



# AUA

Association of University Anesthesiologists

# Update

Spring 2005

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## University of Miami/Jackson Memorial Hospital Center for Patient Safety Celebrates Grand Opening

W. Andrew Kofke, M.D., M.B.A.  
AUA Update Editor

I attended the grand opening celebration of the University of Miami/Jackson Memorial Hospital Center for Patient Safety in Miami, Florida, on Thursday, January 13, 2005, at Jackson Memorial Hospital. This was the culmination of a several-year effort to set up this center as a statewide patient safety resource. Included in the program was a live, patient-centered simulation production arising in the midst of a speech by Paul R. Barach, M.D., in which health care professionals acted out management issues in

a simulated pregnant trauma patient. A frank debriefing session followed.

The celebration attracted hundreds from throughout Jackson Hospital and the school of medicine plus many important people from Miami and throughout Florida. Original funding for the center was the result of a patient safety mishap that, rather than leading to medical litigation, resulted in the commitment of a grieving family to improve patient safety through a strategic philanthropic donation. This occasion allowed for public expression of appreciation for their selfless response to a personal tragedy.



The simulated and very "pregnant" trauma patient arrives and is en route to the simulation center for diagnosis and surgical therapy.

The role of two other anesthesiology departments in ambitious simulation and patient safety programs also are highlighted in this issue on pages 2 and 3.

The Center for Patient Safety is an innovative, first-of-its-kind facility dedicated to stimulating the growth of patient safety knowledge through research and clinical investigations. On October 8, 2003, the University of Miami/Jackson Memorial Hospital Center for Patient Safety was charged by the Florida Agency for Health Care Administration with the responsibility of measuring the quality of health care and analyzing the requirements to understand the needs of consumers/patients in the state of Florida. This resulted in formation of a consortium of academic and state entities in collaboration with the private sector that outlined a systems-based approach patterned on successful programs in other high-risk enterprises to implement patient safety initiatives.

In the past year, the center led this coalition to pass the most comprehensive patient safety legislation in the United

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UM-JMH  
CENTER FOR PATIENT SAFETY

DEPARTMENT OF ANESTHESIOLOGY

# Simulation in Oregon

## A Local and Statewide Effort



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**M**edical simulation programs are gaining the attention of multiple institutions and organizations. The programmatic challenges of establishing a viable simulation program are complex and involve multiple factors that are often overlooked or are approached only in retrospect. Other sectors and disciplines are gaining considerable experience and expertise in health care simulation, which was previously dominated by anesthesiology. This article briefly describes the simulation activities at Oregon Health and Science University (OHSU) in Portland and in the state of Oregon.

### Simulation at OHSU

OHSU has established a 6,000-square-foot simulation facility and comprehensive simulation infrastructure to allow for the smooth integration of this methodology into our entire university system. Physicians, nurses, residents and students at OHSU learn skills and resource management relating to patient care. They are challenged at all levels of training. In just two years of operation, we are nearing capacity utilization.

Simulation at OHSU is not only about education but also the infrastructure built to support it. The complexities of broad-based simulation program development<sup>1</sup> are now better understood. Rather than view these complexities as barriers, we have sought to understand them and to work to address them. The current system is a multidisciplinary and interdisciplinary simulation effort that is open to anyone from the schools of medicine and nursing. Traditionally we look at interdisciplinary simulation at the trainee/scenario level alone. Beyond education, maintaining a successful interdisciplinary program is complex and requires multiple levels of interdisciplinary activity: 1) interdisciplinary executive support and directives; and 2) interdisciplinary simulation faculty/specialist development and activities. These interdisciplinary components are critical and are intentionally part of the OHSU simulation infrastructure.

A system and an innovative model have been developed at OHSU that allow us to manage not only a simulation facility but to expand and accommodate growing demand beyond any facility boundaries. The administrative infrastructure created over the last two years continues to evolve and now includes seven individuals (specialists, managers and support staff). It

is co-directed by Michael A. Seropian, M.D., and Bonnie Driggers, R.N., M.S., M.P.A. This system provides the structure and expertise required to implement the complex endeavor of multidisciplinary, large-scale health care simulation. Standards have been developed to ensure superior and consistent experiences throughout the institution. The system does not seek to mandate curricula or use. Scenarios are standardized through databases that are accessible to all disciplines through simple keyword searches.



*Michael A. Seropian, M.D.,  
F.R.C.P.C.*

Departments and groups do not have to reinvent the wheel and spend precious dollars and time in doing so. Faculty have access to training and infrastructure elements to facilitate the development of programs specific to their needs. Departments wishing to use this methodology provide their own faculty to be trained.

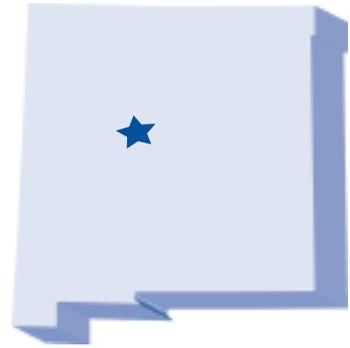
The roll-out of simulation to the different sectors has been phased as per a detailed business plan to ensure successful overall implementation. Currently simulation use at our institution is dominated by nursing. This is expected and intentional, as this is the group with the greatest volume, readiness and demand. Our model projects expansion of services to the hospital system and systemwide resident training (both currently developing) and finally medical students. This phased implementation is occurring both in parallel and in series. These projections are market-driven and based on considerations of volume, need, political and cultural barriers and cost implications. Expansion to multiple sites will occur. These will not be satellite sites; instead, they will be parts of the whole.

### Funding

The simulation program is funded from a variety of sources, including the schools of medicine and nursing, hospital administration and from external consultation and service contracts. Ownership is open to expansion but is limited to the executive, who represents the broader system. Equal representation and ownership are ensured by separating percent utilization from ownership. Consider the facility, infrastructure and its systems (e.g., portable units) like a library — a resource for all. The Department of Anesthesiology and Peri-Operative Medicine

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# Simulation at UNM



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The University of New Mexico School of Medicine and the University of New Mexico Hospital in Albuquerque entered into a joint venture to develop the "BATCAVE," a comprehensive simulation center serving all learners within our Health Sciences Center. We are often asked why we chose the name BATCAVE. It is an acronym for Basic Advance Trauma Computer-Assisted Virtual Experience, but more importantly, it's because Batman stored his high-tech equipment in the batcave! This "catchy" word has given us good name recognition. If you ask anyone within our institution where the BATCAVE is, they will know.

Opened in January 2001, the center's mission is to coordinate and centralize all simulation activities in a cost-effective manner. We provide our users with equipment and space as well as technical and educational design support. In this way, we have relieved individual departments and hospital units of the need to provide initial equipment purchase costs and ongoing costs such as support staff, warranties, etc.

Our facility supports:

## *Patient Simulation*

Mannequins are utilized ranging from passive models with no interactive capacity to high-fidelity computer-controlled simulators. The educational objectives of the learners determine the patient simulator used. We have laboratories available in which we are able to mock up any hospital environment to increase the reality for the learner.

## *Partial-Task Simulation*

The center supports the surgical skills laboratories to teach basic and advanced procedures. We utilize simple simulators such as pigs' feet as well as complex computer-controlled simulators such as the Minimally Invasive Surgical Trainer. In addition we have a complete orthopedic joint laboratory and an ear, nose and throat temporal bone laboratory.

## *Nationally Accredited Courses*

Advanced cardiac life support, pediatric advanced life support and other nationally accredited courses are taught within our center. This has allowed us to incorporate more sophisticated simulations within these courses to challenge our more advanced learners.

Although the high-tech computer-controlled simulators are the show pieces, which we think about when we say the word "simulation," the true strength of our center is our large (500-plus piece) low-fidelity collection. These models can be used to teach learners simple tasks such as placement of a nasogastric tube, foley or intravenous catheter as well as complex procedures such as hysteroscopy, cystoscopy or chest tube insertion.

Last year 10,991 learners utilized our center. These learners included medical students; physician assistants; pharmacists; hospital nurses and nursing students; respiratory, physical and occupational therapists; surgical technologists; physicians in practice; and housestaff from anesthesiology, internal medicine, family and emergency medicine, pediatrics, general surgery, orthopedics, urology and obstetrics/gynecology.

The department of anesthesiology utilizes our facilities for teaching residents and medical students. Medical students in the third year of training are introduced to clinical skills during a one-week rotation with the department. If students elect a fourth-year rotation with the department of anesthesiology, they utilize the simulation facility under the supervision of the anesthesiology faculty to supplement their operating room experiences. All anesthesiology residents have a simulation experience every two months that is standardized and coordinated with the didactic curriculum.

It is the goal of all BATCAVE personnel to ensure that faculty, residents and other learners who come to our facility are fully supported in a superbly equipped and comfortable educational environment.



*David H. Wilks, M.D.*

A screenshot of a web browser displaying a newsroom article from the Association of American Medical Colleges (AAMC). The article title is "Pitt's simulation program and others are highlighted by the Association of American Medical Colleges at:" and the URL is "www.aamc.org/newsroom/reporter/april05/simulators.htm". The AAMC logo is visible in the top left corner of the browser window.

**Pitt's simulation program and others are highlighted by the Association of American Medical Colleges at:**

[www.aamc.org/newsroom/reporter/april05/simulators.htm](http://www.aamc.org/newsroom/reporter/april05/simulators.htm)

# Nicholas M. Greene, M.D. (1922-2004)

## *A Man on a Mission*

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Much has been and will be said about Nick Greene, whose life (1922-2004) was spent professionally toiling in that most pioneering of places, academic anesthesiology. When Nick graduated from Columbia University School of Medicine in 1946, there was no such thing as anesthesiology in most of the medical schools in the United States and around the world. The creation of a bona fide academic discipline became his cause, and the creation of academic departments around the world became the measure of his success.

Of course Nick was not the only person who took this challenge as his own; many others have before, with and after him, but none was more articulate, determined and successful. His original treatise on the subject, *Anesthesia and the University*,<sup>1</sup> published in 1975, had a very simple theme: Anesthesiology has a body of work that distinguishes it from other disciplines, and those who create it and teach it are as important to the university as other scholars who work in such fields as internal medicine and surgery.

We all know it is one thing to chart a vision and quite another to accomplish it. This is what set Nick apart. His simple mission was clear, and if one examines his professional life, one sees that he steadfastly lived his creed and practiced what he spoke. He set about scholarship in the only way one can be successful, by working at it night and day. There was no rest. For example he compiled the world's most complete study of the physiology of spinal anesthesia, which was published as another remarkable monograph in 1958.<sup>2</sup> He did not confine his work to research, but also embodied organizational leadership. He was probably most distinguished in these roles. He led anesthesiology at the University of Rochester and Yale University. In these roles, he served as a role model for countless medical students, residents and faculty. All who

worked with Nick in any of these capacities were inspired by his devotion, intellect, determination and civility. His occasional stands to be sure that anesthesiology got its due were few, and successful.

When one has as a mission the transformation of a specialty from a trade to a profession, there is no better place to do this than as editor of the journals of the field. Thus Nick Greene was Editor-in-Chief of *Anesthesiology* (1973-76) and *Anesthesia & Analgesia* (1977-91). His unfaltering determination to improve these journals by seeking outstanding editors, by personally editing every single manuscript published and, most importantly, by seeing that the best hypothesis-driven research was published were the ways that he influenced our specialty. He helped to move it from the anecdotal and observational to the scientifically sound so that it would stand alongside the best work published in other clinical disciplines' journals.

When Nick and I were updating his book,<sup>3</sup> I was bemoaning the difficulty today in trying to keep academics in university departments of anesthesiology, and in his very gentle and knowing way, he smiled and said, "You have no idea what hard is." And that puts things in perspective: The obstacles to academic success pale in comparison to those from 50 years ago. The work is unfinished, but without Nick Greene, academic anesthesiology would still be a dream, not the reality it is in so many places in and outside our country. Thanks, Nick, mission accomplished.

#### References:

1. Greene NM. *Anesthesiology and the University*. Philadelphia: Lippincott; 1975
2. Greene NM. *Physiology of Spinal Anesthesia*. Malabar, FL: R. E. Krieger Publishing Co; 1976.
3. Reves JG, Greene NM. *Anesthesiology and the Academic Medical Center: Place and Promise at the Start of the New Millennium*. International Anesthesiology Clinics 38. Philadelphia: Lippincott Williams & Wilkins; 2000.



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The National Resident Matching Program (NRMP) was established in 1952 to allow graduating medical students in the United States the opportunity to explore their options prior to making a decision about postgraduate training. It accomplishes this goal by providing a uniform date of appointment to positions in graduate medical education (GME). Five organizations sponsor the Match: the American Board of Medical Specialties, the American Medical Association, the Association of American Medical Colleges, the American Hospital Association and the Council of Medical Specialty Societies. In 2004 the NRMP's Main Residency Match enrolled 3,763 programs, which together provided 23,704 positions. A total of 31,140 applicants were registered for the NRMP. Of these, 15,237 were senior students enrolled in accredited U.S. allopathic medical schools.

### How the Match Works

The matching process is conducted using a mathematical algorithm that uses the preferences expressed by applicants and programs on rank order lists submitted to the NRMP. The process starts by an attempt to place an applicant into the program indicated as most-preferred on that applicant's list. If the program did not list the applicant, an attempt is made to place the applicant in the second-choice program and so on until the applicant obtains a "tentative" match or until all the applicant's choices have been exhausted. This tentative match is dependent upon the program having an unfilled position. If there is no unfilled position, then the applicant must be more preferred by the program than another applicant who is already tentatively matched to the program. In this case, the applicant who is the least-preferred tentative match is removed from the program. When an applicant is removed from a previously made tentative match, an attempt is made to re-match, starting from the top of the applicant's list. This process is carried out for all applicants until each applicant has been tentatively matched to the most preferred choice or all choices have been exhausted. When all applicants have been considered, the match is complete, and all tentative matches become final.

In considering this algorithm, program directors should include only those applicants on their rank order list whom they truly want and should be certain to rank applicants in sequence according to true preferences. The rank order list may be amended as often as necessary until the rank order list deadline. A program's rank order list is not complete and will not be used in the Match until it has been certified by the program director. Each time the list is changed, the new version must be certified. It is important to remember that the listing of an applicant by a program on its certified rank order list establishes a commitment to offer and accept an appointment if a match occurs.

### Applicants

Several categories of applicants can participate in the NRMP. Sponsored applicants are those students enrolled in a medical school accredited by the Liaison Committee on Medical Education (LCME) <[www.lcme.org](http://www.lcme.org)>, whose dean has determined that the applicant is eligible to participate in the Match. If the dean of student affairs determines that a sponsored applicant is ineligible to enter GME by July 1 in the year of the Match, the school must immediately revoke its sponsorship of that individual and notify the NRMP prior to the rank order list certification deadline. An independent applicant refers to an individual who is already graduated from an LCME-accredited medical school, a Canadian medical school student/graduate, an osteopathic medical school student/graduate or a student/graduate of an international medical school. To participate in the Match, a student or graduate of an international medical school must have passed, by the NRMP's rank order list deadline, all examinations required for Educational Commission for Foreign Medical Graduates (ECFMG) certification. The NRMP will verify the credentials of independent applicants.

Applicants may participate in the Match as a couple and link their rank order lists. Applicants registered as a couple are treated by the Match only as a couple and will match to the most-preferred pair of programs where both applicants have been offered positions. If two applicants who registered as a couple do not obtain a match as a couple, the Match will not try to find a separate match for either of them individually.

### Programs

Four categories of programs participate in the Main Residency Match. Categorical programs begin in the PGY-I year and provide the training required for board certification. Advanced programs offer PGY-2 positions that begin the year after the Match and require a year of preliminary training. Preliminary programs provide one year of training as a prerequisite for advanced programs. Physician programs are reserved for physicians who have had prior graduate medical training. An institution can link a preliminary program with an advanced program to provide continuous training at a single institution. This feature limits the ranking of the preliminary program to only those applicants who ranked the advanced program. Only applicants who match to the advanced program can be matched to these preliminary spots.

The NRMP gives institutions the option of reverting unfilled positions in one program to another program during the



Robert R. Gaiser, M.D.

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matching process. Institutions use this option to prevent the possibility that positions go unfilled. Reversions are set up in anticipation of a quota not being filled instead of in reaction to empty slots. The deadline for making changes to quotas for programs is the end of January of the year of the Match. Match Program Quota changes are communicated by the institutional official or the program director using the NRMP Web site. Quota changes will not be accepted after the January deadline. Programs that want to reduce their quota to zero must withdraw from the Match.

### Participation in the Match

The entire matching process is conducted on the World Wide Web using the NRMP's Registration, Ranking and Results System (R3 System). Each year the NRMP automatically "rolls over" into the new Match every program that participated the previous year. To participate in the Match, a program must be activated by the NRMP institutional official who first activates the institution and then the individual programs. Activation of the institution does not activate the individual programs for participation. Failure to activate a program renders it ineligible for matching. Program directors cannot activate a program, and new programs cannot be added after the January 31 program quota change deadline.

Once a program is activated, the program director must log on to the Match site annually and register online to access the registration, ranking and results information.

During the registration process, the institutional official, the institutional administrator and the program director must electronically sign the NRMP's Match Participation Agreement, promising to abide by the policies and procedures of the NRMP. This agreement is governed by the laws of the State of Illinois, but Illinois' conflicts of laws provisions are not to be construed to apply to the laws of any other jurisdiction. As such, any person participating in the Match, both applicants and programs, must be aware of the policies and procedures in their state.

### Procedures and Policies

The entire Match, from registration through Match Day, is governed by the NRMP's Match Participation Agreement. There is one cardinal rule: *Neither the program nor the applicant may make a verbal or written contract for appointment prior to the Match.* In addition, although applicants and programs volunteer how they plan to rank each other, it is a material breach of the Match Participation Agreement to request the information. Each party may express a high level of interest, but references to how each will rank the other must not be solicited.

Programs must provide applicants with a copy of the actual appointment contract that the applicant will be expected to sign if matched to the program and inform them about eligibility and institutional employment requirements. It is recommended that these policies be shared in writing and that the program obtain a written acknowledgement from each applicant. This policy was established to ensure that an applicant meets the institution's eligibility prior to the Match and to ensure that no problems occur after a Match.

The outcome of the Match is binding; however, an applicant or a program may request a waiver of the Match if the fulfillment of the Match commitment would create serious hardship. In such cases, the institution must request the waiver from the NRMP. In addition, if an applicant requests a waiver, the program may not offer the matched position to another person until a waiver is granted by the NRMP or until the applicant indicates that the position will not be accepted even if the waiver is denied. If the program offers the position prior to the granting of a waiver, the NRMP will investigate whether the program violated the Match Participation Agreement. An applicant whose waiver is denied and who does not accept the matched position cannot accept a position in an NRMP Match-participating program to commence training for one year from the date of denial. An NRMP Match-participating program is also prohibited from offering a position to an applicant whose waiver request was denied if training would commence during the one-year prohibition. Offering a position within the one-year period is a Match violation. It is also a violation if a program knowingly offers a position to an applicant who matched to a concurrent-year position in another program. Prior to offering a position, programs must take reasonable steps to ascertain the applicant's Match status, including contacting the NRMP to obtain that information.

Consequences of confirmed violations are severe. For a program, the violation report is sent to the Accreditation Council for Graduate Medical Education Residency Review Committee and the respective specialty program directors association. The program that committed the violation may be barred from subsequent matches and/or identified as a Match violator for up to three years or permanently. For applicants, the applicant's medical school, as well as programs ranked by the applicant, are notified. If the applicant is a foreign-trained physician, the violation report is sent to the ECFMG. The applicant may be barred from subsequent NRMP matches and/or identified as a Match violator to participating programs for up to three years or permanently.

Applicants, school officials, program directors or institutional officials may report suspected violations. The NRMP will not initiate an investigation until it has received a written or electronic report. The person reporting the violation may request anonymity. The NRMP will evaluate and investigate allegations and generate a preliminary report. If the results indicate a violation may have occurred, the preliminary report is sent to the involved parties to provide an opportunity to review, correct and add information. The parties have 10 business days to respond to the preliminary report. All information is then reviewed by an NRMP Review Panel that includes members of the NRMP's Board of Directors. The Review Panel prepares a final report that is sent to the subject of the investigation, who has 10 days to appeal on procedural grounds or request arbitration. If neither of those events occurs, the Review Panel Report becomes the final report, and it is distributed according to NRMP policy. The NRMP marks with a red flag those applicants and programs who have been found to be in violation of the NRMP Match Participation Agreement so that users of the R3 System will be aware that a violation occurred.

Any dispute with the NRMP must be settled by arbitration in accordance with the commercial rules of the American

Arbitration Association. The arbitrators must conduct all arbitration proceedings in the Office of the American Arbitration Association in Chicago, Illinois. The time period to contest a decision of the NRMP is 10 days from receipt of the NRMP report and then 30 days to file a demand for arbitration.

### How to Avoid a Match Violation

The easiest way to avoid a match violation is to adhere to professional standards in all interactions with applicants. After registering in the R3 System, every Match participant is e-mailed the NRMP's Statement on Professionalism. In addition Match participants should read carefully the NRMP's Match Participation Agreement, which is signed electronically during registration, and the Violations Policy. All three documents are posted on the NRMP's public Web site at <www.nrmp.org>. The specific rights and responsibilities are summarized in this article. It is the responsibility of the program director to be aware of the Match Participation Agreement when the program director logs on for the first time. A match is a binding commitment between an institution and an applicant, and only the NRMP may grant a waiver. Applicants, program directors, institutional officials and deans of student affairs are required to comply with the terms and conditions of the NRMP.

One of the most common violations is the offering of a written or verbal contract to a U.S. senior allopathic medical student

prior to Match Day. Another common violation occurs when an applicant does not accept a matched position. The Match Participation Agreement states that the listing of a program on the applicant's certified rank order list and the listing of an applicant on a program's certified rank order list establishes a binding commitment to accept/offer an appointment if a match results. Failure to honor that commitment is a material breach of the agreement. If the applicant does not honor the Match and has not been granted a waiver, a program that participates in the Match may not offer a position to that applicant for a one-year period. A violation occurs if the program director asks an applicant where he/she intends to rank the program.

Each year the NRMP is contacted by applicants who believe an error has occurred in the Match because they did not match to programs whose directors had promised them positions. Some applicants misconstrue certain statements as a commitment on the part of the program. An example might be such a statement as, "We hope to have the opportunity to work with you in the coming year." Program directors should avoid making misleading statements.

The NRMP works for both applicants and programs. Success occurs when all participants maintain a professional standard and abide by the rules.

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## Simulation in Oregon: A Local and Statewide Effort

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has played a critical role in supporting the concepts developed at our institution and also provided much of the expertise to train other disciplines in simulation.

### Statewide Simulation

In late 2003, we had the unique opportunity to provide leadership in the development of multisector/discipline simulation programs throughout Oregon. Our model was used and adapted to facilitate smooth and efficient program implementation at other independent sites in Oregon. The results of this model are demonstrable and have been replicated. The goal was to ensure sustainable, multidisciplinary, high-quality simulation opportunities based on best-practice and experience. Oregon has moved from one simulation program to 19, serving multiple disciplines/sectors in just one and one-half years.

The statewide effort is the work of many. Through collaboration of key health care representative organizations, we created the Oregon Simulation Alliance in November 2003, a non-governing statewide coordinating body. Representation included the majority of health sectors and the governor's office. The premise of this collaboration was to provide for efficient transfer of knowledge to decrease cost, time to implementation and to decrease the likelihood of duplication. Within the first six months, \$1,050,000 were secured for equipment, faculty development and training. Formative elements and goals of

this collaboration included the need for simulation related to education, training, planning, cost efficiency, networking and involvement of multiple sectors/disciplines. Common standards, infrastructure elements, scenarios and curricula were all top priorities. Statewide simulation specialist training has begun as we move to strengthen the underpinnings of the simulation network that has been created. The state has contracted with OHSU to provide training that moves beyond the traditional two- to five-day course. It also allows trainees to participate in real simulation sessions to gain hands-on operating and debriefing experience. This process spans months, not weeks.

This statewide project is a national first that hopefully will act as a template for successful statewide simulation program development. Time will test the resilience and foundations of this project. We are working with several institutions nationally as we would very much like to see the model tested and further refined in other institutions. This is an exciting time for simulation at OHSU and throughout the state. Our journey has given us valuable insight and experience.

### Reference:

1. Seropian M, et al. An approach to simulation program development. *J Nurs Ed.* 2004; 43(4):170-174.

# RRC and Dialectic Struggle

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Professions change through a dialectic process in which a thesis is opposed by antithesis and transient resolution creates a new order that is subjected to the same process. This is contrasted to an evolutionary concept in which change occurs in a natural course of events and, although difficult, is unlikely to create the same angst as a dialectic struggle. Anesthesiology finds itself at a point of controversy, and while healthy, it is important to ensure that all discussions are factual and lack rhetoric for its sake. There have been a number of articles, e-mail discussions and meetings in which the position (thesis) of the Residency Review Committee for Anesthesiology (RRC) has been challenged (antithesis), and the resulting decisions will affect our profession for years to come. Therefore, at the risk of increasing confusion, I would like to present the following information for possible clarification and definite discussion.

I have been an AUA member for almost 20 years, and I am an immediate past member of the AUA Educational Advisory Board. Furthermore I have been an academic department chair for 14 of the last 16 years and a member of the RRC for Anesthesiology for the last six years. I will soon transition to become an anesthesiology representative to the RRC for Anesthesiology Transitional Year Review Committee, a position that may have later relevance to this discussion. These bona fides are meant only to allow each of you to determine whether or not these comments have relevance and possible validity.

## Regulation

Medical education in the United States is a highly regulated commodity, and since the Flexner Report in the early years of the last century, the American Medical Association (AMA) has undertaken the oversight responsibility to ensure not only the quality but also the relevance and timeliness of medical education. The responsibility for medical schools resides in the Licensing Committee for Medical Education (LCME), while the graduate programs reside with specialty RRCs under the auspices of the Accreditation Council for Graduate Medical Education (ACGME). Each RRC is composed of three AMA representatives (typically specialty AMA member physicians recommended to AMA by the specialty society), the specialty society represented by the training program (in our case, the American Society of Anesthesiologists [ASA]) and the adjudicating and certifying authority of the specialty (in our case, the American Board of Anesthesiology [ABA]). In addition a resident member is chosen from the resident component of the specialty society (ASA Resident Component). ACGME headquarters staff supports the RRC, and these individuals are readily available and provide constant support to individual programs and their directors.

Typically the RRC for Anesthesiology discusses its activities with department chairs and program directors at the Annual

Meeting of the Society of Academic Anesthesiology Chairs/Association of Anesthesiology Program Directors (SAAC/AAPD) and frequently at AUA meetings. Presentations also are made by ABA in similar venues, and residents and interested practitioners in the board-certification process have access to the RRC and ABA at the Annual Meeting and through direct correspondence at all times.

The RRC for Anesthesiology then, is representative of its governing and accrediting bodies. Each RRC member serves a three-year term appointment that is renewable once. In this context, the RRC undertakes constant evaluation and refinement of the core educational curriculum and its implementation by the individual programs accredited to train residents. A training program's accreditation involves a written submission (Program Information Form [PIF]) that reflects the program's adherence to the published program requirements (educational content and performance, clinical experience components, institutional and facility support, etc.) and a site visit designed to correlate the written documentation with its practical and actual implementation.

## Site Visit

An individual approved by the ACGME and RRC for Anesthesiology performs the site visit. In the past, primarily anesthesiologists with an interest in serving the specialty and with credentials appropriate to evaluating a residency program performed this activity; many of you will have served in this capacity. The frequency with which a site visitor was utilized depended upon specialty need, reviewer availability and competence and the desire to initiate new individuals into the process when necessary. The situation is analogous to that of the Board examiners who, depending upon their performance, receive appointments and promotion within the system. In recent years, however, this system has changed somewhat, and 25 of 27 RRCs are utilizing a cadre of individuals employed by ACGME as "professional" site visitors. These are either physicians or individuals with educational credentials whose activities and reports are carefully regulated and evaluated by the individual specialty RRC. The reason for the change is to provide the RRCs greater consistency and exactitude in the site surveyor's reports and to decrease personal opinion, which can, at times, obscure the information to be discussed.

It should be remembered that the purpose of the site visit is to provide the RRC an objective validation of the information contained in the PIF; it is not an opportunity to convince the site visitor of the program's integrity. In my experience on the RRC, most programs have benefited from this arrangement; certainly the reports we evaluate are more standardized and comparable across programs. It should be remembered



*Philip D. Lumb, M.B.,  
F.C.C.M.*

that the RRC retains the prerogative to assign a specialty site visitor to any program and that all site visitors and their activities are reviewed by the individual RRC. In my opinion, the integrity of the process has never been higher, and individual programs have been advantaged by evaluations. I believe it is inappropriate to confuse the accreditation process with political considerations. The actions and integrity of (y)our RRC representatives are open to challenge in any of the forums previously mentioned, and I believe that accountability is open and ensured by the structure of the appointment and reappointment process and term limits.

### **Restructuring the Curriculum**

The RRC for Anesthesiology has introduced an initiative to restructure the curriculum into a four-year continuum. This has created interest, passion and confusion, despite the fact that the initiative has been discussed at SAAC/AAPD and AUA for more than four years. This is not an inappropriate or unexpected situation when change is advocated, and the rationale for and introduction of the curricular change were not as detailed and explicit as necessary. The RRC, however, has been receptive to suggested changes, and the current discussion should focus on a few key points:

1. A four-year educational and professional training continuum defined by anesthesiology;
2. The duration of specific rotational components; and
3. The accreditation and transition process.

Unfortunately many discussions to date have been misleading and have focused more on individual program components than on the concept itself. The four-year continuum does not preclude residents transferring from another training program into anesthesiology; it merely specifies the requirements necessary for completing residency training by the time the final Certificate of Clinical Competence is due. The curriculum as proposed provides elective time during the current 36-month continuum that will accommodate most candidates. The continuum, however, will give the specialty greater presence to invoke its credentials onto the transitional year and other preliminary training experiences currently taken by almost 35 percent of our trainees. We should be proud that anesthesiology recognizes its unique needs, especially as we ensure that our specialists will be physicians first, with the requisite opportunity for training and experience following medical school graduation. It is possible that these requirements may prolong some training, but the likely impact of this is small and unlikely to deter either programs or anticipated trainees from pursuing excellent clinicians wishing to change specialties. I anticipate that concordance with the transitional year will benefit our specialty and improve the educational and clinical experiences of our trainees.

### **A Critical Component**

Critical care medicine and its impact on anesthesiology residency training has long been a discussion topic at the meetings of AUA, SAAC/AAPD, ASA and other meetings in which anesthesiologists with critical care interest congregate. Several years ago, the ASA House of Delegates passed a resolution

supporting increased training in critical care medicine during residency. The American Society of Critical Care Anesthesiologists supported this as did many program directors and other interested individuals, not as a means to “retake” critical care, but as excellent additional experience and training for anesthesiologists. The initially envisioned six-month duration has been reduced to four months on the rec-

***“The current health of our specialty appears to be excellent, so is it appropriate to stimulate change at a time of strength?”***

ommendations made to the RRC at the recent SAAC/AAPD meeting in Boston, Massachusetts. It is likely that increased exposure to critical care medicine and its anesthesiology-related components will increase aptitude and skill in those areas of our profession requiring greater familiarity with the interdigitation of skills and technologies between the operating room and intensive care unit. Certainly additional training in this integrated and essential field will more closely parallel the common credentials of international graduates whose experience and responsibilities in critical care medicine often exceed those in our current curriculum. The four-year continuum will be subject to change over time as it accommodates the new requirements of our specialty; the dialectic struggle will continue to force appropriate reform. It is imperative that an organization prepares itself to maintain a leadership role despite unpredictable change in its modus operandi. The curriculum must incorporate our best efforts to accommodate change within the structure of an educational experience designed to enhance professionalism and skill.

### **Making a Healthy Specialty Healthier**

The current health of our specialty appears to be excellent, so is it appropriate to stimulate change at a time of strength? Perhaps this is the most appropriate time to create a new paradigm and vision for a robust profession focused on both current and future goals. The speed of innovation is increasing, and challenges for future anesthesiologists will be proportionately greater than anything the current generation has faced in its professional lifetime. The tools for success must be provided to those individuals entering the specialty in the next decade in order for them to be current in the next half century. The proposed curriculum will continue to change and adapt as necessity dictates; it would be shortsighted of us to trammel its progress at this crucial time.

As a profession, we must focus on the future. As its educational leaders, we must focus our attention to the challenges ahead and not be sidetracked by status quo arguments that fail to incorporate possibility for change and future excellence.

# The Team Approach to Fix the Medicare Teaching Rule

Eugene P. Sinclair, M.D., President  
American Society of Anesthesiologists

In traveling around the country, meeting and speaking with anesthesiologists, particularly those from academic anesthesiology departments, it is hard to find anyone not familiar with the economic hardships battering academic programs. More specifically, everyone seems to know of Medicare's discriminatory payment rule for teaching anesthesiologists and wants it corrected. Some are aware that correcting this inequity is a legislative priority of the American Society of Anesthesiologists (ASA). Since few know, however, of the recent changes within ASA that have made this a team effort with the academic anesthesiology community, I will digress to explain the background leading to a strengthened relationship before updating the readers on the status of our joint efforts.

In 1996 an ASA task force chaired by Past President Harry H. Bird, M.D., recommended "the creation of one full membership in the ASA Board of Directors" to represent academic anesthesiology.

To explain the basis for its recommendation, the task force report continued:

*"(This) representative should serve without limitation of terms and can thereby provide substantial continuity. It is the committee's opinion that the next few years will be critical relative to the supply of high quality physicians entering anesthesiology and critical as to public policy determinations about graduate medical education and how it will be supported ... The committee is aware that many distinguished anesthesiologists associated with training programs are already active in ASA governance. They are usually elected or appointed, however, with much broader responsibilities and it is unrealistic to look to these individuals to be the primary advocates and agenda setters for training program issues."*

The task force recommendation was considered serially by several ASA committees. In 2003 a position on the ASA Board of Directors to represent academic anesthesiology and a standing ASA committee on academic anesthesiology became realities with approval of the following recommendations in the report of an Ad Hoc Committee on Academic Anesthesiology chaired by ASA President-Elect Orin F. Guidry, M.D.:

*"The committee agrees with the wisdom of this statement (i.e., the quotation from Dr. Bird's report) and recommends that the ASA Committee on Bylaws prepare appropriate Bylaws changes to establish a position on the Board of Directors that has the above characteristics to be presented to the August 2003 Board of Directors meeting."*

*"The committee recommends that the ASA Committee on Bylaws prepare appropriate Bylaws changes to establish a Committee on Academic Anesthesiology to be presented to the August 2003 Board of Directors meeting."*

*"The ad hoc committee believes that the duties of this standing committee should be to:*

1. Maintain a liaison between academic anesthesiology and the Society,

2. Represent the interests of academic anesthesiology to the Society,
3. Study and make recommendations pertaining to present and future challenges to academic anesthesiology and to the specialty in general,
4. Interact with other committees to ensure that issues confronting academic anesthesiology are resolved in a strategic fashion,
5. Carry out other activities relative to academic anesthesiology as may be requested.



Eugene P. Sinclair, M.D.

*"The ad hoc committee believes that this standing committee should be in the Section on Professional Practice in the Division of Professional Affairs."*

Now I will return to the background and a current status report on our work to correct the teaching rule. In 1995, Medicare issued new rules for teaching physicians. The 1995 rule effectively negated Health Care Financing Administration (now Centers for Medicare & Medicaid Services [CMS]) Intermediary Letter 372, which, prior to that time, had permitted teaching anesthesiologists to oversee two concurrent resident cases, with billing permissible for each case at full reimbursement as long as an "attending physician" relationship was established in each case. In the case of "surgical, high-risk or other complex procedures," the 1995 rules state that "the teaching physician must be present during all critical portions of the procedure and must be immediately available to furnish services during the entire service or procedure."

Logic dictates that this same rule should apply to anesthesiology, but this has not been the case. Instead, for teaching anesthesiologists, the rule has allowed full reimbursement for only a single case involving a single resident, thereby reducing reimbursement for anesthesiology training by 50 percent when two residents are supervised concurrently.

In 2002 the Task Force on Graduate Medical Education, also chaired by Dr. Guidry, recommended that the ASA Committee on Governmental Affairs and the ASA Washington Office study the issue of reimbursement for medically directing residents and lobby to change to a system of 100-percent reimbursement.

In his August 2003 report to the Board of Directors, ASA President James E. Cottrell, M.D., wrote, "We continue to make progress in gaining support for a proposal to improve Medicare reimbursement for teaching resident physicians." Despite public and private assurances from CMS in 2004 that the proposal would be implemented, it was rejected. With that setback, ASA intensified its efforts in August 2004 with the addition of another lobbying firm, Health Policy Source, Inc. (HPS), to our legislative consulting team to assist with the initiative. HPS staff has been instrumental in scheduling

recent meetings between ASA representatives and key CMS decision-makers and political appointees. The anesthesiology participants in these meetings are ASA Vice-President for Professional Affairs Alexander A. Hannenberg, M.D.; Philip G. Boysen, M.D., ASA Academic Anesthesiology Director and Immediate Past President of the Society of Academic Anesthesiology Chairs (SAAC); and SAAC President Lydia A. Conlay, M.D., Ph.D. They have been assisted by ASA Washington Office staff members Ronald Szabat, J.D., L.L.M., Director of Governmental and Legal Affairs, and Karin Bierstein, J.D., ASA Assistant Director of Governmental Affairs (Regulatory).

In recent meetings, Dr. Boysen and Dr. Conlay have provided critical input regarding the causal relationship between the Medicare teaching rule, the resulting economic harm to academic anesthesiology departments and the devastating consequences for teaching programs. The net result of this team approach is that ASA, SAAC and the Association of

Anesthesiology Program Directors are strategically positioning anesthesiology for a favorable resolution at the earliest juncture this year.

The vision of Dr. Bird and Dr. Guidry and the committees they chaired established the infrastructure to support a powerful joint effort to correct the teaching rule. Clearly, without the combination of resources from ASA and the academic anesthesiology community, efforts to correct the Medicare payment rule for teaching anesthesiologists would be much less powerful and credible. Although recent meetings between CMS officials and representatives from ASA and SAAC have been promising and productive, two conclusions are obvious:

1. We must sustain the intensity of our resolve to succeed.
2. We must continue strengthening the relationship between ASA and the academic anesthesiology community.

## Center for Patient Safety Celebrates Grand Opening

*Continued from page 1*

States. Some of the other key initiatives during the past year include designing and implementing a patient safety curriculum for training medical professionals, designing safe medical devices, studying team safety training methods and community outreach on patient safety and quality improvement projects.

“Patient safety training and research are about helping providers learn to do the right thing and avoid doing the wrong thing,” said Dr. Barach, Director of the Center for Patient Safety and Associate Professor of Anesthesiology. “The goal is to teach all health care professionals how to deliver high-quality, safe care from day one of their education.” Simulation is an integral element of the University of Miami’s approach to patient safety. The University of Miami Department of Anesthesiology faculty have played an important role in this achievement.

Taking advantage of the pioneering work done at Stanford University, Harvard University and other institutions, the University of Miami and many institutions across the United States are now actively running or building simulator centers. Many, if not most, rely on the expertise of their academic anesthesiology faculty.



*Honorary guests at the opening of the University of Miami/Jackson Memorial Hospital Center for Patient Safety were, from left to right, Augustin “Gus” Barrera, Education Commissioner for Dade County; Paul R. Barach, M.D., Director of the Center for Patient Safety; U.S. Congressman Mario Diaz-Balart; U.S. Congresswoman Ileana Ros-Lehtinen; John Clarkson, M.D., Dean of the University of Miami Leonard M. Miller School of Medicine; and David A. Lubarsky, M.D., Professor and Chair of the Department of Anesthesiology, Perioperative Medicine and Pain Management at the University of Miami School of Medicine.*

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## Elephant in the Closet



To read more about medicine's "elephant," see the January-March 2005 California Society of Anesthesiologists (CSA) Bulletin at [www.csaahq.org](http://www.csaahq.org). Click on "Publications," then "CSA Bulletins," and look for Volume 54, Number 1.

## AUA 52nd Annual Meeting May 6-8, 2005

Baltimore Marriott Waterfront Hotel  
Baltimore, Maryland

Jointly Sponsored by AUA and Johns Hopkins University and University of Maryland.

### Thursday, May 5

Welcome Reception

### Friday, May 6

American Society of Anesthesiologists (ASA) Open Forum on Intraoperative Awareness and Brain Function Monitoring: Jeffrey C. Apfelbaum, M.D.

Oral Presentations: C. Michael Crowder, M.D., Ph.D.

"Clinical Implications of Unraveling Pain Mechanisms": Clifford Woolf, M.D.

ASA President's Address: Eugene P. Sinclair, M.D.

AUA President's Panel: "Renewal of Academic Anesthesiology: What Is Our Vision and Plan?" David L. Brown, M.D., Ronald D. Miller, M.D., Steven C. Hall, M.D., Myer H. Rosenthal, M.D., Mark A. Warner, M.D.

NIH Session: Alison E. Cole, Ph.D., Daniel G. Remick, M.D., Keith W. Miller, M.D.

Friday Evening Reception

### Saturday, May 7

Host Program — University of Maryland: William A. Whiteford, B.A., Susan H. Hadary, B.A.

Host Program — Johns Hopkins University: Michell Bush, D.V.M, Dip. A.C.Z.M., Mario Livio, Ph.D.

"Are Cost-Containment Initiatives a Form of Human Subject Research Without Patient Safeguards?" Peter Rock, M.D., Stanley H. Rosenbaum, M.D., Michael A. Rie, M.D., E. Greg Koski, M.D., Ph.D., Peter J. Cohen, M.D., J.D.

Poster Discussion with Faculty Moderators: C. Michael Crowder, M.D., Ph.D.

Saturday Reception and Dinner

### Sunday, May 8

Oral Presentations

For online registration, program updates and more information about AUA's host institutions Johns Hopkins University and the University of Maryland, visit: [www.auahq.org](http://www.auahq.org), call (847) 825-5586 or e-mail at [auameetings@asahq.org](mailto:auameetings@asahq.org).