Respondents indicated several reasons as to why or why not programs have transitioned to the integrated program, with lack of funding being the primary indication of not making the transition. Upon responding with their level of agreement to several statements, respondents indicated that they agreed that the integrated training program is superior to the independent program and is not negatively effecting the specialty.

CONCLUSIONS: The transition to the integrated plastic surgery residency program is continuing to grow. Most respondents in this survey indicated their belief in the superiority of the integrated program. However, a large proportion of respondents stated that they neither agreed nor disagreed with several of the provided statements concerning which residency program is superior. Thus, further research is needed to discern whether or not the integrated program is in fact superior to the independent residency training program. (J Surg Ed 73:799-806. © 2016 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: plastic surgery, residency, training, integrated, independent

COMPETENCIES: Medical Knowledge, Professionalism, Practice-Based Learning and Improvement

INTRODUCTION

Many changing aspects of surgical practice and knowledge over the past few decades have led to an evolution of current residency training structures for surgical specialization. Increased patient knowledge and access to medical information, the rapid pace of technological advancement, as well as an increased understanding of the scientific basis for disease

Correspondence: Inquiries to Bruce Mast, MD, FACS and Elizabeth Pace, MS, Department of Plastic Surgery, University of Florida College of Medicine, 1600 SW Archer Rd, Gainesville FL 32603; fax: (352) 273-8639; e-mail: ekp09@ufl.edu, bruce.mast@surgery.ufl.edu

¹ Contact person: Shirley Ambrosino.

have all contributed to this demand for unique residency training for surgical subspecialties.^{1,2} It is due to factors such as these that training in surgical specialties is seeing an evolution to a separate full residency rather than a classic fellowship after core training in general surgery.³

Advocates for a change in curriculum for surgical training suggest that programs should first and foremost match future surgical practices as best as possible. Training modalities should then also be both efficient and broad, excluding irrelevant information and skills not needed for future focused practice, while also allowing for the support of life-long learning in a specific area of surgery.^{1,4} This focused training would allow less common clinical experiences required for the so-called core specialty (i.e., general surgery) to be more available to those who would remain within that field. Vascular surgery and cardiothoracic surgery were some of the first specialties to use this focused form of residency training. There are currently 51 and 24 integrated vascular and cardiothoracic programs vs. 106 and 67 independent programs, respectively (Table).

Otolaryngology, neurosurgery, and urology have long ago separated from the core of full general surgery training because of the anatomic specialization that lent itself to such separation. Plastic surgery training has largely remained an off-shoot of general surgery with the *independent* training program. This functioned similar to a fellowship as a 3-year program with most trainees having completed a core residency in general surgery, with small minority training in otolaryngology. However, recognition of a greater disparity of the specialty from general surgery led to a change in this format. In the 1990s, the *combined or coordinated* program was initiated in which trainees entered a 6-year program directly from medical school. The first 3 years was ostensibly the same as the postgraduate year 1-3 in general surgery, which were followed by 3 years in plastic surgery. Only a handful of programs opted for this change.⁵

The combined or coordinated program has been replaced by the *integrated* program. This is a 6-year core residency in plastic surgery, matriculating trainees through the match program, similar to all other core programs. The residency provides broad surgical exposure to trauma, vascular surgery, general surgery, as well as emergency medicine, orthopedics, and anesthesia. Additionally, oral maxillofacial surgery, head and neck surgery, and dermatology are frequent components.⁶ Over the past 5 years, there has been a surge in the transition to the *integrated* training model for plastic surgery. This shift has brought into question the program's effectiveness and efficiency as compared to the previous training programs. No studies have assessed surgical educator's viewpoints on the transition to the new curriculum, as well as the potential positive and negative aspects of using the integrated program. Furthermore, analysis of the factors involved in deciding on a change in residency training has not yet been done. This survey assesses these issues from the perspective

of the educators, specifically seeking their opinion regarding effectiveness of training, quality of trainees, effects on patient care, and institutional barriers. The questionnaire would also be used to begin to evaluate whether the shift in training modalities would improve graduating residents' capabilities to handle the ongoing evolution of the specialization.

METHODS

Current program directors of plastic surgery residency training programs across the United States were identified via program lists provided by the American Council of Academic Plastic Surgeons. A total of 92 plastic surgery residency program directors of both integrated and independent residency programs were identified. In June 2014, an anonymous 13-question survey was sent out electronically using surveymonkey.com. Program directors were asked to personally respond and also to forward the survey to members of their own faculty. The viewpoints of residency program faculty members were included in this study owing to their various personal interactions with teaching and working alongside resident physicians as opposed to the given program directors at their respective institutions. Results were analyzed using surveymonkey.com and Microsoft Excel. Then 2 subsequent reminded emails were sent as a means of maximizing responses.

The survey was designed to gather data regarding the type of training programs, the history of training at the institution, and timing of transition if a change in format occurred. Specific queries were made with the objective of assessing consensus regarding factors that influenced a change in format, as well as factors that affect overall training and career choices among trainees.

RESULTS

Demographics

Electronic surveys were sent to 92 plastic surgery residency program directors. Program directors were then asked to forward the survey to members of their faculty. Of the 44 anonymous responses, 37 program directors (86.1%) and 6 faculty members (13.9%) participated. The respective home institutions of the various respondents were not identified. From the 37 program directors of 92 originally queried, a 40.2% overall response rate was achieved. Of the respondents, 11.6% were female and 88.4% were male. Most respondents were 51 to 60 years of age (44.2%), with 11.6% aged 31 to 40, 27.9% aged 41 to 50, and 16.3% aged 60 years or older. Academic ranking at the respondents' current institutions was 4.65% clinical lecturers, 23.3% assistant professors, 11.63% associate professors, and 60.47% professors.

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