Special Article

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Quality Anesthesia Care:

A Model of Future Practice of Anesthesiology

Preamble

The American Board of Anesthesiology exists primarily to certify specialists on the basis of fulfillment of several criteria, including requisite training, testimony of clinical competence, and success in examinations. These criteria evolved largely from a chimera of the certified specialist created by successive generations of Board Directors. A precise word definition of this physician has been elusive and inconstant. The description changed as expectations of the Board perceived this specialist performing as a consultant in the medical world at large. The need for a word description is now pressing, primarily as the prerequisite to his (her) identification. What will be expected of this certified specialist in the medical world as it will be? Shall he be trained differently for this role? How will he be identified? The first step toward answering these questions was the description of the world in which he will work. The statement that follows is this description, a working document of the Board, which now acknowledges the special contributions of Richard Theye, M.D., for its initiation, and Robert M. Epstein, M.D., for its completion. This statement represents the opinion of a small group of anesthesiologists, who hope its publication will lead to critical review by many anesthesiologists and a more broadly based perspective.

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In recent years a changing pattern of anesthetic practice has evolved. Traditionally, anesthesiologists have provided health care to patients on a personal basis. Some have also supervised the work of other anesthesia personnel, principally nurse anesthetists. Anesthesiologists are, in addition, increasingly involved with subspecialty practice and extending the domain of the specialty to areas other than the operating suite. The American Board of Anesthesiology believes that these changes are appropriate and should be encouraged.

The Board holds to the view that the emerging patterns of practice, of delivery of anesthesia care and the forms of training appropriate to them should be described. It does so for its own guidance in planning both its educational requirements and its evaluating and certifying processes. The model on which decisions must be based will critically influence the form of those decisions. The Board is aware that its own agenda for the future may influence (although not determine) the conduct of training programs and ultimately the nature of their product, the practitioner. It thus requires a specific model for its guidance. The Board also recognizes that as a planning document this model will be continuously modified in the light of general medical developments.

In addition, the Board believes that the increasing complexity of anesthetic care, the management of more profoundly sick patients and the development of commensurate abilities of the specialty to provide the necessary care should provide the impetus to an increasing use of a team approach for the delivery of anesthesia care. To ensure that the public receives the full measure of knowledge and skills which the specialty can bring to bear for the benefit of patients, all anesthetic administrations should be by or under the direction of an anesthesiologist. Both the physician and non-physician members of the anesthesia care team must possess the requisite technical skills, reliability and commitment to patient care. The role of the anesthesiologist in directing the non-physician members of this team is distinguished by a physician's capacity to exercise medical judgment in the diagnosis

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and prescription of medical therapy. The anesthesiologist, who, when appropriate, may be responsible for the care of more than a single patient at one time, should serve increasingly as the prescriber of preoperative, operative, postoperative, and intensive care for each, based on their medical conditions. As team leader the physician is responsible for reviewing the anesthetic care plan with non-physician anesthesia personnel, for the supervision of the delivery of their services, and for the initiation of necessary medical treatments as events dictate. In addition, the physician should possess the scholarship to acquire, evaluate and apply new information and technical advances for the benefit of patients.

The Board believes that this practice pattern can unquestionably enhance the quality of care. To assure it, the training of anesthesiologists must emphasize the acquisition of the broad knowledge of medicine needed to serve as leaders and consultants to the anesthetic care team. Accompanying this must be a thorough grounding in the theory as well as the practice of the discipline of anesthesiology, and extension of this educational experience to encompass all areas of specialty practice. These include, in addition to surgical and obstetric anesthetic administration, active participation in pain therapy centers, respiratory therapy, intensive care units, emergency services and other appropriate areas of practice. The educational requirements of the Board are designed to accomplish these goals.

Thus, the Board intends that the qualified anesthesiologist will follow an educational track that leads first to primary qualification as a general anesthesiologist. Anesthesia subspecialty training, training for direction of intensive care, and training for the leadership of the anesthesia care team represent additional elements of education, which cannot stand alone. The Board intends, however, that the properly qualified physician have the opportunity for additional training in one or more areas of anesthesiology beyond that level of education and training necessary to permit personally administered anesthesia care. It expects the training cycle to include time spent in intensive pursuit of one or more of the subspecialty areas of anesthesiology, such as pediatric anesthesia, obstetrical anesthesia, cardiac anesthesia, neuroanesthesia, the study and management of pain, the intensive care of the acutely ill, or research in areas related to the science of anesthesia.

The Board recognizes that there are many subspecialty areas of anesthesiology. It intends to examine all candidates in each, but it does not expect that every physician achieving certification will be equally proficient in all areas. Those physicians who intend to concentrate in one or more subspecialty areas of anesthetic practice, including intensive care, may be expected to seek a major portion of their final year of training in that practice area. Evolution of such programs may in the future justify the development of certificates of special competence in subspecialties of anesthesia.

The Board believes that the anesthesiologist as leader of the anesthesia care team must be trained to assume responsibility for the performance and the educational standards to be met by the non-physician anesthetist. The Board accepts a role in encouraging the development of complementary educational programs for physician and non-physician anesthesia personnel to their mutual benefit and for the production of professionals prepared to function in concert.

Finally, a realistic view of the setting in which American medicine is practiced requires consideration for the need for anesthesia care services in non-referral hospitals. Such services, although expected to be less complex than those performed in major centers, do span the specialized fields of surgical practice. The broadly trained anesthesiologist will be best prepared to undertake the responsibility for broad-based care of this nature. The non-physician personnel employed in the most peripheral settings may be required to function with a minimum of direct supervision by an anesthesiologist. This capability is likely to be best developed when their educational programs permit a full opportunity for learning the role of a team member, as a student, which should be followed by a period of further experience as an active team member in the referral hospital setting. Until such time as an anesthesiologist can be responsible for all anesthetic administrations, the activities of non-physician anesthesia personnel in these settings should be under the purview of qualified anesthesiologists from the region. Their responsibilities would be to provide educational direction, review of complications, and audit of quality of care, and to serve as consultants on policies, procedures, and equipment to the designated non-anesthesiologist physician serving as responsible chief of service. Ideally, the physicians and non-physician anesthesia personnel in peripheral settings will return to the referral centers at intervals to refresh prior skills and learn new ones. The recertification procedures for anesthesiologists to be developed by the Board should encourage such efforts.

American Board of Anesthesiology