Attitudes and Perceptions of Surgical Oncology Fellows: The Right Voice at the Almost Right Time

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Surgical advances have historically been driven, to a great degree, by the effort to eliminate or control neoplastic disease. As a consequence, oncologic surgery and general surgery have evolved as one field, setting the basis for modern training in general surgery. This training paradigm was not questioned until the 1940s, when the emergence of the nascent fields of medical oncology and radiation oncology led some surgeons to recommend a distinct board of oncology under the oversight of the American Board of Surgery.¹

Over the next 7 decades, the discipline of surgical oncology continued to grow and evolve, resulting in the formation of its own society, the Society of Surgical Oncology (SSO), and a training mechanism under the oversight of the SSO. The subject of subspecialty recognition by the American Board of Surgery and American Board of Medical Specialties, however, continued to resurface periodically, but never gained sufficient support. On April 28, 2011, the American Board of Surgery announced a new certificate in complex general surgical oncology (CGSO). The detailed efforts of those who made the certification of CGSO a reality are recounted in the presidential address of Fabrizio Michelassi, MD, to the SSO.² Board certification, in general, is offered to

graduates of programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), and on June 10, 2012, the ACGME board of directors approved accreditation for CGSO programs meeting their standards.

The certification of CGSO as a specialty certainly raised significant debate within the general surgery community and among a segment of surgical oncologists. Although issues such as grandfathering and scope of practice were controversial points debated among practicing surgeons, issues pertaining to the training and certification of present and future surgical oncology fellows were not generally disputed. However, along with accreditation by the ACGME and certification by the American Board of Surgery came a mandate to strictly adhere to policies, procedures, and requirements of each organization, including adherence to duty-hour regulations, moonlighting restrictions, and an additional qualifying and certifying examination (in CGSO).

In this issue of *Annals of Surgical Oncology*, Lee et al. assess the opinions and understanding of present surgical oncology fellows and a subset of applicants for CGSO fellowships regarding board certification and ACGME accreditation of surgical oncology.³ The authors developed a 29-question survey designed to sample the attitudes and perceptions of those trainees enrolled in the 19 ACGME-accredited CGSO fellowships at the time of the survey (plus 3 Canadian programs that met the reciprocity criteria set by the American Board of Surgery). Thus, each of the potential respondents would be eligible to sit for the CGSO board examinations upon successful completion of their fellowship. The authors also offered the survey, on a voluntary basis, to candidates interviewing for the CGSO fellowship offered by the authors' institution. Therefore, although this survey was designed to sample the full spectrum of CGSO fellowships, the candidate responders represent a relatively small subset of surgical residents

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interviewing at one particular CGSO fellowship program, the John Wayne Cancer Institute in Santa Monica, California. Seventy-nine CGSO fellows responded out of a total of 110 surveyed, and 31 John Wayne Cancer Institute CGSO applicants completed the survey.

This study is clearly limited by its small sample size, especially the candidate cohort. However, with an average of 99 applicants entering the CGSO match each year for 57 positions, it will take a number of years before a truly comprehensive and statistically sound study on the attitudes and perceptions of CGSO trainees and applicants will be feasible (unpublished SSO Training Committee Report to the SSO Executive Council; CGSO match report for 2012–2014). Until such time as a larger, more robust survey is feasible, the present study offers some insights that should not be ignored. In fact, even the demographic data are of some interest: that there is no significant difference in the number of men versus women at either the CGSO fellowship level or the applicant level. Furthermore, 100 % of both CGSO fellows and applicants self-report a desire to enter an academic or academic-affiliated practice, which appear to be the landing zones for those seeking additional expertise to provide modern-day surgical management of cancer patients. Of course, the applicant data are specific to a single CGSO program and cannot be assumed to represent the broader CGSO applicant pool.

The study authors explored the attitudes of present fellows and applicants toward ACGME accreditation of CGSO fellowships. Approximately 80 % (80 % fellows, 79 % applicants) of overall respondents stated that ACGME accreditation of the fellowship programs did not influence their decision to enter the discipline of surgical oncology. For the fellow cohort, it is likely that the training program they were attending transitioned from SSO oversight to ACGME accreditation during the time they were attending. Therefore, it is difficult to interpret the impact of accreditation on their decision. However, one way to interpret the low impact of ACGME accreditation on the decision to enter surgical oncology is that for those surgical trainees pursuing surgical oncology, their interest in the subspecialty outweighed the specifics of oversight and regulations. This mind-set may well evolve as the real or perceived significance and value of added subspecialty certification in CGSO becomes apparent in the future. A second possibility is that these trainees became accustomed to ACGME oversight during their general surgery training and it did not play significant role in their fellowship decisions. Finally, those surveyed may not fully appreciate the potential benefit to their training and subsequent clinical practice of a standardized and tested curriculum because the process is only in its infancy. Likewise, the impact of public perception regarding added certification in surgical oncology can not yet be appreciated or measured.

More significantly, whereas 56 % of fellows stated they would be more likely to apply to an ACGME-accredited CGSO fellowship program over a nonaccredited program, 84 % of applicants responded that ACGME accreditation would influence their decision. This difference was statistically significant. Once again, it is difficult to interpret the fellow response, considering that this group of fellows predated ACGME oversight. The applicant response is more telling and likely reflects the candidates' recognition that attending an ACGME-accredited program represents the only viable path towards achieving Board certification in CGSO (accredited Canadian program graduates may apply for reciprocity by the American Board of Surgery) and obtaining the perceived added value of this subspecialty certificate. The concept of the added value of an American Board of Surgery subspecialty certificate is addressed by the survey as well. The overwhelming majority of respondents (78 % of overall subjects, 75 % of fellows, and 81 % of candidates) believed that CGSO certification makes surgical oncology a more attractive subspecialty to general surgery residents. Seventy-three percent of fellows and 94 % of candidates felt that obtaining board certification would be helpful in their effort to obtain their career goals. The majority also confirmed that obtaining certification is important. Therefore, at least from perspective of trainees, there does appear to be an added value to certification in CGSO.

Because eligibility for CGSO certification requires successful completion of an ACGME-accredited fellowship, the SSO agreed to discontinue oversight and the approval process for surgical oncology fellowship programs once the ACGME assumed responsibility. This represented a significant culture shift in the discipline of surgical oncology, as the SSO had prided itself on its training programs for decades. In fact, education and learning still remains a critical component of the SSO's mission and values.⁴ Although the transfer of oversight to the ACGME stimulated significant debate among many SSO members, there was little feedback from the trainee point of view. Nearly half of the respondents of this survey answered that the ACGME regulations will not affect the training of surgical oncologists. The authors attributed this interesting response to the fact that the SSO has had vigorous oversight of their training programs for decades and had encouraged their programs to follow many ACGME initiatives before the official transfer of oversight. Although we certainly hope that this is true, we are not at all surprised that the trainees and applicants thought that the ACGME oversight would have little impact on their training in surgical oncology. These applicants and trainees have, in essence, come of age under ACGME regulations and oversight. Duty-hour regulations, core competencies, and the Milestones Project may all be new to the practicing

surgical oncologist and surgical oncology faculty at academic medical centers, but general surgery residents and their program directors have been working within this system for years. Had the authors surveyed the CGSO program directors, which unfortunately they did not, we suspect the program directors would have expressed significantly more concern about the impact of the ACGME on CGSO training than the fellows and applicants did. This is not to say that the majority of CGSO program directors did not prepare well in advance for ACGME oversight. We know that they did. However, implementation is always more challenging when it comes to new training paradigms.

The article presented additional interesting data worthy of discussion, but these data are not the focus of this editorial. What makes this article unique and valuable, even with its small sample size and extremely limited candidate group, is that it captures the opinions and feelings of the trainees at the moment of birth of a new subspecialty. The subjects of this study were vulnerable (new training oversight, new rules, and new exams), but they also had the most

to gain (board certification in CGSO). A larger sample size, a more representative candidate group, and a survey of present CGSO program directors would have enhanced this article, but future surveys and publications will no doubt address these concerns. Throughout the multidecade debate surrounding CGSO subspecialization, voices of trainees were infrequently heard. It is to the authors' credit that they have given CGSO trainees a voice, at a critical time, when, we hope, all of the key players are listening.

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