See Article page 353.

Commentary: Perspectives after surgical training in Japan and the United States

Yota Suzuki, MD, and Ikenna Okereke, MD

Combining the perspectives of 2 surgeons, one a former thoracic surgery mentee of Dr Asamura and the other a current cardiothoracic surgery program director in the US, presents a unique opportunity to discuss the article by Ikeda and colleagues.¹ Dr Asamura, best known for his contribution to the current lymph node map and staging system,^{2,3} has been an influential figure in thoracic surgery around the world. Our combined experiences have allowed us to compare the experiences of training in Japan versus the United States. From the viewpoint of a trainee who has experienced both systems, we see some advantages in each approach.

As the authors described, the thoracic surgeon in Japan has relatively less general surgery exposure, with only 3 years of general surgery in the standard Japanese system and only 1 year of general surgery in the integrated Japanese system. It is true that an earlier focus on subspecialty surgery is trending in the United States.⁴ And a recent survey showed that only 4% of integrated cardiothoracic residents in the United States plan to perform general surgery during their career.⁵ Despite these data, trainees in the United States have much more familiarity with general surgery than those in Japan.

This decreased breadth of training in Japan highlights a major paradigm difference in Japan. Training in Japan is often for a more specific role and a more precise geographic location. An early focus on thoracic surgery

Yota Suzuki, MD, and Ikenna Okereke, MD

CENTRAL MESSAGE

The training of thoracic surgeons in Japan differs from that in other countries. Examining these differences will help training in all countries to evolve in the face of changing needs of the public.

is beneficial for exposure and continuous interaction with the same attending. And trainees in Japan are much more likely to stay with their institution even after certification. Most trainees develop a relationship with their mentors as an apprenticeship, a relationship that can last for many years after official certification. Given this model, the more specialized training seems better suited for Japan.

An old Japanese saying is that the sushi chef needs “3 years to learn to cook rice, and then 8 more years to learn to make sushi.” The Japanese system has favored a longer time of subspecialized technical training, with a “watch and learn” model from a technical master. The narrower scope of surgeries has led to most thoracic surgeons in Japan not performing surgeries below the diaphragm. As more countries, including the United States, adopt integrated training pathways, it will be important to document whether the range of surgeries decreases. Will thoracic surgeons in the United States be less likely to perform hiatal hernia repairs, Heller myotomies, and jejunostomy insertions over time? Is an increased focus by thoracic surgeons on operations in the chest a benefit for public health? Do thoracic surgeons risk losing particular cases forever by increasing the amount of integrated training?

Strategies for training thoracic surgeons vary around the world. These strategies are strongly influenced by culture and patterns of employment in each country. It will be crucial for institutions to compare training pathways

From the Division of Cardiothoracic Surgery, University of Texas Medical Branch, Galveston, Tex.

Disclosures: The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication Nov 29, 2020; revisions received Nov 29, 2020; accepted for publication Dec 1, 2020; available ahead of print Dec 5, 2020.

Address for reprints: Ikenna Okereke, MD, Division of Thoracic Surgery, University of Texas Medical Branch, 301 University Blvd, Galveston, TX 77555 (E-mail: ikokerek@utmb.edu).

J Thorac Cardiovasc Surg 2022;163:359-60

0022-5223/\$36.00

Copyright © 2020 by The American Association for Thoracic Surgery

<https://doi.org/10.1016/j.jtcvs.2020.12.003>

internationally and to understand the consequences of each pathway for thoracic surgery in that country.

References

- Ikeda N, Asamura H, Chida M. Training program of general thoracic surgery in Japan: present status and future tasks. *J Thorac Cardiovasc Surg.* 2022;163:353-8.
- Rusch VW, Asamura H, Watanabe H, Giroux DJ, Rami-Porta R, Goldstraw P. The IASLC lung cancer staging project: a proposal for a new international lymph node map in the forthcoming seventh edition of the TNM classification for lung cancer. *J Thorac Oncol.* 2009;4:568-77.
- Asamura H, Chansky K, Crowley J, Goldstraw P, Rusch VW, Vansteenkiste JF, et al. The International Association for the Study of Lung Cancer lung cancer staging project: proposals for the revision of the N descriptors in the forthcoming 8th edition of the TNM classification for lung cancer. *J Thorac Oncol.* 2015;10:1675-84.
- Zhu Y, Goldstone AB, Woo YJ. Integrated thoracic surgery residency: current status and future evolution. *Semin Thorac Cardiovasc Surg.* 2019;31:345-9.
- Tchanchaleishvili V, Lapar DJ, Stephens EH, Berfield KS, Odell DD, Denino WF. Current integrated cardiothoracic surgery residents: a Thoracic Surgery Residents Association survey. *Ann Thorac Surg.* 2015;99:1040-7.

See Article page 353.

Commentary: Thoracic surgery trainees on the launching pad: When will they be ready to fly?

Taryne A. Imai, MD

Variations of curricular components and assessment metrics exist among cardiothoracic surgery training around the world. Some of this variation may be due to cultural differences among different countries, differing standards of accreditation, or differing medical workforce needs.¹⁻³ Despite international differences in training, we share a common goal of graduating thoracic surgeons who can competently operate and are ready for independent practice. However, how do we know when our trainees are ready to “fly” on their own, especially when definitions of competence and perceptions of preparedness still remain ambivalent? In this issue of the *Journal*, Ikeda and colleagues⁴ detail the structure and requirements of thoracic surgery training in Japan. The authors also discuss how they mitigate declining levels of autonomy during training with a postcertification apprenticeship-type practice.

The ideal length of training and the timing of when specialty training should be introduced is globally debatable,

Taryne A. Imai, MD

CENTRAL MESSAGE

The Japanese training system exemplifies the importance of mentorship in producing competent thoracic surgeons ready to “fly” on their own.

with many programs now offering a variety of permutations and tracks. The Japanese system is no different and offers 2 types of thoracic surgery tracks. The traditional program is composed of 3 fundamental years in general surgery followed by 3 subspecialty years in thoracic surgery. In 2018, Japan introduced an integrated program, with a focus in general surgery for the first year, followed by the option for early introduction in thoracic surgery for the remaining 2 years. After the completion of these 3 fundamental years, trainees then proceed to subspecialty training in thoracic surgery. Although training requirements are the same for both tracks, trainees in the integrated track who complete all the requirements may finish in fewer than 6 years due to early introduction of thoracic surgery. Overall, the length of training in Japan is shorter when compared with the training system in the United States. In addition, the

From the Division of Thoracic Surgery, Department of Surgery, Cedars-Sinai Medical Center, Los Angeles, Calif.

Disclosures: The author reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication Dec 14, 2020; revisions received Dec 14, 2020; accepted for publication Dec 15, 2020; available ahead of print Dec 26, 2020.

Address for reprints: Taryne A. Imai, MD, Division of Thoracic Surgery, Department of Surgery, 8631 W. 3rd St, East Tower, Suite 240E, Los Angeles, CA 90048 (E-mail: Taryne.Imai@cshs.org).

J Thorac Cardiovasc Surg 2022;163:360-1
0022-5223/\$36.00

Copyright © 2021 by The American Association for Thoracic Surgery
<https://doi.org/10.1016/j.jtcvs.2020.12.072>