EDITORIAL

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Thoracic surgery residency: It's a long way to the other side of the table!

When you're a junior resident scrubbing with a senior surgeon on a given case it can be very illusory. There's music playing, the chief might be chatting about some football game last night, and whatever case it is, uniportal lobectomy, bronchoplasty, tubeless pleurectomy, whatever, can seem to happen almost effortlessly.

But, performing thoracic surgery is not at all like a train going along tracks to a predetermined destination with the chief being the engineer making minor adjustments. Rather, once you're on the surgeon's side of the table, perhaps a better analogy is carrying an injured patriot on your back through the jungle with booby traps right and left and no map, trying to navigate to base.

Training in thoracic surgery never has been idyllic and likely never will be. It is intense and rigorous. The justification for this intensity is, and always has been, the magnitude of patient illness in those who need thoracic interventions for lung cancer. This disease burden warrants nothing less than the best effort that trainees and attending staff can provide. But, this intensity translates into the opportunity to participate in many different clinical situations in a short time. It allows to absorb as much experience and mentorship as possible.

Undoubtedly, mentors are a part of the answer to this question. First and foremost, mentors come in many forms. Of course, there are mentors who have an impact, whether good or bad, during your training. The clear message is that mentors after your training are as important, if not more so, than mentors during your training. We are a product of those who came before us. A large part of this experience is passed down from professors and mentors. There are opinions, advice, technical skills, and approaches that influence us every day. Each is valuable in the moment that it is needed.

The idea is to walk away with the best from everyone, to immerse into a culture that will support one for a lifetime. There are innumerable aspects to a successful and competent surgeon: technical ability, knowledge, and judgment among many others. We all develop and then continue to evolve a style. The evolutionary pressures put on by a training program will be the most important part of the internship.

Another point to make is that learning is lifelong. I would suggest that is the most valuable thing to learn in training - learning is lifelong. Learning to be a thoracic surgeon is a dynamic process that must of necessity change with changing times. It is almost axiomatic that a new graduate in an existing practice will adapt and learn from the practice partners. The culture of learning developed in residency training must persist into practice and that this ''culture of learning'' is the most important thing that you learn in your training.

Part of the fun, and the imperative, of thoracic surgery is to embrace new technology (uniportal, robotic, etc.) and new or modified procedures, and thus to embrace learning. To do this, it is necessary to fall back on the learning pattern that was, I would hope, instilled in residency training.

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