

# The Accreditation Council for Graduate Medical Education Special Report on Clinical Learners in Procedural Environments: Several Elephants in a Very Small Room

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Modern health care is complex, multidisciplinary, dynamic, expensive, and stressful. All these elements make it challenging for trainees. As such, the well-being of trainees has long been recognized as worthy of explicit examination. Interestingly though, formal examination has typically avoided procedural areas, namely operating rooms, which are arguably the most complex, multidisciplinary, dynamic, expensive, and stressful. Thus, the special update from the Clinical Learning Environment Report (CLER) for the sponsoring institutions accredited by the Accreditation Council for Graduate Medical Education (ACGME)<sup>1</sup> is welcomed. The report has recently been made public<sup>1</sup> and includes six focus areas: patient safety, quality/disparities, care transitions, supervision, well-being, and professionalism. Data informing the findings were derived from group and individual interviews combined with walk rounds, including observation of trainees in the operating room and perioperative care spaces. Importantly, both physicians (anesthesiologists and surgeons) and nurses were interviewed and involved in the assessment.

The ultimate take-home from this report is that despite the very close working conditions of the modern operating room, the environment there is siloed. Our trainees, their attendings, and the nursing staff are communicatively partitioned even while huddled around the same patient. This leads to numerous problems, most of which have a common root in communication. The findings are not surprising to anyone who works in an operating room and reflect the state of medicine in general:



**“... the [OR] environment ... is siloed. [Our] trainees, [their] attendings, and [the] nursing staff are communicatively partitioned even while huddled around the same patient.”**

we don't talk (or listen) to each other. Indeed, the historical tolerance for poor communication in high-stakes procedural arenas, though endemic in broader society, become even more starkly absurd when concentrated in a single operating room. Several proverbial elephants crowded into a very small room. Viewed as a microcosm of the larger health system, these failures to communicate in the perioperative space are anticipatable. It is self-evident that departments of anesthesiology, nursing, and surgery have different approaches and special interests, which when distanced from the actual patient seem “understandable.” However, when projected around a patient lying naked and paralyzed on a table, they make for a poor learning environment and propagate suboptimal behavior on another generation of practitioners.

Reassuringly, the study showed that most residents and fellows were being appropriately supervised in the operating room. Surgeons did surgery, anesthesiologists did anesthesiology, and nurses did nursing, all with attentive specialty-specific oversight and professionalism. However, what was lacking was evidence of meaningful interaction between these groups.

Transdisciplinary communication was sparse, relatively speaking, which is remarkable for people standing 6 inches from one another for hours. The surgical timeout (when people are forced to stop and talk to one another) was perfunctory. Trainee participation in timeouts was passive, and postprocedural debriefs were even less meaningful. As the “team” moved out of the room, the pattern was

Image: J. P. Rathmell.

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even stronger. The trainees' roles in transitions of care were typically unscripted and unstandardized. Anesthesiology trainees were more involved than surgeons, but both were purveyors of weak handoffs. Although standard handoffs were sometimes observed, so-called "equal" handoffs (saying the same thing for everyone), "equitable" handoffs (which adapt the process for cases of different complexities) were atypical. Importantly, although transitions are recognized as the times where most communication errors occur, they remain the times when attending supervision is least present.

Moving beyond direct patient interactions, trainees were inconsistent participants in safety event investigations. Though they felt responsible in the room, particularly for "their part of the procedure," they were not part of the activities outside the room, and little effort to teach multidisciplinary process improvement was seen. Certainly, the examination of major safety events through discipline-specific morbidity and mortality conferences involved trainees, but trainee participation in root cause analysis and process change was generally not seen. This suggests both an ongoing culture of delegation rather than participation in safety and process improvement and propagation of that culture through our influence on trainees.

Why are trainees communicatively inept? Because their teachers are. They are just mimicking what they see. Poor communication between trainees *and* between attendings is common. Anesthesiology, nursing, and surgery remain siloed communities . . . frighteningly so! This reflects highly siloed organizational structures that segregate the activities, education, careers, and finances of anesthesiologists, nurses, and surgeons . . . let's also not forget technicians, environmental staff, sterile processing teams, and administrative support staff—all of which must come together in procedural environments to achieve safe and efficacious outcomes.

This is not just an issue of interdisciplinary professional conduct but permeates our core mission: patient care. We don't train people to communicate with their patients. Trainees often do not meet the people on whom they operate or anesthetize; they just show up. They are typically not involved in the consenting process or explicitly trained to discuss difficult choices or have difficult conversations. It is infrequent that the training paradigm includes explicit preparation for an individual case, and this lack of individuality really shows up in patients with special communication needs such as visual impairment, hearing loss, or mobility concerns. To be sure, time and logistics play a role in this, but so does a culture that is permissive for a system that devalues the process and commodifies the patient. Do we really want to solve the equation for efficiency at the expense of resiliency?

Since we do not teach people to communicate, they don't learn what is important to their colleagues. Our trainees' understanding of specific responsibilities owned

by anesthesia, nursing, and surgical trainees is tacit, not explicit. There is little awareness of the educational goals across specialties. This extends to the general well-being of our trainees. Well-being programs are limited, and often, the well-being of one group is maintained at the expense of another, particularly as it relates to throughput and efficiency. Needs of members of the team need to be recognized as a team, not individual departments or constituencies. The CLER also noted continued problems with professionalism and tolerance thereof. This certainly relates to well-being, as disruptive behavior is a sign of a lack of well-being.

What can be done? We suggest that as institutional leaders we can structure environments that encourage transdisciplinary communication and awareness. At our institution, we actually closed the operating rooms in all three hospitals across our system for a day and brought everyone (administrators, anesthesiologists, environmental service workers, nurses, surgeons, and technicians) into a much larger room (the basketball stadium) to explicitly rededicate ourselves to communicating with one another and creating a culture of respect, teamwork, and ownership. This signature event was preceded by months of listening sessions and kicked off a formal program of transdisciplinary problem solving. Responses to identified problems are now approached with teams of people, including trainees, and indeed, some of the hardest problems have been addressed through the creativity of trainees combined with the subject matter expertise of faculty and staff. Trainees have been invited into every phase of the quality journey, from daily huddles to systematic root cause analyses. Increasingly, we invite nurses and anesthesiologists to surgical morbidity and mortality conference, providing the opportunity for different perspectives to be heard and understood. The communication structure of the preoperative clinic has also grown to help surgeons and surgical trainees understand the value that anesthesiologists can bring in mitigating risks before scheduling the procedure. There is much to do, but this report maps a needed course of how to organize, and it rings true to the efforts we have made to date. Each constituency has its own elephant in the room, and it is time we start recognizing that.

Of note, the report acknowledges that it was done pre-pandemic, though it suggests that its findings are relevant to both the pre- and post- (intra-) pandemic world. This points out that all environments are within other environments. Thus, any examination of a specific place must recognize that it is nested within other encompassing places. Looking at the operating room is like examining a raft in rough seas. The operating room builds around a patient, with teams in departments, within health systems, within national health structures responding to a global pandemic, in the broad setting of political and social unrest. It seems that training people to talk and listen to one another and work together as a team might be a good idea.

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1. Accreditation Council for Graduate Medical Education. CLER Operative and Procedural Subprotocol: Special Report 2021. Available at: <https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/>. Accessed September 30, 2021.