RRC NEWS
ANESTHESIOLOGY

Accreditation Council for Graduate Medical Education

MARCH 2011

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Simulation: New Revision to Program Requirements

At its February 6-8, 2011 meeting, the ACGME Board of Directors approved the following focused revision to the Program Requirements for Anesthesiology:

> *IV.A.6 Residents must participate in at least one simulated clinical experience each year.*

This requirement becomes effective on July 1, 2011; associated changes to the program information form (PIF) will also be posted at that time.

To assist program directors in understanding expectations for the simulation experience, the Review Committee has developed a Frequently Asked Question, which will be added to the FAQ document posted on the Committee's web page soon. In it, the Committee states that residents must participate in at least one yearly simulated intra-operative clinical experience that serves to improve and assess medical knowledge, interpersonal and communication skills, professionalism, systems-based practice, and/or practice-based learning and improvement. While the simulation experience can be provided in a formal simulation center, the Committee does not require that any program uses a formal simulator or have a simulation center. However, programs are encouraged to incorporate surgeons and nurses into the simulation experience. The Committee also believes that a formal debriefing mechanism is an important component of each simulation session in order to ensure that the participants receive meaningful competency-based outcomes assessment.

The following will be added to the PIF, in the "Patient Care—Clinical Experiences (Anesthesiology) section:

Do residents participate in at least one simulated experience each year?	Yes/No

Describe the simulation experience, including details on:

1. how the experience serves to improve:
   a. Medical knowledge
   b. Interpersonal and communication skills
   c. Professionalism
   d. Systems-based practice
   e. Practice-based learning and improvement

(cont. p.2)

MEETING AND AGENDA CLOSING DATES

MEETING:	APRIL 28-29, 2011
AGENDA:	**CLOSED**
MEETING:	OCTOBER 27-28, 2011
AGENDA CLOSING:	AUGUST 18, 2011

NOTIFICATION DEADLINES

5 DAYS AFTER MEETING:
E-MAIL NOTIFICATION OF REVIEW STATUS/CYCLE LENGTH AUTOMATICALLY SENT TO PROGRAM DIRECTOR AND DIO

60 DAYS AFTER MEETING:
E-MAIL ALERT SENT STATING THAT LETTER OF NOTIFICATION IS POSTED IN ADS.

UNTIL THE OFFICIAL LETTER IS POSTED IN ADS, REVIEW COMMITTEE STAFF MEMBERS ARE UNABLE/NOT PERMITTED TO DISCUSS THE COMMITTEE'S ACTION OR SPECIFIC DETAILS OF THE AREAS OF NON-COMPLIANCE.

2. how and what other personnel (e.g., surgeons, nurses) are incorporated in the experience
3. the formal debriefing mechanism that is used

Update on Impact of Approved Revisions to the Common Program Requirements on Specialty-Specific Program Requirements

Revisions to the ACGME Common Program Requirements related to duty hours in the learning and working environment were approved by the ACGME Board of Directors on Monday, September 27, 2010 with an effective date of July 1, 2011. The revised Common Program Requirements include several sections that necessitate further specialty-specific requirements or definitions. Several of these areas, as denoted by an asterisk below, required immediate action; others may be developed over the next year for implementation in July 2012. No other additions will be made to the duty hour section or other sections of these requirements.

The following areas required specialty-specific definitions to be developed by each Review Committee. Included with each area is a brief summary of what the Review Committee developed:

1. Define licensed independent practitioners who may have primary responsibility for patient care (VI.D.1).
   - *The Review Committee made no provision for any other independent practitioners to have primary responsibility for anesthesiology residents.*
2. Describe achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available (VI.D.5.a.1).
   - *The Review Committee added no specialty-specific language to this section. PGY-1 residents in anesthesiology are considered in the clinical base year (CBY). These residents must achieve competencies specific to each rotation.*
3. Specify optimal clinical workload (VI.E).
   - *The Review Committee added no specialty-specific language to this section at this time. It will study this area during the coming year to determine how it will further specify optimal clinical workload.*
4. Define elements of teamwork that must be present in each specialty (VI.F).
   - *The Review Committee added no specialty-specific language in this area. The current requirements already include expectations for teamwork.*
5. Define Intermediate level residents and residents in the final years of education (senior level residents) (VI.G.5.b and c).*
   - *The Review Committee has defined that intermediate level residents are those who have completed all goals and objectives of the CBY and CA-1 year and have progressed to the CA-2 year. Senior residents are those who have achieved the goals and objectives of all core rotations and fulfilled all minimum case requirements.*
6. Define circumstances when "senior residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty (VI.G.5.c.1)."*
   - *The Review Committee will provide some additional language by which to judge circumstances under which senior residents may stay on duty with fewer than eight hours free.*
7. Review Committees may specify the maximum number of consecutive weeks of night float and the maximum number of months of night float per year (VI.G.6).*
   - *The Review Committee will not limit the maximum number of weeks of night float at this time.*

All Review Committees submitted their revisions to the ACGME, for review and approval at the recent ACGME Board meeting. The final, approved language was posted on the ACGME website on March 1, 2011, and becomes effective July 1, 2011. Any additional information that develops will be provided in future editions of this newsletter.

Subspecialty Program Requirements Update

The Review Committee is currently in the process of revising the program requirements for adult cardiothoracic and pediatric anesthesiology, as well as for critical care medicine. The proposed revised documents will soon be posted for review and comment on the ACGME website. Look for an announcement of the posting in the ACGME's weekly *e-Communication*.

Proposed requirements for graduate medical education in obstetric anesthesiology, a new subspecialty, were recently posted for review and comment on the ACGME website. The deadline for submission of any comments regarding this set of requirements has already passed. Information on the further development of these requirements will be communicated via the ACGME's weekly *e-Communication*, as well as future editions of this newsletter.

Listing Resident Complement

The Review Committee recently changed the way that program listings and accreditation letters of notification in the Accreditation Data System (ADS) reflect a program's approved resident complement. The Committee has always expected that a program's "total number" of residents, i.e., the only number that had previously been reported, was to be evenly distributed across the three years of clinical anesthesia (CA) education. Four-year programs (with integrated clinical base years), could accept up to one third of that "total number" into the first year of the program. For example, if a three-year program was approved for 30 residents, the Committee expected an even distribution of 10 residents at each level. If a four-year program was approved for 30 residents, the Committee expected no more than 10 residents in the first year, and an even distribution of 10 residents in each of the three CA years. However, those expectations were not previously made explicit by the Committee, and this lack of clarity has historically been a source of confusion among program directors and designated institutional officials (DIOs).

In an effort to clarify the resident complement, the Review Committee now reports the approved resident complement number by level, in addition to the total number of residents in the entire three- or four-year program. The three-year program previously listed as "30 total residents" is now reported as 10-10-10 [30]. The four-year program previously listed as "30 total residents" is now reported as 10-10-10-10 [40]. This change does not mean that a program cannot have a slightly uneven distribution in its complement; however, this new reporting format now requires that all variations in resident complement for a period of more than three months be formally requested through ADS as a "temporary increase in resident complement." A variation within a single year by one or two residents should generally expect a quick approval; greater variations will be reviewed by the Committee on a case-by-case basis.

Faculty Equivalent Qualifications

Core Programs: The Program Requirements for Anesthesiology state that a program's physician faculty—including the program director—"must have current certification in the specialty by the American Board of Anesthesiology (ABA), or *specialty qualifications that are acceptable to the Review Committee*." Many program directors and DIOs ask exactly what specialty qualifications are acceptable to the Review Committee in lieu of ABA certification. The most straightforward answer is that there is generally no equivalent to ABA certification. However, the Committee has regarded experience plus certification from international Boards as acceptable, so long as the individuals are in the process of obtaining ABA certification (i.e., through the "Alternate Entry Path to Specialty Certification Examinations" [see *Booklet of Information*, American Board of Anesthesiology, February 2010, p. 41]). In most cases, certification by the Royal College of Physicians and Surgeons of Canada or the Royal College of Anesthetists is also acceptable.

Subspecialty Programs: In general, the Review Committee will accept experience in place of certification for adult cardiothoracic, pediatric, and soon-to-be-approved, obstetric anesthesiology, for which no certification currently exists. However, in these subspecialties, faculty must be certified in anesthesiology, or showing evidence of progress toward certification. For critical care and pain medicine, faculty members must provide evidence of certification in critical care and pain medicine. The same expectations for international medical graduates apply to subspecialty programs as with the core anesthesiology program.

Interim Approval for New Program Directors

The Program Requirements for Anesthesiology outline the qualifications necessary for appointment as program director. In addition to certification, licensure, and medical staff appointment, those qualifications include:

> *II.A.3.e. faculty experience, leadership, organizational and administrative qualifications, and the ability to function effectively within an institutional governance. The program director must have significant academic achievements in anesthesiology, such as publications, the development of educational programs, or the conduct of research.*

Program director changes must be reported through ADS. At its spring and fall meetings, the Review Committee considers all information regarding program directors changes to determine whether appointees meet these qualifications. Until the Committee formally approves the appointment, it recognizes the appointee as an "interim" program director. It is not unusual for the Committee to request additional information or to suggest that a more qualified person be appointed to the position. The Committee may also move up a site visit in order to evaluate whether the appointment of a new program director has had any adverse impact on the educational program. On occasion, the Committee may approve a program director upon condition that

that he or she engages in additional professional development, or that a mentoring process to support the new program director be instituted.

Expectations for the Clinical Base Year (CBY)

The Review Committee has noted that program directors continue to express some confusion regarding expectations for the educational content of the CBY. Program requirement Int.B.2.a outlines expectations for the CBY that apply regardless of whether this year is part of an integrated program or is a separate year prior to a three-year program. These align with the ABA's qualifications to sit for the certification examination.

Notably, the CBY must occur in a program accredited by the ACGME. In addition, all CBY requirements must be met before the resident enters the final (CA-3) year of the program if not completed as part of the CBY.

The Committee also notes the following clarifications to the component requirements of PR. Int.B.2.a).4)…":

At least six months of the Clinical Base Year rotations must include experience in caring for inpatients in internal medicine, pediatrics, surgery, or any of the surgical specialties, obstetrics and gynecology, neurology, family medicine, or any combination of these. In addition, there should be rotations in critical care and emergency medicine, with at least one month, but no more than two months, devoted to each. Up to one month may be taken in anesthesiology. Rotations should ensure continuity of teaching and clinical experience. Each month of training may be counted only once. For example, a rotation in a pediatric intensive care unit may count as either a month in pediatrics or a month in critical care medicine.

- "At least six months of the Clinical Base Year rotations must include experience in caring for **inpatients**…"

As noted, these six months must be spent on inpatient services; ICU rotations cannot substitute for these inpatient rotations. The Review Committee is aware that a misleading example is included at the end of this program requirement which suggests that an ICU month can be used to fulfill the inpatient care experience. This example is no longer consistent with the Committee's expectations, and will be removed during the next revision to the program requirements. The Review Committee expects that programs will adjust their CBY rotations accordingly beginning **July 1, 2011**, since it may be impossible to make immediate changes in the curriculum during the current academic year.

- "…In addition, there should be rotations in **critical care**…"

The maximum of two months of critical care medicine includes any ICU rotation and these rotations cannot be counted as part of the CBY requirement for six months of inpatient experience.

- "…Up to one month may be taken in **anesthesiology**…"

In this requirement, "anesthesiology" refers to intra-operative or procedural anesthesia rotations, and does not refer to *every* kind of rotation sponsored by an anesthesiology program or department.

Resident Case Log System: "Resident Minimums Report"

Program directors are aware of the mandatory use of the ACGME Resident Case Log System (PR II.A.4.q). and s).), and the minimum numbers of procedures that residents are required to perform during the program (PR IV.A.5.a).(1).a).-l).). However, they may not be aware of a report available for monitoring residents' progress in reaching those minimum numbers. The "Resident Minimums Report," available on the "Reports" tab in the system, can be viewed by both the resident and the program director, who can tell at a glance how many procedures a given resident has performed in any of the areas for which there is a required minimum number—and that minimum number is printed directly beside the resident's total on the report.

The Review Committee thanks the observant program directors who called its attention to some discrepancies between the program requirement language and the language used on the report, which was causing some confusion. The Committee is pleased to report that there is now complete congruence between the requirements and the minimums report.

2011-2012 will be the third year that programs have used the revised system, which requires reporting of individual cases by the resident rather than aggregate totals. Therefore, in the fall of 2012, the ACGME will analyze the data from the first cohort of graduates that used the revised system for all three of the clinical anesthesia years of their programs. The Review Committee looks forward to sharing those data with program directors late next year.

Faculty Roster in Program Information Forms Includes Four Educational Activity Categories

In order to be consistent with all other specialties, the ACGME has revised the Faculty Roster in the

Common PIF for the following specialties: anesthesiology, colon and rectal surgery, dermatology, family medicine, medical genetics, nuclear medicine, obstetrics and gynecology, orthopaedic surgery, pathology-anatomic and clinical, pediatrics, physical medicine and rehabilitation, and radiation oncology, as well as for the transitional year. The revision expanded the 'Average hours/week devoted to Resident Education' to include four categories - clinical supervision, administration, didactic/teaching, and research. NOTE: the total number of hours worked previously entered for each faculty member has been stored; however, the data for these four categories will initially appear as zeros. For each faculty physician listed in the PIF roster, the program must insert the hours for each category of resident education according to the following legend (in the future this information will appear in the PIF as a 'mouse over').

Category of Resident Education	Examples of Resident Educational Activities
Clinical supervision	Bedside rounds; outpatient precepting; operative supervision
Administration	Program oversight; curriculum development; faculty, resident and program evaluation; career counseling
Non-clinical didactics/teaching	Lectures; simulation; case discussions; preparation time for and participation in: journal clubs, conferences, lectures, simulation, case discussions, manuscript editing with resident
Resident research	Mentoring and/or working with residents/fellows; peer-reviewed funding; publication of original research or review articles in peer-reviewed journals or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; participation in national committees or educational organizations

Changing a Dependent Subspecialty Relationship from One Specialty/Core Program to a New Specialty/Core Program Requires Review Committee Approval for Subspecialty Programs in Hospice and Palliative Medicine

Dependent subspecialty programs are required to function in conjunction with an ACGME-accredited residency (also known as a specialty or core) program. The continued accreditation of the subspecialty is dependent on the specialty program's maintaining its accreditation. The dependent subspecialty program must be sponsored by the same ACGME-accredited sponsoring institution of the linked specialty program and should be geographically proximate to the specialty program. In the case of hospice and palliative medicine, the Review Committee for Family Medicine accredits all of these programs, which may be aligned with specialty programs in anesthesiology, emergency medicine, family medicine, internal medicine, neurology, psychiatry, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, radiation oncology, or surgery.

Should any of hospice and palliative medicine programs need to realign and establish a new dependent relationship with a new specialty/core program, the program director of the subspecialty program must first request voluntary withdrawal of accreditation through ADS, and then formally submit a new application to the Review Committee for Family Medicine, per that Committee's process. The sponsoring institution's GMEC and DIO must approve both the voluntary withdrawal and the new application.

ACGME staff members of the Review Committee for Anesthesiology can answer questions and provide guidance about this process. Contact information can be found on p.1 of this newsletter.

Proposals for Innovative Projects

The Review Committee accepts proposals for innovative projects from programs reviewed during a Committee meeting. Instructions and criteria regarding submitting such proposals can be found on the Review Committee's web page on the ACGME website, or via this direct link: www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp. An innovative project is one that typically requires some variation from existing requirements. The Committee studies these proposals very carefully. Program directors should expect that approval for these projects may take as long as a year of ongoing dialogue with the Committee. In addition, all innovative projects automatically require an annual progress report to the Committee to determine whether the project can continue or not.

Frequently Asked Questions

The Committee has recently undertaken a review of its FAQ document (available on the Committee web page). A revised set of FAQs will be posted in the near future. Watch for an announcement of the posting in the ACGME's weekly *e-Communication*.

AN@acgme.org

In an effort to improve communication with Review Committee staff, a new mailbox has been created specifically for anesthesiology. AN@acgme.org should be used by program directors and coordinators for any "routine" questions regarding program requirements, PIFs, and for general questions about ACGME accreditation procedures or processes. This mailbox is monitored daily, and the Committee staff is committed to responding to these questions within approximately two business days, barring any more complicated issues, which may take longer.

Note that use of the mailbox is not meant to interfere with relationships that program directors and coordinators have developed with staff members, and that staff members still welcome direct communication by e-mail or phone. However, as there is always a staff member "on-call" to the AN mailbox, questions submitted that way are guaranteed a quick response. The mailbox will also serve as a repository which will allow staff to collate and categorize questions and answers, leading to standard responses and FAQs to benefit the broad anesthesiology community, an additional reason to use this valuable tool.

Also note that there are other specific mailboxes for the following categories:

Accreditation Data System: webADS@acgme.org
Resident Case Log System: oplog@acgme.org
Resident Surveys: ressurvey@acgme.org

How Are We Doing?

The ACGME's **Department of Accreditation Committees** has been making a concerted effort to improve newsletter content.

Please e-mail Editor Maayan Schwab (mschwab@acgme.org) with feedback on articles in recent issues --

were they useful? interesting? informative?
what are we missing?
what would make them even better?

We thank you in advance for your interest and suggestions!