

Frequently Asked Questions: Regional Anesthesiology and Acute Pain Medicine
Review Committee for Anesthesiology
ACGME

Question	Answer
Institutions	
<p>May more than one regional anesthesiology and acute pain medicine program be associated with a single anesthesiology residency program?</p> <p><i>[Program Requirement: I.A.2.]</i></p>	<p>No. The intent of the requirement that only one regional anesthesia and acute pain fellowship be associated with one core residency program is to ensure that both the fellows and the residents have sufficient numbers of cases to allow an optimal learning environment for all trainees. However, given the different areas of focus between the subspecialties of multidisciplinary pain medicine and regional anesthesia and acute pain medicine, both of these distinct fellowships may be associated with the same core residency. Having a regional anesthesia and acute pain fellowship associated with a core residency will not prohibit having fellowships in pain medicine, critical care medicine, cardiac anesthesiology, obstetric anesthesiology, or pediatric anesthesiology.</p>
<p>Why does the Review Committee require a specific minimum number of cases for each type of procedure?</p> <p><i>[Program Requirements: IV.A.3.a).(1)-IV.A.3.b).(1).(d).(i)]</i></p>	<p>The Review Committee uses these procedure minimums to ensure that a program has the ability to provide the opportunity for each of its fellows to perform the needed number and type of cases. Minimum case numbers are not intended to serve as a benchmark for assessing competency along a spectrum of proficiency towards mastery.</p>
<p>Why are the regional anesthesiology and acute pain medicine block case requirements broken down by area of the body rather than by specific techniques?</p> <p><i>[Program Requirements: IV.A.3.a).(1).(c).(i)-(ii)]</i></p>	<p>It is important that fellows graduate with expertise in procedures within various territories of innervation and a broad array of potential nerve block interventions that they can offer the patient who presents for surgery or with acute pain. Rather than require set numbers of specific block techniques, the Committee understands that there are often many nerve block alternatives to cover the same area of innervation, and the choice of nerve block technique may depend on a balance of many factors. The justification for minimum numbers of both proximal and distal nerve block techniques is to avoid the potential for a fellow to satisfy the requirement for upper extremity, for example, by simply performing 100 of the same block technique. In addition, while new block types emerge in clinical practice and others fall out of favor, the need to block specific areas of the body remains more constant.</p>

Question	Answer
<p>What constitutes a “unique” new patient and how should a fellow document it in his/her Case Logs?</p> <p><i>[Program Requirement: IV.A.3.a).(2).(d)]</i></p>	<p>A “unique” new patient encounter is one acute pain consult per patient, which may include the daily management of a patient’s continuous peripheral nerve block or epidural infusion. Managing the same patient for three consecutive days will count as one unique new patient encounter and not three. However, a fellow who inserts a continuous peripheral nerve block catheter and also manages the same patient’s acute pain after surgery may include this patient twice in the Case Log System as one continuous catheter insertion procedure and one acute pain encounter. Likewise, one fellow can utilize a nerve block procedure in his/her Case Logs while a different fellow may count the same patient as a pain consultation encounter if he/she plays this distinct role in the same patient’s care.</p>
<p>What constitutes experience with the age-assessment and treatment of acute pain in children, if no direct care of pediatric patients is required?</p> <p><i>[Program Requirement: IV.A.3.a).(4).(a)]</i></p>	<p>The Review Committee believes it is imperative that a fellow in acute pain fellowship is aware of assessment and management of acute pain in children. This ‘detail’ requirement ensures fellows are provided with a meaningful experience in acute pain medicine, with or without regional anesthesiology, in the pediatric population. That experience does not need to be a formal rotation, however.</p> <p>Examples of a quality pediatric experience in acute pain medicine include a dedicated block of time spent rounding with an inpatient pediatric pain service, intermittent encounters with pediatric patients on a combined adult/pediatric acute pain service, or time spent with a pediatric block/procedure service. This experience should include understanding the educational issues around the topic of pediatric acute pain and regional anesthesia and, when possible, practical clinical experience with working with parents, children and performing blocks. While exposure to this patient population may be sporadic in certain settings where fellows have little or no exposure to children, fellows in all programs will nonetheless receive exposure to adolescents.</p> <p>The scope and value of the experience would be more in rounding on the pediatric pain service, or participating in the consent process for pediatric cases. The experience does not necessarily have to involve the physical act of doing procedures on pediatric patients, however, as graduates of regional anesthesiology and acute pain medicine programs head into clinical practice, they may very well be asked to engage in the care of pediatric patients in locations where there are not preexisting robust pediatric pain services.</p>

Question	Answer
<p>From which specialties should the program seek faculty participation in multidisciplinary conferences outside the subspecialty?</p> <p><i>[Program Requirement: IV.A.3.b).(1).(d)]</i></p>	<p>Regional anesthesiology and acute pain medicine programs need faculty members from non-medical disciplines and therapies to participate in their multidisciplinary conferences, as well as subspecialists outside of anesthesiology. While other anesthesiology subspecialty faculty members may participate in the multidisciplinary conferences, the requirement will not be met without the contributions of faculty members from outside anesthesiology.</p> <p>Examples of such non-anesthesiology faculty members include, but are not limited to, surgeons, physical therapists, social workers, pharmacists, nurses, and other medical specialists.</p>
<p>Do “local” conferences include in-house multidisciplinary conferences?</p> <p><i>[Program Requirement: IV.A.3.b).(1).(d).(i)]</i></p>	<p>Yes; local conferences do include in-house multi-disciplinary conferences.</p>