

SUBSPECIALTIES IN ANESTHESIOLOGY: PRO ACCREDITATION

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*****I have nothing to disclose***

**WHY BOTHER
SEEKING
ACCREDITATION
FOR A
SUBSPECIALTY
FELLOWSHIP?**

PRACTICAL ISSUES

- ACGME accreditation allows for allocation of GME funding (if any is available).
- Certain visas allow IMG trainees to stay in the U.S. only if they are enrolled in ACGME accredited fellowships.

PRACTICAL ISSUES

- How do we assure the public and others that our fellowship grads are well-trained and have not just been “cheap labor”?
- If accreditation is not required, any program can offer fellowship positions without regard for the quality of their training, i.e. abuse of a cheap workforce
- Accreditation holds fellowships accountable for the training they offer.

PRACTICAL ISSUES

Accreditation legitimizes our physician subspecialty practices.

- Eg. CRNAs in LA attempted to expand their scope of practice into Pain Management; a defining argument against this was that even we as anesthesiologists recognize that a Pain Medicine practice requires a fellowship.

**BUT WHY
OBSTETRIC
ANESTHESIA
FELLOWSHIPS?**



"I'm going to give it to you straight, Mrs. Watson, for a 27 year old you're in pretty bad shape."

MEDICAL ENVIRONMENT

- Advances in medical and obstetric management enable more women with complex medical and obstetric conditions to carry their pregnancies to viability.
- E.g. congenital cardiac lesions, Marfan's syndrome, primary pulmonary hypertension, osteogenesis imperfecta

MEDICAL ENVIRONMENT

- Consultants in obstetric anesthesia are needed for multi-disciplinary care to “bridge” the specialties of medicine, surgery and obstetrics during care conferences and delivery of these patients.
- OB has Maternal-Fetal Medicine fellowships, IM has Obstetric Medicine fellowships.
- How do we document our expertise when caring for these patients?

MEDICAL ENVIRONMENT

Our RRC Program Requirements state:

“The faculty should have...individuals who have specialized expertise in the subspecialties of anesthesiology...didactic and clinical teaching must be provided by faculty with documented interests and expertise in the subspecialty involved.”

MEDICAL ENVIRONMENT

- Hospital administrators and Anesthesiology groups in both academic and large private practices desire fellowship-trained individuals to fill the role of Chief of Obstetric Anesthesia.
- Our colleagues in obstetrics and neonatology expect it.

•Published by
ACOG and AAP
with ASA's input.

•The section on
inpatient perinatal
care services
describes optimal
anesthesia
coverage for L&D
and staffing by
other medical
professionals.

guidelines for
**PERINATAL
CARE**

Fifth Edition

American Academy
of Pediatrics



The American College
of Obstetricians
and Gynecologists



2007 GUIDELINES FOR PERINATAL CARE, 6TH ED.

- **Level I (Basic) Care Facility:**
“Anesthesia personnel with credentials to administer obstetric anesthesia should be available on a 24-hour basis.”
- **Level II (Specialty) Care Facility:** “The director of obstetric anesthesia services should be board certified in anesthesia and should have training and experience in obstetric anesthesia.”

2007 GUIDELINES FOR PERINATAL CARE, 6TH ED.

- **Level III (Subspecialty) Care Facility:** “A board-certified anesthesiologist with **special training** or experience in maternal-fetal anesthesia should be in charge of obstetric anesthesia services...Pediatric anesthesiologists should be available for all neonatal surgical procedures.”
- What should that “**special training**” be, if not a fellowship?!

**WHY ISN' T
RESIDENCY
TRAINING
ADEQUATE FOR
EVERYONE?**

TRAINING ENVIRONMENT

- Although we don't directly compete with other specialties as Pain or Critical Care do, our OB colleagues have a fellowship in Maternal Fetal Medicine, Internal Medicine has a fellowship in Obstetric Medicine.
- Few anesthesiology residencies can offer sufficient clinical experience during the CA years to provide optimal training for a high-risk mother with co-morbidities.

TRAINING ENVIRONMENT

- Few residencies can offer trainees the time, research skills or opportunities to produce high quality obstetric anesthesia research.
- There is a distinct body of subspecialty knowledge from that obtained during residency → distinct scientific medical knowledge, distinct journals (IJOA, OAD).

**WHAT DOES THE
ACGME HAVE TO
SAY ABOUT
ACCREDITING
FELLOWSHIPS?**

ACCREDITATION CRITERIA

1. **The existence of a body of scientific medical knowledge underlying the subspecialty that is in large part distinct from, or more detailed than, that of other areas in which accreditation is already offered.**
 - Major textbooks devoted to obstetric anesthesia (eg. Chestnut), journals (eg. IJOA), ASA practice guidelines

ACCREDITATION CRITERIA

2. The existence of a sufficiently large group of physicians who concentrate their practice in the proposed subspecialty area.

- SOAP has 1100 members
- There are ~ 29 current fellowship programs or CA-4 year options offered in the U.S.

ACCREDITATION CRITERIA

3. The existence of national medical societies with a principal interest in the proposed subspecialty area, peer-reviewed journals published in the specialty area, and a number of national and regional meetings.

- The Society for Obstetric Anesthesia and Perinatology is over 40 years old, and ~50% of SOAP members attend the annual meeting.
- There are 5 additional U.S. meetings on obstetric anesthesia and at least 5 international meetings

ACCREDITATION CRITERIA

4. **The regular presence in academic units and health care organizations of educational programs, research activities, and clinical services such that the subspecialty is broadly available nationally.**
 - *Guidelines for Perinatal Care* states that a board-certified anesthesiologist with special training in maternal-fetal anesthesia should be in charge of obstetric anesthesia services at a level III (subspecialty) care hospital, as most teaching / training hospitals will be.

ACCREDITATION CRITERIA

5. **The projected number of programs to be accredited must be sufficient to assure that accreditation is a cost-effective method of quality evaluation.**
 - ~29 programs advertise a CA-4 position on the SOAP website; accreditation would *probably* draw greater numbers of fellows, although that remains to be seen.

CURRENT ENVIRONMENT

- Within anesthesiology, interest in women's health, interest in the subspecialty of obstetric anesthesia, and creation of societies of obstetric anesthesia (eg. SOAP, OAA) are increasing worldwide.
- There is a large group of physicians who concentrate their practice in obstetric anesthesia, and further growth is expected.

ACCREDITATION CRITERIA

6. **The duration of the fellowship must be at least one year beyond the core specialty and the educational program must be primarily clinical.**
 - Current CA-4 programs in obstetric anesthesia require at least one year of training with options for extension to do further research.

ACCREDITATION CRITERIA

7. **The accreditation of programs in the specialty area must not have an adverse effect on core anesthesiology training.**
 - Goals and objectives for fellows are distinct.
 - Obstetrics residencies often call on obstetric anesthesiologists to educate OB residents and fellows in critical care and pain management.
 - Having fellowships is the way to ensure there are sufficient numbers of trained experts in the field to adequately educate future generations.

**WHO WILL
TRAIN OUR
GENERALISTS
AND
SPECIALISTS OF
TOMORROW?**

CONCLUSIONS

The accreditation of specialty fellowships, through their uniform training requirements and periodic reviews, will assure that future generations of anesthesiologists have the clinical, research and educational foundations required to provide:

- High quality, cost effective clinical care
- Education for both generalists and subspecialists
- Through research, generation of new knowledge to benefit our patients

