

New ACGME Requirements for Anesthesiology Residency Programs: Assessing Their Impact

The new program requirements from the Anesthesiology RRC state that (1) residents will spend at least 16 months in various subspecialty rotations and (2) that research experiences can occur at any time during their curriculums¹. Specifically, rotations in obstetric, pediatric, neuro and cardiothoracic anesthesia will increase to two months, critical care to four and pain to three months, with an additional month for preoperative medicine. The paper by Wajda et al, published in this issue of JEPM², in a pilot survey attempts to gauge the sentiment of current residents in their program with regard to this ACGME mandated change. This work is interesting because it highlights discussions occurring in academic anesthesiology departments around the country about the new training rules.

Wajda and colleagues conducted a pilot survey of their program's 56 residents (only 22 responded) and report that the majority of their responders felt that training in non-operating room anesthesia was currently sufficient and perceived the proposed training changes will adversely affect resident training. On the surface, this might be seen as a somewhat predictable response by current trainees, which perhaps also is shared by a number of educators. They report that the impact of this change will force their training program to begin subspecialty rotations for some residents during their second month of clinical anesthesia. This is necessary in order to accommodate the needs of their on-call team, specifically, the need for the senior resident to have complete all key rotations prior to be in charge of the call team.

The challenges inherent in assessing the impact of the new training rules are evident in the paper of Wajda. Curriculum changes always sharply focus the issues about balance of service versus education. These issues also go beyond the focus of this manuscript because Wajda et al. addressed only one aspect of the new training requirements and confined their assessment to residents' opinions. In addition, the methods Wajda et al employed serve as a useful reminder of the pitfalls of survey-based investigation.

First, their 39% response rate from an already select group (one of over a hundred anesthesiology training programs) poses the very real danger of non-response bias. This means that residents who did not respond to the survey might somehow systematically have had different opinions than the responders, for example they may not have felt so strongly about the potentially negative impact of the new rules, and therefore might have felt less motivated to respond to the survey because it was not much of an issue for them. A second, limitation of this work was their choice of directed, versus open-ended questions. Their

questions clearly indicate an opinion to the responder by the way they were written, and the authors may have gotten the answers they expected, based on the way the questions were phrased.

Third, this was a survey from only one program and therefore cannot be taken as representative of anesthesia residents across the country. Local factors such as strongly voiced faculty opinions, demographic makeup of the house staff and special characteristics of the local teaching hospital environment may have further contributed to residents forming an opinion that is not representative of their national peers.

Fourth, it is doubtful that current residents are truly able to give an informed opinion on the questions that were asked in the survey. This is evident in the seeming equation of the performance of a pre-anesthesia preparation with “doing a pre-op”. Were residents adequately, uniformly and impartially educated about the new rules and their impact? Did they, for example, take into consideration that the new rules might be beneficial because they allow research experiences to be taken at any time during the curriculum? These questions might have more impact if directed to graduates of this program, and preferably graduates of many different programs.

An area not addressed by the authors is the possibility of answering program needs by integrating the anesthesiology curriculum into 48 months. Although more pain, critical care and perioperative medicine training is required in the new rules, the option to place some or all of these additional requirements into the Clinical Base Year (PGY-1) would decrease the impact on OR anesthesia time. This element of curriculum planning is not addressed in the work of Wajda, perhaps because this program does not have an integrated Clinical Base Year. The ACGME takes a relatively dim view toward program responses that are dictated by service needs, as opposed to optimal educational experience. This would argue strongly for the integrated 48 month curriculum, especially for a program structured like the one surveyed by Wajda et al.

How could the authors have improved their educational investigative methods to avoid these shortcomings? To better deal with the issue of response bias, they might have spent more resources on increasing response rates and compared some of the relevant characteristics of responders and non-responders (e.g.: the fraction of residents taking research electives or the fraction who rate themselves as having strong opinions about the new rules). To counteract the criticism of lack of generalizability, Wajda et al (and potential future investigators) might seriously consider extending surveys across several programs, even if they are in the same geographic area, as well as to program graduates. Finally, their survey instrument might undergo further evolution to ensure maximally informed responses.

Resident opinion matters! It would therefore be particularly gratifying to see a survey of trainees incorporate as many safeguards against criticism as possible. Assuring that all surveyed residents were adequately and uniformly informed about the issue and its implications on the training program might have been one approach. Attempting a comparison with faculty or alumni opinions might be another.

Readers should understand that the survey of Wajda et al. was conceived as a pilot study to determine if there was a need for further study and evaluation of acceptance of the new ACGME regulations; as such its quality and scientific value are legitimately up for debate. Yet it is sometimes necessary to bring an education-related study into the public forum, because it calls attention to an important development in the present time. JEPM offers authors the opportunity for alternative publication that still allows for useful discussion among the education community. The paper by Wajda et al, while published in JEPM, occupies the status of a non-peer review contribution, such as an abstract and should be acknowledged as such.

We invite you, the readers of JEPM, to take this opportunity to comment; after all, you are the affected anesthesiology educators dealing with the reality of rotation schedules, advising residents and worrying about their training outcomes!

Armin Schubert, MD, MBA
John E. Tetzlaff, MD

¹ Warner MA, Hall SC. Research Training in Anesthesiology: Expand It Now! *Anesthesiology* 105:446-448; 2006

² Wajda M, Lee M, O'Neill D, Morimoto M, Yepfenhard L, Kim J. Anesthesia Residents Have a Negative Opinion on Proposed ACGME Changes to the Curriculum. *JEPM* volume IX, 2007 www.jepmonline.org