

**LONGITUDINAL CARE EXPERIENCE DURING RESIDENCY AND FELLOWSHIP TRAINING IN
ANESTHESIOLOGY**

After discussion during the February and March 2007 meetings of the RRC for anesthesiology, the Committee felt that the best approach to improving resident involvement in longitudinal care of their patients was to provide further guidance to Program Directors in the form of a detailed FAQ. Here is the wording we propose and a link to the revised document on longitudinal care:

Q. What are the RRC's expectations regarding pre- and post-op requirements?

A. Every department should define and describe on the Program Information Form a standardized approach to ensuring continuity of care from the preoperative setting through the postoperative period. Every resident or fellow must have the information needed to anesthetize the patient and have postoperative follow-up in both the immediate and longer-term periods. How this is accomplished will vary from one department to another, and the RRC encourages individual programs to be innovative to their approach. For a detailed discussion of anesthesiology resident and fellow involvement in longitudinal care as well as a suggested approach for programs, please refer to the following document: [LONGITUDINAL CARE EXPERIENCE DURING RESIDENCY AND FELLOWSHIP TRAINING IN ANESTHESIOLOGY](#).

LONGITUDINAL CARE EXPERIENCE DURING RESIDENCY AND FELLOWSHIP TRAINING IN ANESTHESIOLOGY

Background:

Clinical anesthesia training during the CA-1 through CA-3 years, as well as during training in many of the anesthesiology subspecialty fellowships, must encompass all aspects of perioperative care and must provide sufficient exposure to the decision-making process leading to choices during anesthetic management and the consequences of the anesthetic management to allow residents to develop the sound clinical judgment that will allow them to function as consultants in anesthesiology. This judgment can take hold only by assuring that all residents and fellows witness the care of individual patients, from the pre-operative evaluation through to recovery and hospital discharge, or perhaps beyond hospital discharge when appropriate. At present, the ACGME Program Requirements for Graduate Medical Education in Anesthesiology contain few provisions that will assure that all residents will attain this type of exposure to longitudinal care of the same patient throughout the perioperative period. Indeed, many recent changes have lowered the chance that a given resident or fellow will care for their own patients from pre-operative evaluation through to discharge. It is common for patients to be seen in an outpatient setting for preoperative evaluation days or weeks before planned surgery; on-call schedules mandate that residents and fellows are often relieved during the course of providing anesthesia for any given patient; and many patients are discharged soon after surgery. All of these aspects of modern medicine reduce the probability that residents and fellows will learn to effectively assess the anesthetic implications of co-existing disease in their own patients, decide on a course of action for intraoperative anesthesia, and then see the consequences of their own choices following surgery.

At present, the only language contained within the Program Requirements that speaks directly to the need for residents to document their involvement in both pre- and postoperative care is the following:

“A comprehensive anesthesia record must be maintained... The patient’s medical record should contain evidence of preoperative and postoperative anesthesia assessment.”¹

This language has been largely interpreted by Program Directors to mean that a pre- and postoperative note must be in place on each patient’s chart, and nothing more. Given the limits of short hospital stays, outpatient surgery, and call schedules, it is a difficult task to get even marginal compliance among residents and fellows in writing postoperative notes, thus this provision is largely viewed as of marginal benefit to the overall training process. The idea that routinely visiting patient’s postoperatively and writing brief follow-up notes seems to provide little in the way of the longitudinal care we are trying to assure that all residents and fellows receive.

An approach to assuring experience with “continuity of care” during residency and fellowship training in anesthesiology:

Every department should define and describe on the Program Information Form a standardized approach to ensuring continuity of care from the preoperative setting through the postoperative period. Every resident must have the information needed to anesthetize the patient and have postoperative follow-up in both the immediate and longer-term periods. How this is accomplished will vary from one department to another, but the essential components needed to assure resident exposure to continuity of care include the following:

Preoperatively:

¹ ACGME Program Requirements for Graduate Medical Education in Anesthesiology, Section F. Clinical Components, 2. Clinical Documentation, b) Patient Records; 2008 revised ACGME Program Requirements for Graduate Medical Education in Anesthesiology, Section H. Clinical Documentation, 2. Patient Records.

- All residents must gain experience in preoperative clinical assessment to ensure that the patient is medically prepared for surgery and anesthesia. Because more than one person is often involved in carrying out the preoperative evaluation, for any given patient, the anesthesia resident must have reviewed all information and addressed any outstanding issues prior to the patient going to the operating room.
- It is expected that the anesthesiology resident will establish a relationship with the patient prior to administration of any sedative or other drugs.

Postoperatively:

- Whenever practical, the anesthesiology resident caring for the patient in the operating room should provide follow-up with the patient in the PACU and within 24 hours after surgery. This can be done through a direct patient visit or phone communication.
- All departments should be encouraged to develop a standardized system that assures that all patients are contacted postoperatively (in person or by phone, for same-day patients). This could be accomplished using a designated resident and/or nurse (or a combination thereof) to do all of the post-op visits/calls on any given day.
- All data regarding the patient's postoperative course must be made available to the resident and must be reviewed either in person or electronically for each patient they care for in the operating room. If the department has a different resident or other health care provider carrying out the postoperative follow-up, the department must develop a method for communicating the findings and outcome to the resident who provided anesthesia.
- The department should maintain documentation that the residents have participated in preoperative and postoperative care for each patient for whom they provide clinical services.

Adverse Event Monitoring:

- The department must provide a means for each resident to identify and review all adverse events that arise in the patients that they have cared for. Each department will have to define "adverse event" and have a way to determine if the event is related to anesthesia care or not (eg; postop MI, central line infection).
- When an adverse event appears, the resident involved in that particular case is then notified and required to carry through on any further follow-up required. The resident should discuss the adverse outcome with the faculty member who was assigned to the case and develop a rational follow-up plan, including a discussion regarding a plan to make further contact with the patient. A list of these adverse events and their resolution should be a part of each resident's assessment portfolio.
- Departments are encouraged to be innovative in their approach to monitoring adverse events and incorporating this in to resident education. These requirements can be met in a number of ways. Electronic medical records may be very helpful, if they are set up to provide this kind of follow-up communication. Postoperative notes could be forwarded to the resident who anesthetized the patient and the resident would then have to confirm that the records have been reviewed and all issues addressed. Other systems might be put in place, such as phone communication.

Improving resident involvement in longitudinal care is an area that is very amenable to "best practices"; the RRC encourages individual programs to be innovative in their approach to involving residents in the overall care of the patients they care for in the operating room.