Anesthesia Education

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President's Corner

The Value of SEA Membership: What's New for 2012 and Beyond

Scott A. Schartel, D.O.

SEA continues to work to advance the education of medical students and physicians in anesthesiology. In keeping with the strategic plan developed in 2010, this year's Spring Meeting will include an opportunity for participants to extend the meeting to participate in the Medical Education Research Certificate (MERC) program from the American Association of Medical Colleges. While the number of people who can participate in the MERC program is limited, if it proves to be a success, it will be repeated at future meetings. The leadership of the Society believes that offering additional advanced educational programs provides additional value for our members.

Another advance has been the addition of Web-based educational content for members. If you log on to the Member's Only portion of the website, you can watch a presentation by Viji Kurup, M.D., residency program director at Yale University, about the problems and potential of social media use in medicine. During the coming months, additional presentations will be posted. Providing educational content to our members on demand so they can use it when it is best for them is another way SEA is working to add value for our members.

With ACGME's plan to implement educational milestones in July 2013 and the announcement of the "Next Accreditation System," which will begin for anesthesiology in July 2014, SEA will be working to provide our members with education and resources to implement the changes. SEA is well positioned to help our members adapt to the GME paradigm shift from processed-based to outcomes-based educational assessment.

"Providing educational content to our members on demand so they can use it when it is best for them is another way SEA is working to add value for our members."

I encourage you to explore the many benefits of SEA membership. Get involved, attend our meetings and join a committee. SEA has a great history of advancing education in our specialty – your active participation in the Society will ensure a great future.

Inside

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Spring 2012 SEA Annual Meeting in Milwaukee

Planning is complete for the Spring 2012 SEA Annual Meeting in Milwaukee. The timely theme of "Doing More With Less: Teaching Quality and Safety in the Real World" will address unique challenges in residency training today.

David Warltier, M.D., Ph.D., John P. Kampine Professor and Chair of the Department of Anesthesiology, Medical College of Wisconsin, will open the meeting by discussing "Unique Educational Programs." Several nationally known speakers will address issues relevant to the meeting theme, such as teaching quality and safety in the operating room, effects of work-hour changes, and quick and effective feedback in the O.R. COL Charles Callahan, Dept. Commander and Chief of Staff at Walter Reed National Military Medical Center, will address "Doing More With Less: Lessons From a Medical Corps at War." Deborah Simpson, Ph.D., Associate Dean for Educational Affairs, MCW, an internationally renowned educator, will present "Bridging Learning Research to Teaching in Anesthesia."

We are honored to present the AAMC sponsored MERC workshops for the first time at a SEA meeting. This program will increase knowledge and understanding of medical education research, promote the role of clinicians as informed consumers of the medical education research literature, and improve our role as effective collaborators in medical education research. A certificate will be presented upon completion of this six-workshop series. Additionally, 18 SEA workshops will be offered, ranging from "Getting Ready for Overnight Call: Use of High-Fidelity Simulation" to "Learning by Doing to Creating Killer E-Learning: New Concepts for Creating High Quality, Technologically Innovative, Efficient Teaching Materials."

Elena J. Holak, M.D., PharmD

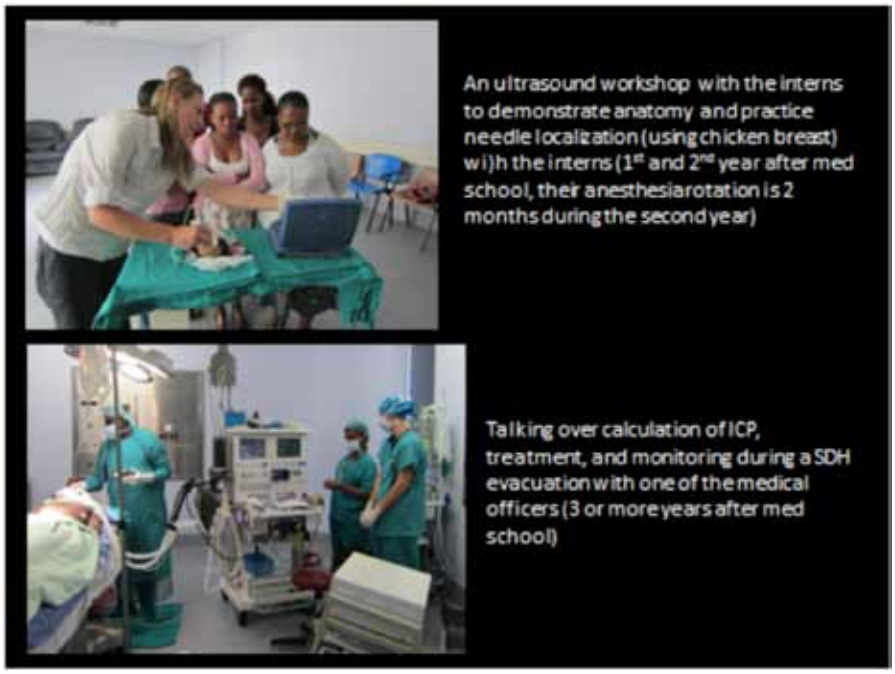
The historic Pfister Hotel, a landmark in downtown Milwaukee, will be the meeting venue. Only a short walk from the shores of Lake Michigan, the Pfister provides quick access to local attractions, including the Milwaukee Art Museum with the Santiago Calatrava-designed Quadrucci Pavilion on the breathtaking lakefront; the Harley Davidson Museum and factory; and the Milwaukee Public Museum. Dinner cruises are available on the Milwaukee River, which flows through downtown. Other attractions of interest in Brew City include the MillerCoors and Sprecher Breweries, offering regular tours. History buffs may enjoy the Milwaukee Public Museum or Old World Wisconsin. Sports enthusiasts may catch a Milwaukee Brewers baseball game and revel in the uniqueness of the retractable roof at Miller Park.

As you stroll along the Riverwalk on your way to some of the finest dining in the country, don't forget to stop for a photo op with the Bronze Fonz! The Safety House Restaurant requires a secret password for entry! Test your detective skills at this secret restaurant.

An amazing educational program is planned. I hope you will be able to attend the Spring 2012 Annual Meeting in Milwaukee!

Global Outreach Committee Report

This is warming up to be an exciting year for our committee. I am delighted to announce that Viji Kurup, M.D., from Yale, has accepted the position of Designee Chair. Viji has been extremely active in SEA for many years, particularly on the Website Committee in recent times. Part of her heart has always been with global outreach, and she has always done her best to stay involved with our committee, making valuable contributions to our work. We are lucky and appreciative to have several active members on the committee, but Lena Dohlman, M.D. and I are very excited to have Viji join us in a more formal capacity.



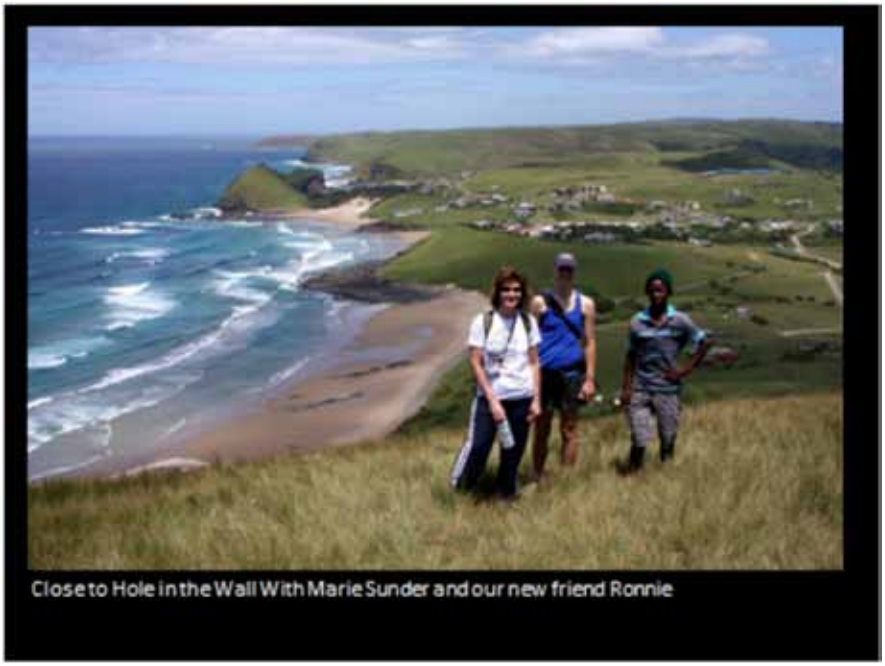
Several of the donors have been funding one or two entire fellowships in this incredible way for many years, and we owe them a huge "thank you." I cannot let this opportunity pass to thank everyone who gives to these fellowships. In October, at the SEA meeting in Chicago, we raised more than $2,500 for the SEA Fellowship just over lunch. People were handing me $20 bills and checks for varying amounts. It was a humbling experience that I hope we can repeat so that more residents, and therefore students in developing countries, can benefit.

Joanna Davies, M.B.B.S., F.R.C.A.

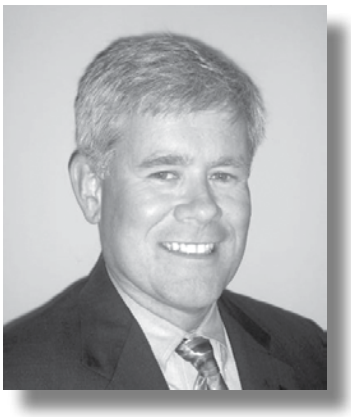
Our new site in Blantyre, Malawi, is now operational. By the time you read this email we will have had four volunteers visit there this year, with more scheduled to go in June and September. The students are thriving on the teaching and I look forward to speaking to them all when I visit in May.

Just to whet your appetite, below are a couple recent photos from Anne Cherry, one of our SEA-HVO Traveling Fellows, who has been in South Africa this year. As you can see, it is not all work!

The next bit of news we want to share is that we have 33 applicants for the SEA/HVO Traveling Fellowships this year. This is a jump of 25 percent from last year, which encourages me that global health work continues to grow and motivate people. I also hope that the enthusiasm of previous Fellows and the stories they have to tell are spreading around all residency programs, inspiring residents to apply. Dr. Dohlman has done an amazing job of procuring donors again this year. We will be offering eight, maybe nine fellowships, including the SEA Fellowship.



ACGME Milestone Update



J. Thomas McLarney, M.D.

The fall and winter have been a busy time in regard to the milestones. Last summer and fall, the ACGME assembled interdisciplinary expert panels to develop milestones for the competencies of professionalism, practice-based learning and improvement, systems-based practice, and interpersonal and communication skills since these were felt to be common across specialties. These milestones are considered suggestive but not compulsory for each RRC. Patient care and medical knowledge were left to each individual specialty to develop since these must be more individualized for each medical specialty. Anesthesiology has assembled a group that will develop milestones for patient care and medical knowledge.

Of note, a special report titled "The Next Accreditation System-Rationale and Benefits" was published in the February 22 edition of *The New England Journal of Medicine*. The authors were headed by Thomas J. Nasca, M.D., M.A.C.P., chief executive officer of ACGME. In the article, limitations of the current system are discussed as well as the evolution of the Next Accreditation System (NAS). The article states "A key element of the NAS is the measurement and reporting of outcomes through the educational milestones, which is a natural progression of the work on the six competencies." The aim is to create a logical trajectory of professional development in essential elements of competency and meet criteria for effective assessment, including feasibility, demonstration of beneficial effect on learning, and acceptability in the community."

As the milestones project has progressed, it has become apparent that the NAS will not only be involved in residency training and the accreditation of resident training programs, but that it will someday project back toward undergraduate training in medical school as well as be a natural segue into ongoing lifelong learning and maintenance of certification. The article showed four selected milestones that had been developed by the aforementioned expert panels with explanations from levels one through five of each milestone.

From the special report, the timetable is that by July 2013 the NAS will be implemented by seven of the 26 ACGME-accredited core specialties, and the NAS will be implemented in July 2014 for the rest of the specialties and the transitional year, including anesthesiology. The ACGME is focusing a great deal of effort on collaborating with all the major stakeholder organizations to facilitate the transition into the NAS.

The SEA leadership also feels it is critically important to help disseminate information and facilitate discussion among our membership regarding the milestones and the NAS. The SEA Spring Meeting will have a discussion forum dedicated to the milestones and the NAS, as each Fall and Spring Meeting has for the last two years. We anticipate that this will continue into the future.

Thoughts From the Membership Committee

Paul W. Kranner, M.D.

First, the Membership Committee would like to welcome the new members who've joined the Society over the past year, while extending a special thanks to those longstanding members (and old friends) who have continued to view membership in SEA as a valuable part of their professional careers. Their experience, combined with the enthusiasm of the next generation of educators, makes us the vibrant and progressive society that we are today. This reality highlights the two principle goals of the Membership Committee – recruitment of our up-and-coming junior faculty educators as new Society members, and retention of current members as they progress through their careers.

Toward these goals, the Committee is focusing on better defining the benefits of Society membership. There is certainly no doubt that the educational and networking opportunities that accompany attendance at Society meetings are hugely beneficial. However, in this day of ever-increasing demands on everyone's time and professional funds, actual ongoing membership in the Society must carry clear benefits as well. The Membership Committee is committed to defining and developing these "members only" benefits that will promote both new membership and retention, while never losing sight of SEA's goals of being a resource to everyone interested in anesthesia education. Ideas are always welcome – contact a committee member today!

Society for Simulation in Healthcare Anesthesia Special Interest Group Update for 2012

Rebecca D. Minehart, M.D.

The Society for Simulation in Healthcare Anesthesia Special Interest Group (SIG) had a productive meeting recently in San Diego at the 12th International Meeting for Simulation in Healthcare (IMSH 2012). SEA members Sara Goldhaber-Fiebert and Rebecca Minehart co-chair this group. Members represented six countries, and while most were practicing anesthesiologists, members also included executive members of the American Association of Oral and Maxillofacial Surgeons.

The Anesthesia SIG supported a great number of submissions to IMSH 2012, including a workshop on enhancing simulation programs for new anesthesia residents, with representatives from eight academic institutions facilitating discussion. The focus this upcoming year will be to continue to collaborate across institutions on using simulation to train a variety of individuals, including novice anesthesia residents in their first month, private practice anesthesiologists and CRNAs credentialing or refreshing their skills, and oral surgeons training to use sedation in the clinic setting. Other areas of interest for the group include supporting anesthesiologists using simulation for MOCA®, and how best to integrate simulation into anesthesiology residencies to satisfy the new 2011 RRC for Anesthesiology requirements. The Anesthesia SIG will support members in hosting workshops, plenary panels, research presentations and other scholarly submissions to next year's IMSH meeting on January 26-30, 2013. Submissions have already begun and closes on July 31, 2012.

One final education goal for the Anesthesia SIG is to organize and collect various web-based simulation resources for its members, for easy access and incorporation into teaching. Those interested should feel free to contact Sara (**saragf@stanford.edu**) or Rebecca (**rminehart@partners.org**) for ways to become involved in this dynamic group.

Update on Page 2 Anesthesiology

L. Jane Easdown, M.D.C.M.

Page2Anesthesiology is celebrating a one-year birthday! This very successful blog site for the journal *Anesthesiology* focuses on education topics that will be of interest to SEA members. A blog (from "web" and "log") differs from other publications in that the articles have more personal observations and are linked to other print sources. Alan Jay Schwartz, M.D. and I write education blogs on topics such as adult learning, giving feedback, duty hours and other items which are timely or topical.

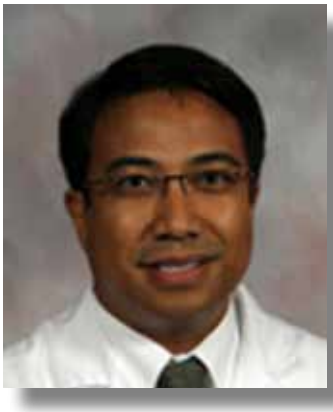
Our SEA meeting speakers have had the opportunity to add blogs to the site, and soon we will see an entry by Lena Dohlman, M.D. on the SEA-HVO scholarship program. The editor of *Anesthesiology*, James Eisenach, M.D., and the online editor, J. Lance Lichtor, M.D., initiated Page2 to be a vehicle for more rapid communication between the journal and its readership. It is also intended to draw attention to key journal articles and demonstrate the practical and clinical relevance of that content in a format which is immediate and very accessible. This is a terrific method to keep up to date with the latest literature with an insider view. And you can ask questions or offer your own comments.

Readers of Page 2 access the blog on Facebook and Twitter and are more likely to use a smartphone and e-tablet to do this. Page2 followers come not only from the U.S. but also from India, the U.K. and Europe. Please visit the site at **http://page2anesthesiology.org** and leave a comment. I am sure you, too, will become a follower!

In-Brief and Out-Brief: A Simple Communication Tool to Optimize Residents' Education

It has been suggested that the principles of adult learning theory can optimize resident education, specifically the identification of clear objectives and the provision of feedback associated with those objectives.[1] In fact, ACGME encourages implementation of these principles by requiring communication of goals and objectives at the beginning of a learning experience and the consistent provision of both formative and summative evaluations. However, the medical literature indicates that residency programs may not be preparing and evaluating residents' training experiences as often or as well as one would hope.[2,3]

In order to effectively communicate learning objectives and ensure performance feedback, our program employed an in-briefing and out-briefing system that occurs throughout the curriculum. For each training rotation, time is allotted for residents to meet face to face with directors of the training rotations that they will begin (in-brief) and the directors of the training rotations that they are ending (out-brief). During the in-brief meeting, faculty provide the resident with the goals and objectives of the upcoming training experience, identify duties and responsibilities of the resident, and relay the expectations for unsatisfactory/satisfactory performance. In addition, this time is used to discuss the resident's expectations, such as his/her self-identified learning goals for the training experience. The out-brief meeting is a time for performance feedback, identification of the resident's strengths, and interactive discussion about the resident's goals and learning needs for continued improvement in the training area. The in-brief/out-briefing system creates a collaborative environment that eases the transition between ongoing training rotations, clearly identifies expectations and learning objectives, and continuously provides concrete feedback about achievement of those objectives. This open and direct communication is meant to help each residency program meet its ultimate goal: to optimize the education of residents and create competent and well-rounded anesthesiologists.



Arthur Calimaran, M.D.

Penni Smith, Ph.D.

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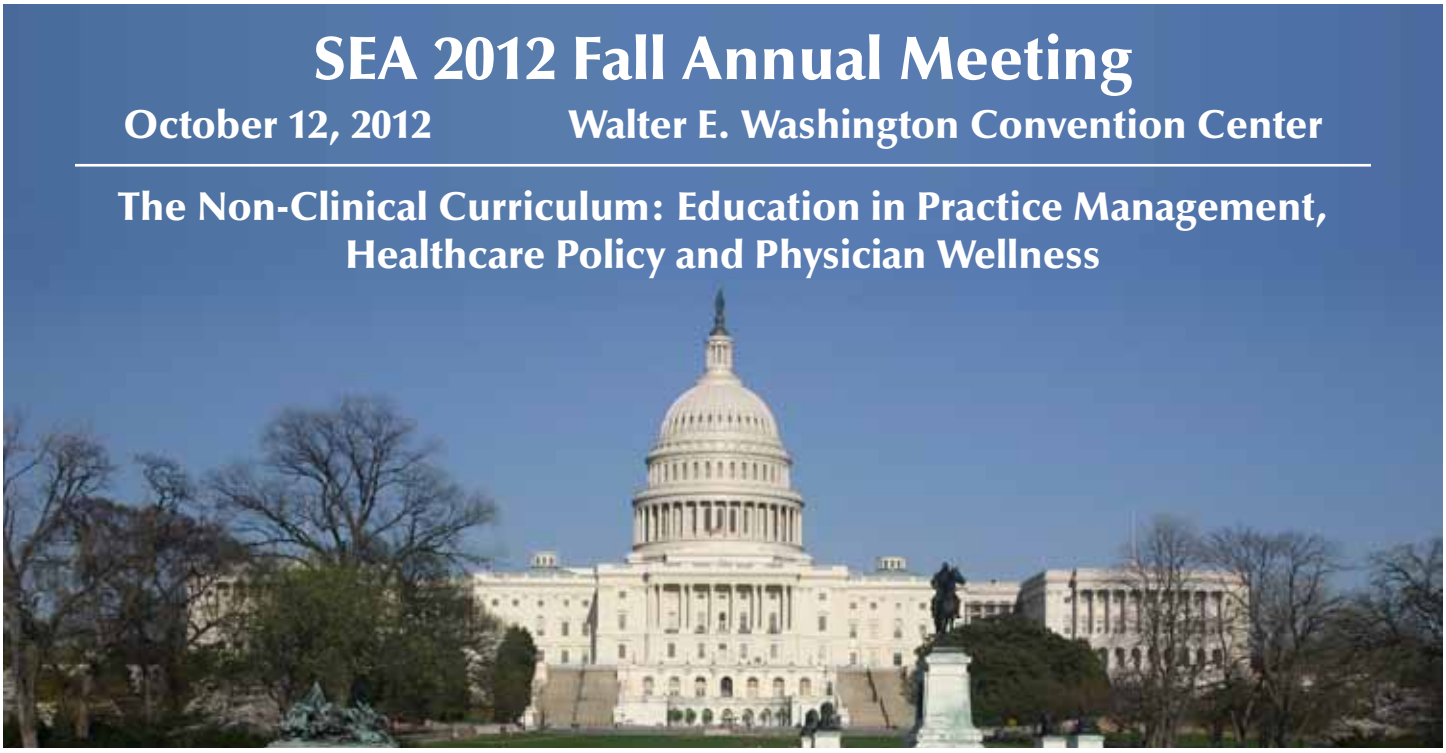

Education Journal Submissions of Interest to Anesthesia

Simulation has become an important adjunct to teaching in anesthesia. David Murray, M.D. has written an excellent review of the literature with reference to simulation training in anesthesia.[1] In it, he looks at 31papers published since 2006 that reveal how simulation is being used. Murray's review shows that simulation is used in both training and assessment. For training, simulation is excellent for psychomotor skills. The literature supports the fact that training on simulators (full-human and parts mannequins) can get novices "up to speed" in the real clinical setting more quickly and with more confidence than those who do not have this training. This is particularly useful for intubation, central line placement and regional techniques. Retention of skills also appears to be better. Clinical judgment training such as in crisis management works well with simulation. Well-devised scenarios can assess communication, planning and reasoning skills necessary to resolve a crisis quickly and well. In anesthesia, critical incidents rarely occur so simulation is an ideal venue to teach how to handle these situations. Communication and team training is well suited to simulation. Diverse professional teams can be brought together to train, mostly to prevent crises, as well as to resolve issues. Several institutions have successfully used simulation for patient safety training.

"Well-devised scenarios can assess communication, planning and reasoning skills necessary to resolve a crisis quickly and well. In anesthesia, critical incidents rarely occur so simulation is an ideal venue to teach how to handle these situations."

Performance assessment is a newer use for simulation. Murray's review summarized that Israel is presently using simulation in its board-certification process with good success. Again, the scenarios must be carefully constructed to do more that just measure psychomotor skills. Examinees have reported a preference for this type of testing.

Two other recent articles suggest that simulation is not the be all and end all of training. Walsh et al. compared expert-, peer- and computer-assisted learning[2] of urinary catheterization. Their results suggest that computer-assisted training is good for basic novice training of psychomotor skills. But if extrinsic feedback is sought, expert teachers, such as faculty, gave better information to the students than either computers or peers.

Laiou et al.[3] looked at training of placement of LMAs, comparing results of mannequin work and live patients. In a randomized controlled trial, medical students were either lightly or intensely trained in LMA placement on mannequins.

Saundra Curry, M.D.

They then worked on real patients. Intense training did not significantly improve performance. The conclusion of the paper was that LMA placement was not a difficult skill to learn and didn't require intense training. Thus, the difficulty of the task should be taken into consideration when planning simulation training

In summary, simulation is a valuable tool for anesthesia training. The above articles emphasize this but also suggest that other means of training are also useful.

References:

1. Murray DJ. Current trends in simulation training in anesthesia: a review. *Minerva Anestesiololgia*. 2011; 77:528-33.
2. Walsh CM, Rose DN, Dubrowski A, et al. Learning in the simulated setting: a comparison of expert-, peer-, and computer-assisted learning. *Academic Medicine*. 2011; 86:S12-S16.
3. Laiou E, Clutton-Brock TH, Lilford RJ, Taylor CA. The effects of laryngeal mask airway passage simulation training on the acquisition of undergraduate clinical skills: a randomized controlled trial. *BMC Medical Education*. 2011; 11:57.

A Personal Tool for a Successful Career

In comparison to the curriculum vitae, the teaching portfolio (TP) offers versatility and detailed scholarly activity, thus allowing professionals to track different stages of their careers and reflect upon it. Employers and chairpersons are able to have comprehensive representation of an individual's professional activities. The TP will provide documentation of expertise, research progress, teaching experience and educational accomplishments.

Current challenges we face today and how the TP can help:

- Increased undergraduate involvement in faculty research. How would you integrate your research into your courses and enhance student participation in your work? How would you demonstrate interactions and evaluations for different levels of trainees: medical students, respiratory therapist, nurses, high school students?
- Increased usage of technology in the classroom and workplace. How would you use wikis, and/or web-based resources to have a substantial impact on a course that you teach? How would you demonstrate those interactions?
- Interdisciplinary curriculums: self documentation of descriptive scholarly activity with emphasis on regional, national and international audiences. How could you archive this if your department does not provide a record of such educational interactions?

Use your TP to provide not only continuing documentation of professional and scholarly activities, but also to improve your skills, hone your ideas, and develop new tracts and techniques. Instead of updating your CV when appropriate, the TP allows for professional development in all areas of practice: both private and academic.

Who Are You and What Can the Teaching Portfolio Offer You?

Novice Teacher

- Documents progress in professional education courses (CME content).
- Documenting progress in teaching methods.
- Satisfactory delivery of standards-based content in teaching clinical experiences.
- Maintenance of Certification in Anesthesiology (MOCA®).
- Allowing early feedback of teaching techniques (strengths and weaknesses).
- Documentation of minimum standards in education and memberships in committees and societies.
- Templates serve as guide to start and maintain professional progress.

Apprentice (Student) Teacher

Alexandra Bastien, M.D.

- **Formulates** a philosophy of teaching statement.
- Completion of student teaching using standards-based unit plans and lesson plans.
- Teaching certificate awarded.
- Initiates role modeling for professional journals subscription/ reviewing.
- **A teaching portfolio may be used to land your first job!**

Proficient (Entry-Level or Tenure Track) Teacher

- Philosophy statement reflects on **progress** of career as teacher and scholar.
- Archives curriculum material that are standards-based and demonstrate contributing content.
- Allows review and reflection on teaching philosophy.
- Organized referencing of educational activities : content and feedback.

Accomplished Teacher

- Philosophy of teaching statement shows that scholarship and teaching are **linked**.
- Content of unit and lesson plans are standards-based and focus on your institutions professional promotions structure.
- Content can demonstrate command of the research base on effective teaching.
- Documenting CME in area of interest to tract becoming an expert in field.

Distinguished Teacher

- Philosophy of teaching statement perceives the relationship between the teacher as scholar and the scholar as teacher.
- Demonstrating expertise in vital themes in teaching philosophy.
- Demonstrating challenging and engaging teaching content, developing possibly new teaching concepts.
- Archiving expertise in systems-based learning tools. Archiving techniques using **current technology**.

Continued on page 10

A Personal Tool for a Successful Career

Continued from page 9

Master Teacher

- Systematically reassess your philosophy of teaching statement, the relationship between the teacher as scholar and the scholar as teacher.
- Portfolio can be used to demonstrate mastery of clinical concepts supporting your philosophical viewpoint.
- Document command of educational content: main ideas, turning points and supporting details.
- Demonstrate materials used in teaching, outcomes data, storage for feedback on effective teaching.
- Archives advanced degrees and privileging/consultations in area of expertise.

Chairpersons/Employers

- **Preparing a Program Information Form (PIF)**.
- Electronic database for queries such as research and scholarly activity within a department.
- Credentialing.
- Personal templates for creating PIF documentations.
- Assessments for teaching awards.
- Documenting general departmental teaching effectiveness.
- Contract renewals and individual assessments.
- Can be used for promotion and tenure within a department.

Private Practitioners: Independent Practitioners

- Documenting CME.
- MOCA® requirements.
- Self assessments.
- Workshops and reimbursement portfolio for professional activities.
- Tracking personal skills.
- Quality assurance/quality improvement.

Look for the Teaching Portfolio on the SEA website and make a difference in your career. Invest in yourself.

Reference:

1. Drake FD, McBride LW. The summative teaching portfolio and the reflective practitioner of history. *The History Teacher.* 2000; 34(1):41-60.

New Curricula Ideas

Traditional curricula in anesthesiology have either focused on an area of anesthesia practice such as ambulatory, pediatric or cardiac anesthesia, etc. or in the case of simulator-based teaching have focused on the recognition and therapy of disease states (bronchospasm, pneumothorax, bleeding, etc.). In this structure, it was easy to provide CA-resident level appropriate teaching.

However, anesthesiologists will be asked to not only provide anesthesia for an ever-growing percutaneous practice pursued by surgeons and non-surgically trained physicians but also to redefine what is safe practice in these locations. It is fair to say that most patients considered for percutaneous procedures are often too sick to withstand a similar open procedure. Complications in percutaneous procedures are rare, but when they happen it often requires emergency surgical intervention.

Thus, every growing practice of percutaneous medicine asks for a new way of formalized teaching. For example, is ASA Physical Status still a valid measure for risk stratification of patients undergoing percutaneous procedures? Does ASA status guide staff allocation and teaching opportunities for residents? Or should we be using the necessary team approach in a hybrid lab as a model in teaching system-based practice?

Anesthesiologists and their work stations are often pushed to the corner of a percutaneous intervention room, yet are being called upon to help with providing fast blood replacement and resuscitation in patients who sustained an inadvertent injury to the great vessels by a seemingly harmless percutaneous intervention.

Johanna C. Schwarzenberger, M.D.

Our residents will need to learn not only how to keep such a patient alive but also how to have everyone work together during such a situation, facilitating communication between surgical and non-surgically trained personnel. Percutaneous intervention laboratories thus function as a platform to challenge our own traditional role in the operating room. This said, they provide an opportunity to weave into the curricula opportunities to teach professionalism, organization, crisis management and anticipation of the unimaginable.

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Coming Soon to Your Residency Program

Many of you have already received notices from the ACGME or have read *The New England Journal of Medicine* (NEJM) article about the Next Accreditation System (NAS). The background for this stems from the introduction of the six core competencies in 1999. In 2009, ACGME began a multiyear process of restructuring the accreditation system based on the outcomes of these competencies. There are three aims of NAS: 1) enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, 2) accelerate the movement of ACGME toward accreditation based on educational outcomes, and 3) reduce the burden associated with the current structure and process-based approach. Our specialty, along with the 18 other ACGME-accredited core specialties and the transitional year, will have to implement NAS in July 2014 when the educational milestones, based on specialty-specific achievements that residents are expected to demonstrate at established intervals in their training, have been completed.

According to the *NEJM* article "The NAS will move the ACGME from an episodic assessment of programs to an annual data collection system. Each review committee will perform an annual evaluation of trends in key performance measurements and will extend the period between scheduled accreditation visits to 10 years. In addition to the milestones, other data elements for annual surveillance include the ACGME resident and faculty surveys and operative and case-log data. The NAS will eliminate the program information form.… Programs will conduct a self-study in the NAS before the 10-year site visit.… Programs in the NAS will submit composite milestone data of their residents every 6 months, synchronized with residents' semiannual evaluations. Another key element of the NAS is emphasis on the responsibility of the sponsoring institutions for the quality and safety of the environment for learning and patient care, a key dimension of the 2011 common program requirements."

Leila Mei Pang, M.D.

The key benefits of the NAS include: 1) creation of a national framework for assessment, 2) reducing the burden of the current process-based accreditation and 3) an opportunity for residents to learn in innovative programs. For more details, please refer to the ACGME website **www.ACGME.org** or the *NEJM* special report article (February 22, 2012).