STATE OF NEW HAMPSHIRE
SUPREME COURT
Docket No. 2019-0716

APPEAL OF
NEW HAMPSHIRE ASSOCIATION OF NURSE ANESTHETISTS

Rule 11 Appeal
From the New Hampshire Board of Medicine

BRIEF OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES AND THE AMERICAN BOARD OF ANESTHESIOLOGY AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT NEW HAMPSHIRE BOARD OF MEDICINE

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I. INTRODUCTION

This case is not about whether anesthesia services should be provided by physicians who specialize in anesthesiology or by Certified Registered Nurse Anesthetists ("CRNA"). The issue here is whether the New Hampshire Board of Medicine ("Board of Medicine") can regulate the practice of medicine by adopting a rule to prevent individuals who are not licensed to practice medicine from referring to themselves using a term suggesting that they are practicing medicine. The rule the Board of Medicine adopted will ensure that the terminology used to describe CRNAs will not mislead patients and other health care consumers concerning the qualifications of those providing their care. No one disputes that CRNAs have appropriate training to provide anesthesia care. However, the field of anesthesiology encompasses far more than the intra-operative administration of anesthesia, and the education and training needed to become an anesthesiologist, meaning an expert in the entire field of anesthesiology, is substantially greater than the education and training of a CRNA.

In the health care setting and elsewhere, the term "anesthesiologist" has a specific meaning: a physician who has successfully completed the education and training needed to specialize in entire field of anesthesiology. When physicians, nurses, medical personnel, and patients hear the term, they assume it refers to a physician, not to a nurse. When the same people hear the term "anesthetist" they know that it refers to a CRNA, and not to a physician. Introducing the term "nurse anesthesiologist" can only lead to harmful confusion.

Anesthesiology encompasses far more than just the administration of anesthesia. In addition to providing care for patients while undergoing anesthesia, anesthesiology encompasses the entire area of science and medicine related to the pharmacologic, physiologic, and clinical bases of anesthesia, resuscitation, intensive care, and the management of acute and chronic pain. Anesthesiologists are experts in this entire branch of medicine, not just in the administration of anesthesia during surgery.

The distinction is important because it denotes a significant difference in the knowledge and level of training and the scope of an individual's ability to provide services and respond to problems. Patients have the right not to be confused about who is providing their care or the level of their training. The decision of the Board of Medicine recognized this right, and its ruling was based on its conclusion that professionals providing anesthesia services should not use terms that would mislead a patient or anyone else about the education, training, qualifications, and expertise of the person providing their care.

II. STATEMENT OF INTEREST OF *AMICUS CURIAE*

Since its inception, the mission of the American Board of Anesthesiology, Inc. ("ABA") has been to advance the highest standards of quality in the field of anesthesiology. *See* App. 006 (*About The ABA*, The ABA). The ABA was established in 1937 to certify physicians specializing in anesthesiology. *See* App. 007 (*Our Timeline*, The ABA). In 1941, the Advisory Board for Medical Specialties, later called the American Board of Medical Specialties ("ABMS"), approved the ABA as a separate primary medical specialty board. *Id.* Throughout its history, the ABA has supported

and advanced the practice of anesthesiology for the betterment of public health.

The ABA is responsible for issuing board certification to qualified physicians specializing in anesthesiology. *Id.* at 006 (*About the ABA*, The ABA). As the practice of anesthesiology has progressed, the ABA has added sub-specialty certifications in the areas of critical care medicine, pain management, sleep medicine and pediatric anesthesiology. *Id.* The ABA has developed extensive, research based certification and re-certification resources, assessments and processes to establish and measure high quality standards for anesthesiologists and to ensure that physicians who are Board Certified in anesthesiology engage in lifelong learning and have a commitment to professionalism, quality clinical outcomes and patient safety. *Id.*

As the primary certifying body for anesthesiologists since 1938, the ABA is dedicated to providing a means for physicians to remain current and maintain appropriate standards of care and quality. Achieving ABA certification signifies to patients that an anesthesiologist is highly qualified and provides a means for the public to make informed choices about their anesthesiologists.

The ABMS is an independent organization founded in 1933 to set professional standards for physician practice and board certification. *See* App. 012 (*About the American Board of Medical Specialties*, The American Board of Medical Specialties). One role of ABMS is to identify and define the scope of medical specialties, including anesthesiology. For example, under the Medicare program, Medicare will pay hospitals the cost of certain direct graduate medical educational activities of "approved medical

residency training programs." 42 U.S.C. § 1395ww(h). The term "approved medical residency training program" is defined as a program that meets one of several criteria, including that it may count toward certification of the participant in a specialty or subspecialty listed in the current edition of the Annual Report and Reference Handbook published by ABMS. 42 C.F.R. § 413.75(b).

ABMS seeks to improve the quality of care by elevating the discipline of medicine through board certification. ABMS has 24 Member Boards, each of which offers board certification in different specialties and subspecialties. *See* App. 012 (*About the American Board of Medical Specialties*, The American Board of Medical Specialties). All ABMS Member Boards, including ABA, set specific requirements for training and experience, including the completion of a residency program accredited by the Accreditation Council for Graduate Medical Education ("ACGME"), which a physician must complete to be eligible for board certification. Depending on the specialty, residency programs take from three to seven years. *Id.*, *See* App. 015 (*Board Certification Requirements,* The American Board of Medical Specialties). To become board certified, a physician must also obtain an unrestricted medical license in the United States or Canada and provide letters from their program director or faculty attesting to their professionalism and their competence in the field. *Id.* Upon successful completion of their residency, a physician must then pass the Member Board's certification examination. *Id.* To prevent their board certification from lapsing, physicians are required to comply with the continuing certification process, which includes ongoing assessment, learning, and professionalism, among other requirements. *Id.*

Both ABA and ABMS recognize the long-standing practice of CRNAs and do not seek to limit the scope or diminish their important work in any way. However, the New Hampshire Board of Nursing's use of the term "Nurse Anesthesiologist" directly implicates the practice of medicine and elicits serious concerns regarding public confusion and safety in the patient care setting. It is of vital importance and interest to the ABA and the ABMS to protect the term "anesthesiologist" to ensure that it continues to connote a distinct level of training and quality by a physician, with expertise in the entire field of anesthesiology, to the public.

As such, the ABA and the ABMS submit this *amicus curiae* brief in support of the Respondent's Brief and the Board of Medicine's unanimous Declaratory Ruling that anyone in New Hampshire who identifies themselves as a "nurse anesthesiologist" or otherwise describes themselves using the term "anesthesiologist" in their professional title without a license from the Board of Medicine is holding themselves out as qualified to practice medicine when not qualified or licensed to do so, in violation of New Hampshire Revised Statute Title XXX, Section 329:24 "Unlawful Practice."

III. THE FIRST AMENDMENT DOES NOT PROTECT MISLEADING SPEECH

For the reasons set forth in the Respondents' Brief, the ABMS and ABA agree that the Board of Medicine's rule restricting the use of the title "anesthesiologist" to those licensed to practice medicine merely regulates the practice of medicine and does not restrict speech. The rule does nothing more than further the well-accepted rule that a person who is not licensed to practice medicine cannot represent that they are a physician. However, even

if this Court were to conclude that the use of the term "nurse anesthesiologist" is commercial speech, the Board of Medicine's rule is narrowly designed to prevent misleading speech, so it does not violate the First Amendment.

The First Amendment does not prevent states from regulating commercial speech to prevent it from being misleading. As the Supreme Court stated in *Bates v. State Bar of Arizona*, advertising "that is false, deceptive, or misleading of course is subject to restraint." *Bates v. State Bar of Arizona*, 433 U.S. 350, 383 (1977). Similarly, in *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, the Court explained that "much commercial speech is not provably false, or even wholly false, but only deceptive or misleading." *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 771 (1976). "We foresee no obstacle to a State's dealing effectively with this problem. The First Amendment … does not prohibit a State from insuring that the stream of commercial information flows cleanly as well as freely." *Id.* at 771-72. *See Linmark Associates, Inc. v. Township of Willingboro*, 431 U.S. 85, 98 (1977) (noting difference between banning commercial speech and regulating it to prevent it from being misleading.)

Likewise, the Supreme Court has "long recognized that governmental regulation of the professions is constitutional if the regulations have a rational connection with the applicant's fitness or capacity to practice the profession." *Accountant's Soc'y of Virginia v. Bowman*, 860 F.2d 602, 603-04 (4th Cir. 1988) (internal quotations omitted). Professional regulation "is not invalid, nor is it subject to first

amendment strict scrutiny, merely because it restricts some kinds of speech." *Id.* at 604.

The use of the term "anesthesiologist" is a business or trade label, just as the terms "public accountant" and "PA" were trade labels in *Accountant's Society*. *Id.* at 605. The use of a trade label is not protected by the first amendment if it is false, deceptive, or misleading. *Id.*

The State has an interest in assuring the public that only those who have demonstrated their qualifications as physician specialists in anesthesiology hold themselves out as anesthesiologists. In *Accountant's Society*, the court determined that the State could limit the use of the term "public accountant" to certified public accountants, even though the practice of accounting was not limited to those with CPAs. As the court explained, the "similarity of the title 'public accountant' to 'certified public accountant' is self-evident. In defining 'misleading' for the purpose of regulation of commercial speech, the Supreme Court has explained that when the possibility of deception is self-evident, the state need not survey the public." *Id.* at 605-06 (citing *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 652-53 (1985)).

Likewise, here, it is self-evident that the use of the term "anesthesiologist" by non-physicians has the possibility of deception. While CRNAs are qualified to provide anesthesia care, they are not experts in the entire field of anesthesiology and have not completed anywhere near the level of education and training required of a physician specializing in anesthesiology. Since the creation of the specialty, the public has heard the term "anesthesiologist" and has known that it refers to a physician specializing in anesthesiology, and has heard the terms "nurse anesthetist,"

"CRNA" or "certified registered nurse anesthetist" and has associated those terms with nurses trained to provide anesthesia care. Given the evident potential for confusion that comes from allowing nurses to call themselves "anesthesiologists" or "nurse anesthesiologists," State regulation of those terms is warranted and permissible under the first amendment.

IV. "NURSE ANESTHESIOLOGIST" IS MISLEADING

The ABMS and the ABA respect the practice of CRNAs and do not suggest any limitation to the scope of their practice that is not already imposed by New Hampshire law. However, there are substantial differences in the scope of practice and the educational and training requirements between physicians specializing in anesthesiology and CRNAs that cannot be overlooked or minimized. While CRNAs have expertise in administration of anesthesia, physicians specializing in anesthesiology, including board certified anesthesiologists, remain the foremost experts in the field of anesthesiology. Anesthesiologists are required to undergo five to six more years of education and between 5,631 to 6,631 more clinical hours than CRNAs. *See* App. 018 (*Certification Requirements,* ABA Policy Book); App. 093 (*Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners*, Primary Care Coalition); App. 198 to Brief of the American Association of Nurse Anesthetists as *Amicus Curiae* (*Nurse Anesthetist (CRNA) Degrees, Program Requirements & Coursework*, All Nursing Schools); and App. 194 to the Brief of The American Association of Nurse Anesthetists as *Amicus Curiae* (*Education of Nurse Anesthetists in the United States – At a Glance*, American Association of Nurse Anesthetists).

The term "anesthesiologist" has, since the creation of the specialty, been used to designate physicians specializing in anesthesiology rather than CRNAs. The introduction of the term "nurse anesthesiologist" in this context will mislead patients and healthcare consumers. Nor can any confusion be eliminated by simply referring to CRNAs as "nurse anesthesiologists" while physicians specializing in anesthesiology are called "physician anesthesiologists," because these terms suggest a false equivalence between anesthesiologists and CRNAs. They imply that a "nurse anesthesiologist" and a "physician anesthesiologist" are co-equal experts in the entire field of anesthesiology. This is demonstrably false. Therefore, the Board of Medicine acted appropriately to bar the use of the term by non-physicians.

A. ACGME TRAINING REQUIREMENTS FOR ANESTHIOLOGISTS

To become an anesthesiologist, an individual must first obtain a bachelor's degree, which generally must include a year of biology, physics, general chemistry, and organic chemistry (4 years). The individual must then successfully complete medical school and obtain a Medical Doctor or Doctor of Osteopathy degree (4 years). Following medical school, the individual must complete a one year internship followed by a 3 year residency focused on anesthesiology to become eligible to apply for board certification in anesthesiology from the ABA. See App. 018 (*Certification Requirements*, ABA Policy Book) and App. 093 (*Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners*, Primary Care Coalition). In total, anesthesiologists are required to complete 12 years of education and approximately 15,000-16,000 clinical hours to be eligible

to undergo further rigorous testing to obtain their board certification in anesthesiology. *Id*.

To successfully complete an anesthesiology residency, the resident must demonstrate competence in fundamental clinical skills of medicine, including:

- Obtaining a comprehensive medical history;
- Performing a comprehensive physical examination;
- Assessing a patient's medical conditions;
- Marking appropriate use of diagnostic studies and tests;
- Integrating information to develop a differential diagnosis; and
- Implementing a treatment plan.

In addition, he or she must be able to demonstrate competence in anesthetic management, including care for:

- Patients younger than 12 years of age undergoing surgery or other procedures requiring anesthetics (minimum of 100 patients younger than 12 and at least 20 patients younger than 3 months);
- Patients who are evaluated for management of acute, chronic, or cancer related pain disorders;
    - This experience must involve care for 20 patients presenting for initial evaluation of pain;
    - Residents must be familiar with the breadth of pain management, including clinical experience with interventional pain procedures;
- Patients immediately after anesthesia, including direct care of patients in the post-anesthesia-care unit, and responsibilities for

management of pain, hemodynamic changes and emergencies related to the post-anesthesia care unit; and

- Critically ill patients

A resident must achieve competence in the delivery of anesthetic care to:

- Patients undergoing vaginal delivery (at least 40 patients);
- Patients undergoing cesarian sections (at least 20 patients);
- Patients undergoing cardiac surgery (at least 20 patients, 10 of whom must involve the use of cardiopulmonary bypass);
- Patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, or peripheral vascular surgery (at least 20 patients not including surgery for vascular access or repair of vascular access); patients undergoing procedures for complex, immediate life-threatening pathology (20 patients);
- Patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics (40 patients);
- Patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management (40 patients);
- Patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities;
- Patients whose peri-operative care requires specialized techniques, including a broad spectrum of airway management techniques, central vein and pulmonary artery catheter placement, use of

transesophageal echocardiography and evoked potential and use of electroencephalography;

- Patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite which must include competency in:
    - using surface ultrasound and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia, critical care, and resuscitation;
    - understanding the principles of ultrasound, including the physics of ultrasound transmission, ultrasound transducer construction, and transducer selection for specific applications, to include being able to obtain images with an understanding of limitations and artifacts
    - obtaining standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g., large pericardial effusion);
    - using transthoracic ultrasound for the detection of pneumothorax and pleural effusion;
    - using surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures; and

    - describing techniques, views, and findings in standard language.
- Residents must be able to perform all medical, diagnostic and surgical procedures considered essential for the area of practice.
- Systems based practice: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.

See App. 095 (*ACGME Program Requirements for Graduate Medical Education In Anesthesiology,* Accreditation Council for Graduate Medical Education).

After completion of their residency and obtaining a full and unrestricted license to practice medicine, to become board certified by the ABA a physician must the pass a rigorous written examination which encompasses the entire field of anesthesiology. After obtaining board certification, anesthesiologists are required to maintain their certification by completing assessments of their knowledge, judgment and skills as follows[1]: maintain an active, unrestricted license to practice medicine in at least one jurisdiction of the United States or Canada; complete 120 Maintenance of Certification in Anesthesiology (MOCA) Minute questions every year (or 30 MOCA Minute questions each calendar quarter); complete 250 credits of continuing medical education every 10 years (or

[1] Other organizations assessing a board-certified anesthesiologist's continued qualifications have similar requirements.

125 credits every 5 years) and complete 50 points of Quality Improvement activities every 10 years (or 25 credits every 5 years). *See* App. 158 (*MOCA 2.0 Parts 1-4*, The ABA).

B. TRAINING FOR CRNAs

To become a CRNA, an individual must obtain an Associate's degree with a bridge program (2 years) or a bachelor's degree (4 years); work for 1 year as a Registered Nurse and then obtain a Master's of Nursing in anesthesia (2 years). At that point they are eligible to apply for the National Certification Examination from the National Board of Certification and Recertification of Nurse Anesthetists. *See* App. 198 to Brief of the American Association of Nurse Anesthetists as *Amicus Curiae* (*Nurse Anesthetist (CRNA) Degrees, Program Requirements & Coursework*, All Nursing Schools) and App. 194 to the Brief of The American Association of Nurse Anesthetists as *Amicus Curiae* (*Education of Nurse Anesthetists in the United States – At a Glance*, American Association of Nurse Anesthetists). CRNAs are not required to complete a residency program or undergo clinical training after completing their Master's degree. *Id.* In total, CRNAs are required to complete about five to seven years of education and approximately 9,369 clinical hours prior to obtaining their CRNA certificate. *Id.*

Thereafter, CRNAs are required to meet continuing education requirements: at all times maintain a current, unencumbered state license to practice as a CRNA and complete 40 hours of continuing education credits every 2 years. *See* App. 214 to the Brief of The American Association of Nurse Anesthetists as *Amicus Curiae* (*Step 4: Keep Your CRNA Certification and State APRN License in Good Standing*, MSNedu.org).

C. COMPARISON OF EDUCATION AND TRAINING BETWEEN ANESTHESIOLOGISTS AND CRNAs

Anesthesiologists are required to undergo five to six years more education and 5,631-6,631 more clinical training hours than CRNAs. Additionally, anesthesiologists are required to complete 50 more hours of continuing education training than CRNAs every 10 years. To maintain their ABA board certification, anesthesiologists are required to complete 120 MOCA minute exam questions annually and complete 50 Quality Improvement hours every 10 years. CRNAs are not required to complete any exams or complete similar Quality Improvement hours to maintain their certification.

In addition to the difference in years of education and clinical hours required, the differences in the scope and depth of knowledge between a physician and CRNA cannot be overlooked. Physicians are required to complete courses relevant to the practice of medicine including associated laboratory courses. *See* App. 169 (*Supervision of Nurse Anesthetists*, American Society of Anesthesiologists). This breadth of courses plus the greater duration of course work allow for detailed, comprehensive medical knowledge that prepares a physician to provide a patient with a diagnosis and make appropriate treatment decisions. *Id.* Nurse anesthetists take selected courses related to their areas of nursing focus that are shorter in duration. *Id.* Nursing skills are vital, but they cannot replace the expertise of a physician. An anesthesiologist's education and training prepare him or her to manage comprehensive medical care of the patient in all medical situations, including situations involving anesthesia. *Id.* As such, it is

recognized that an anesthesiologists' distinct qualifications designate them as the foremost experts in the practice of anesthesiology.

A physician's more comprehensive education and training must be recognized, emphasized, and readily understood by the public. While CRNAs are qualified to administer quality anesthesia care, they cannot practice medicine and are not anesthesiologists. An anesthesiologist remains the most highly trained and qualified person to practice anesthesiology. To identify CRNAs as "Nurse Anesthesiologists" dangerously and confusingly blurs the distinction between a nurse and a physician by minimizing and failing to reflect the distinct and comprehensive education, training and expertise of a physician board certified or board eligible in anesthesiology. [2]

D. THE TERM "NURSE ANESTHESIOLOGIST" WILL CAUSE CONFUSION FOR HEALTHCARE CONSUMERS

For decades, the term "anesthesiologist" has been unique to physicians in both healthcare settings and popular usage. The dictionary definition of "anesthesiologist" is "a physician specializing in

[2] The brief of the American Association of Nurse Anesthetists suggests that federal regulators "now recognize that CRNAs are independent providers of anesthesia." Brief of The American Association of Nurse Anesthetists, at 20. This substantially overstates the case. In fact, federal regulations related to participation in Medicare by hospitals specify that if the hospital provides anesthesia services, they "must be provided … under the direction of a qualified doctor of medicine or osteopathy." 42 C.F.R. § 482.52. The regulation further specifies that anesthesia must be administered only by an anesthesiologist, a doctor of medicine or osteopathy, certain other practitioners, or a "certified registered nurse anesthetist (CRNA) … who, unless exempted … *is under the supervision of the operating practitioner or of an anesthesiologist* who is immediately available if needed." 42 C.F.R § 482.52(b)(4) (emphasis added). However, a hospital may be exempted from the physician supervision requirement for CRNAs if the State in which the hospital is located "submits a letter signed by the Governor, requesting exemption from physician supervision of CRNAs." The Governor must attest that it is in the best interests of the State's citizens to opt-out of the physician supervision requirement. 42 C.F.R. § 482.52(c)(1). New Hampshire has opted out of this requirement, but about 20 states have not.

anesthesiology." *See* App. 170 (*Anesthesiologist*, Merriam-Webster), *See also* App. 172 ("Anesthesiologist: 'A physician who specializes in anesthesiology.', *Anesthesiologist*, Dictionary.com); *See also* App. 173 ("An anesthesiologist is a doctor who specializes in giving anesthetics to patients." *Anesthesiologist*, Collins Dictionary).

Patients should not be misled or confused about the qualifications of those who provide their anesthesia services. The recognized and accepted meaning of the term "anesthesiologist" is a physician specializing in the field of anesthesiology. Adding terms such as "certified registered nurse," "nurse" or any other term before "anesthesiologist" will cause patient confusion regarding the knowledge, skill, and training of the person providing their treatment. Moreover, the court can take note of the fact that most people, in conversation, abbreviate titles and names, so prefatory terms such as "nurse" will be dropped and only the term "anesthesiologist" will be said. It is imperative to avoid blurring the distinction between a nurse and a physician because doing so would dangerously minimize and fail to recognize an anesthesiologist's role as the foremost expert in the entire field of anesthesiology care.

The public understands that an "anesthesiologist" is a physician, as was confirmed by the fact that 70% of people answered "yes" when asked whether an anesthesiologist was a type of physician. *See* App. 174 (*AMA Truth In Advertising Survey 2018*, at 7, American Medical Association). The studies relied upon by the Nurse Anesthetists demonstrate that using the term "Nurse Anesthesiologist" will cause confusion. Almost half of the respondents in one study were unable to determine whether "Nurse Anesthesiologist" refers to a nurse or a physician. *See* App. 256 to the Brief

of The American Association of Nurse Anesthetists as *Amicus Curiae* (*National CRNA Survey*, ASCEND PERSPECTIVES (March 28–April 1, 2019)). Although the survey indicated that 53% of respondents recognized that a "Nurse Anesthesiologist" is a member of the nursing profession and a "Physician Anesthesiologist" is a medical doctor,[3] the survey found that 18% of respondents did not understand the distinction and 29% were unsure of the distinction. *Id.* Thus, nearly half, 47%, of the respondents were confused or unable to discern the difference between the terms "Nurse Anesthesiologist" and "Physician Anesthesiologist." *Id.* It is wholly unconvincing to use these survey results to argue that the public is not confused by the term "Nurse Anesthesiologist" when almost half the respondents were confused or otherwise unable to answer a leading question regarding the qualifications and meaning of the term.

E. HEALTHCARE PROVIDERS AND PATIENTS CONSIDER ANESTHESIOLOGISTS TO BE PHYSICIANS

A simple online search of the term "anesthesiologist" yields countless results in which "anesthesiologists" are defined as physicians in clinical settings. The U.S. National Library of Medicine National Institute of Health stated, "Anesthesiologists are physicians who provide medical care to patients in a wide variety of situations… Anesthesiology is a specialized field of medicine practiced by highly trained doctors." *See* App. 206 (*Anesthesiologist: The silent force behind the scene*, The U.S. National Library of Medicine National Institute of Health).

[3] The fact that 53% of people could distinguish between the two was hardly surprising, since the wording of the question suggested the answer ("Would you say you recognize a Nurse Anesthesiologist as a member of the nursing profession and a Physician Anesthesiologist as a medical doctor?")

When receiving healthcare treatment, patients will encounter various healthcare providers including technicians, certified nursing assistants, nurses, physicians, and administrative staff. Patients receiving healthcare treatment are often not well versed in the distinctions between these providers and may not be able to accurately identify the many individuals providing their care. A study by Ferdinand Iannaccone, D.O., a physician at Rutgers New Jersey Medical School, presented to the American Society of Anesthesiologists (ASA) found that more than 90% of patients were aware that anesthesiologists "put patients to sleep," but less than half understood all of their anesthesiologist's duties or treatment administered during their procedure. Dr. Iannacconne remarked that "anesthesia is the topic than many patients know least about and the best way to calm anxiety is to address the unknown." *See* App. 215 (*Study finds many patients unaware of what the anesthesiologist actually does,* Medical Xpress). Therefore, healthcare providers must provide patients with clear, accurate and comprehensive information regarding their medical treatment and the qualifications of the providers administering their treatment.

Numerous examples demonstrate that healthcare providers routinely provide information to patients and laypeople that anesthesiologists are medical doctors or physicians who specialize in providing anesthesia care.

- Hospital for Special Surgery (HSS), a leading academic medical center, offered this definition on its patient information webpage: "An anesthesiologist is a doctor (MD or DO) who practices anesthesia. Anesthesiologists are physicians specializing in perioperative care, developing anesthetic plans, and the

administration of anesthetics. He or she has finished college, then medical school (four years), then an internship (one year) followed by a residency in anesthesia (three years). Some anesthesiologists pursue additional years of training (a fellowship)." *See* App. 218 (*About Hospital for Special Surgery (HSS)*, HSS.edu) and App. 224 (*What is an Anesthesiologist?*, HSS.edu).

- John Hopkins Medicine's patient information "About Your Anesthesiologist" webpage states, "Anesthesiologists are the doctors trained to administer and manage anesthesia given during a surgical procedure." *See* App. 226 (*Anesthesia: About Your Anesthesiologist*, John Hopkins Medicine).
- The University of Maryland School of Medicine's "Patient Information" webpage explains, "An anesthesiologist is actually a perioperative physician, where "peri" means all-around. So, an anesthesiologist is responsible for patient care throughout the surgical experience: before, during, and after the surgery itself. An anesthesiologist also has many responsibilities outside of the surgical suite (operating room)." *See* App. 231 (*Role of the Anesthesiologist*, University of Maryland School of Medicine).
- Sutter Health Hospital's patient information webpage explains, "A doctor who specializes in anesthesia, called an anesthesiologist, will design your anesthetic based on your body composition and your personal health history." *See* App. 232 (*Anesthesia Services*, Sutter Health).

- Anesthesia practice, U.S. Anesthesia Partner's, patient information webpage defines, "Anesthesiologist: Physician specializing in administering analgesia and anesthesia." *See* App. 236 (*Patients: Understanding Anesthesia*,, U.S. Anesthesia Partners).
- Medical News Today states, "An anesthesiologist is a doctor who gives a patient medication so they do not feel pain when they are undergoing surgery." *See* App. 243 (*What do Anesthesiologists do?*, Medical News Today).

Within the healthcare industry, healthcare providers identify "anesthesiologists" as physicians or doctors who specialize in anesthesiology and explain them as such to their patients receiving anesthesiology care.

F. THE GENERAL PUBLIC UNDERSTANDS THAT ANESTHESIOLOGISTS ARE PHYSICIANS

Beyond clinical settings, the public lexicon also understands that "anesthesiologist" identifies a physician specializing in anesthesiology. Use of the term "anesthesiologist" to describe any individual other than a physician is likely to lead to the impression that the individual is a physician. There are numerous examples indicating that the term "anesthesiologist" is commonly used in the public to indicate a physician or doctor engaged in the practice of medicine.

- WebMD states, "A medical doctor (MD) or a doctor of osteopathy (DO) can become an anesthesiologist." *See* App. 250 (*What Does An Anesthesiologist Do?*, Web MD).
- U.S. News & World Report defined, "Anesthesiologists are the physicians responsible for administering general or regional

anesthesia, which allows surgeons and other physicians to complete invasive procedures with little to no discomfort to the patient." *See* App. 254 (*What is an Anesthesiologist?,* U.S News & World Report).

- Careers in Healthcare states, "An Anesthesiologist is a medical doctor who is responsible for prescribing and administering anesthesia to patients as needed." *See* App. 258 (How to *Become an Anesthesiologist,* Careers In Healthcare).
- Western Governors University, "Anesthesiologists are physicians that specialize in the administration of anesthesia." *See* App. 269 (*Nurse anesthetist vs. anesthesiologist,* Western Governors University).

Throughout the public lexicon and throughout the United States, laypeople identify "anesthesiologists" as physicians or doctors who specialize in anesthesiology. Indeed, it would be highly unusual in either the public setting or in the healthcare setting that anyone uses the term "physician anesthesiologist" because the term is redundant: an anesthesiologist is understood to be a physician.

There is no branch of medicine in which specialists use the term "physician" in addition to their specialty designation to clarify that they are a doctor. No one uses the terms "physician pediatrician," "physician cardiologist" or "physician internist," because the public understands that pediatricians, cardiologists, and internists are all physicians. Similarly, it is understood that an "anesthesiologist" is a physician specializing in anesthesiology.

Given the nationwide use of the term “anesthesiologist” to refer to a physician specializing in anesthesiology, adoption of the terms “nurse anesthesiologist” and “physician anesthesiologist” in New Hampshire would also mean that the usage in New Hampshire would be different than in the rest of the country. This will lead to confusion for New Hampshire citizens who travel for healthcare to other states, or citizens of other states who travel for healthcare to New Hampshire.

G. FURTHER CONFUSION WILL RESULT WHEN ALL CRNAS ARE REQUIRED TO OBTAIN DOCTORATE DEGREES

Beginning in 2025, all CRNAs will be required to obtain a doctorate degree. *See* App. 274 (*CRNAs Will Need a Doctorate Degree by 2025*, Nurse.Org). Even now, many CRNAs have doctorate degrees. This does not mean that their education and training will be anywhere near equivalent to the education and training of physicians specializing in anesthesiology as it typically takes an additional one to two years for training (30 to 40 credit hours including 1,000 hours of clinical training) to go from an MSN to a DNP or DNAP degree. *See* App. 279 (Gaines, K., BSN, RN, BA, CBC, *CRNA vs. DNP & DNAP: What’s the Difference,* Nurse.Org).

Numerous nurses and nursing organizations have advocated that nurses, including CRNAs, should use the title “doctor” if they have earned a doctorate degree. *See* App. 291 (*Can You Be Referred to as a Doctor If You Earn a DNP?*, RegisteredNursing.Org); App. 293 (*Some Doctoral-Prepared Nurses Use The Title, “Doctor” and It’s Causing a Heated Debate*, Nurse.Org); App. 297 (*When Nurses Use the Title "Doctor"*, The Journal of Nursing Administration).

Given that most CRNAs will have doctorate degrees, will they be able to identify themselves as "doctor anesthesiologists" or will they identify themselves using a new term such as "doctor nurse anesthesiologist"? Will patients in clinical settings and the public be able to discern the difference between "doctor anesthesiologists" who are CRNAs with doctorate degrees and "physician anesthesiologists" who hold M.D. or D.O. degrees and specialize in anesthesiology? Permitting CRNAs to use the term "nurse anesthesiologist" will lead to further confusion and misunderstanding in clinical settings where differences in a healthcare provider's education and training are of vital importance to patients.

V. CONCLUSION

The decision of the New Hampshire Board of Medicine to restrict the use of the term "anesthesiologist" to physicians is well justified. While CRNAs can administer quality anesthesia care and may be allowed to act independently, physicians specializing in anesthesiology remain the foremost experts in the entire field of anesthesiology across the nation. Nurse anesthetists may administer anesthesia, but they cannot practice medicine.

Patients in clinical settings and the public commonly understand that the term "anesthesiologist" is used to indicate a physician or doctor engaged in the practice of medicine. To identify CRNAs as "nurse anesthesiologists" is misleading as it blurs the distinction between a nurse and a physician by minimizing and failing to reflect that a physician specializing in anesthesiology has a distinct and more comprehensive education, training, and expertise.

Using the term anesthesiologist to denote a nurse, even in conjunction with the term "nurse," will cause confusion in patient care settings, where healthcare consumers already have difficulty discerning the difference between the education, training, and expertise of the individuals providing their care. The Medical Board was justified in concluding that the use of the term "nurse anesthesiologist" would be misleading when half of the population cannot discern the difference between a physician and a nurse when the term "nurse anesthesiologist" is used.

The American Board of Medical Specialties and the American Board of Anesthesiology respectfully request that the Court uphold the New Hampshire Board of Medicine's unanimous Declaratory Ruling that anyone in New Hampshire who identifies themselves as a "Nurse Anesthesiologist" or otherwise describes themselves using the term "Anesthesiologist" in their professional title without a license from the Board of Medicine is holding oneself out as qualified to practice medicine when not qualified or licensed to do so, in violation of RSA 329:24 "Unlawful Practice."

Respectfully submitted.

DATED: July 8, 2020

THE AMERICAN BOARD OF MEDICAL SPECIALTIES and THE AMERICAN BOARD OF ANESTHESIOLOGY

By their attorneys,

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Certification Pursuant to Rule 16(11)

I certify this brief complies with the word limitation in Supreme Court Rule 16(11) of 9,500 words. This brief contains 6,289 words, exclusive of pages containing the table of contents, tables of authorities, and the appendix.

/s/ Derek D. Lick

Derek D. Lick

Counsel for Amici Curiae
The American Board of Medical Specialists and The American Board of Anesthesiology

Certificate of Service

I hereby certify that on July 8, 2020, a copy of this Brief of *Amici Curiae* The American Board of Medical Specialists and The American Board of Anesthesiology was served electronically using the Court's electronic filing system.

/s/ Derek D. Lick

Derek D. Lick

Counsel for Amici Curiae
The American Board of Medical Specialists and The American Board of Anesthesiology

STATE OF NEW HAMPSHIRE
SUPREME COURT
Docket No. 2019-0716

APPEAL OF
NEW HAMPSHIRE ASSOCIATION OF NURSE ANESTHETISTS

Rule 11 Appeal
From the New Hampshire Board of Medicine

APPENDIX TO THE BRIEF OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES AND THE AMERICAN BOARD OF ANESTHESIOLOGY AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT NEW HAMPSHIRE BOARD OF MEDICINE

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APPENDIX TABLE OF CONTENTS

Other Documents Cited in the Brief

PHYSICIAN LOGIN (HTTPS://PORTAL.THEABA.ORG/PAGES/LOGIN.ASPX)

About The ABA

The mission of the American Board of Anesthesiology® (ABA) is to advance the highest standards of the practice of anesthesiology. As the certifying body for anesthesiologists since 1938, the ABA is committed to partnering with physicians to advance lifelong learning and exceptional patient care. The Board administers initial and subspecialty certification exams as well as the Maintenance of Certification in Anesthesiology™ (MOCA®) program, which is designed to promote lifelong learning, a commitment to quality clinical outcomes and patient safety. Based in Raleigh, N.C., the ABA is a nonprofit organization and a member board of the American Board of Medical Specialties.

Click here to view the ABA Media Kit (/PDFs/Media/ABA-Media-Kit).

History Documentary

The history documentary captures our rich history and the pivotal events that have shaped the Board's path. It includes chapters that highlight the early days of anesthesiology, the evolution of the Board's exams, the advancement of the MOCA program and future ABA initiatives.

Our Timeline

Image courtesy of the Wood Library-Museum of Anesthesiology, Schaumburg, Illinois.

1937

A committee representing the American Society of Anesthetists, Inc., the American Society of Regional Anesthesia, Inc., and the Section on Surgery of the American Medical Association was established to devise a plan for an organization that would certify physicians practicing in the field of anesthesiology.

On June 2, 1937, The American Board of Anesthesiology, Inc (ABA), was formed as an affiliate of The American Board of Surgery, Inc.

1938

The Advisory Board for Medical Specialties and the Council on Medical Education of The American Medical Association approves the ABA as an affiliate of The American Board of Surgery.

1941

The Advisory Board for Medical Specialties approves the establishment of the ABA as a separate primary Board.

1977

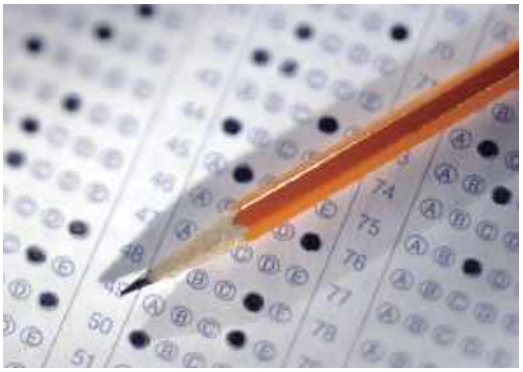
The Society of Critical Care Medicine approaches the American Board of Medical Specialties (ABMS) to discuss official recognition for physicians with expertise in critical care medicine. In response, the ABA and three other member boards begin exploring mechanisms for awarding such recognition.

1985

On March 21, the ABMS votes to permit the ABA and several other member boards to issue certificates in critical care medicine.

1991

ABMS approves our pain management application at its March meeting with the condition that the subspecialty certificate be time-limited. On Sept. 26, ABMS votes to permit us to issue certificates in pain management that would be valid for 10 years.



1996

ABMS approves our proposal for recertification in anesthesiology at its March 21 meeting.

2005

We administer our first annual MOCA Exam in July. In 2007, we begin offering the MOCA Exam two times each year.

1989

We notify the ABMS of our intent to offer subspecialty certification in pain management and have subsequent discussions with other ABMS member boards with an interest in this subspecialty.

1995

We approve a policy of time-limited certification so that all certificates issued on or after Jan. 1, 2000 be valid for 10 years after the candidate passes the certifying exam.

Our office re-locates from Hartford, Conn. to Raleigh, N.C.

1998

ABMS approves the proposals for recertification in critical care medicine and pain management at its Sept. 17 meeting.

2009

We phase out our voluntary recertification program with the administration of the December exam, and the MOCA Examination becomes the only voluntary recertification option for primary certification for diplomates certified before 2000.

The Board brings the question development and administration processes for all exams in-house.

In August, the Board approves the transition to a staged exams process (BASIC, ADVANCED and APPLIED Examinations) to encourage more sustained studying during training and to complement the movement of the Accreditation Council of Graduate Medical Education (ACGME) to competency based training and promotion.

Later that year, the American Board of Pediatrics and the ABA announce a combined, integrated training program in pediatrics and anesthesiology that will require five, not six, years of training for physicians to be fully qualified and certified in both specialties.

2002

In March, ABMS approves changing the name of the subspecialty to Pain Medicine.

We present our proposal for the Maintenance of Certification in Anesthesiology Program® (MOCA®) to ABMS, and the transition from the recertification program to MOCA begins two years later (in 2004).

2010

We begin transitioning from subspecialty recertification to MOCA for Subspecialties (MOCA-SUBS) in January. The last subspecialty recertification exam will be administrated in 2016 and the first MOCA-SUBS examination will be administered in 2017.

2011

In December, the American Board of Internal Medicine and the ABA announce a combined, integrated training program in internal medicine and anesthesiology. ABMS approves our application for Sleep Medicine. These subspecialty certificates are time-limited.

2013

We expand our Raleigh, N.C.-based office space from 13,500 square feet to 32,500 square feet in April to support its growing portfolio of assessments. The staff office and new Assessment Center occupy the 15th floor of the building.

2015

We offer nine Part 2 Examinations at the new Assessment Center.

Candidates can watch the video above to learn more about the new Part 2 Examination process and logistics.

2017

MOCA 2.0 expands to include diplomates with current subspecialty certification.

2012

ABMS approves our time-limited pediatric anesthesiology subspecialty certificate.

2014

We transition to staged exams in July with the first BASIC Examination administration.

Construction begins on the new Assessment Center in Raleigh, N.C., which will house the Part 2 and APPLIED Examinations.

In October, we host our final hotel-based Part 2 Examination in Chicago after 73 years of administering it in hotels throughout the country.

MOCA™ 2.0

2016

We launch the redesigned Maintenance of certification in Anesthesiology Program (MOCA), known as MOCA 2.0®, on Jan. 4. The MOCA Minute® pilot also launched, replacing the MOCA Exam as the MOCA Part 3: Assessment of Knowledge, Judgment, and Skills (formerly the Cognitive Examination).

2018

ABMS approved our request to transition our MOCA Minute pilot to a permanent component of the Maintenance of Certification in Anesthesiology™ (MOCA®) program. The innovative longitudinal assessment has been widely embraced by anesthesiologists and has proven to be a robust evaluation tool for determining if they are maintaining their medical knowledge over time.

(http://www.abms.org/)

The American Board of Anesthesiology® is a Member Board of the American Board of Medical Specialties.

Upcoming Dates

APPLIED Exam Week 7.5
July 18-19

APPLIED Exam Week 8
Sept. 14-17

APPLIED Exam Week 9
Sept. 28-Oct. 1

Quick Links

CREATING A PORTAL ACCOUNT (/PDFS/FOOTER/HOW_TO_CREATE_A_PORTAL_ACCOUNT_AND_APPLY)

RESIDENT PORTAL TIPS (/PDFS/FOOTER/RESIDENT-PORTAL-ACCOUNT-TIPS)

REQUEST DUPLICATE CERTIFICATE (/PDFS/FOOTER/DUPLICATE-CERTIFICATE-REQUEST)

NAME CHANGE (/PDFS/FOOTER/NAME-CHANGE)

DATA REQUEST FORM (/PDFS/DATA-REQUESTS/DATA-REQUEST-FORM)

STATUS DESIGNATIONS (/DIPLOMATES/STATUS-DESIGNATIONS)

Contact Us

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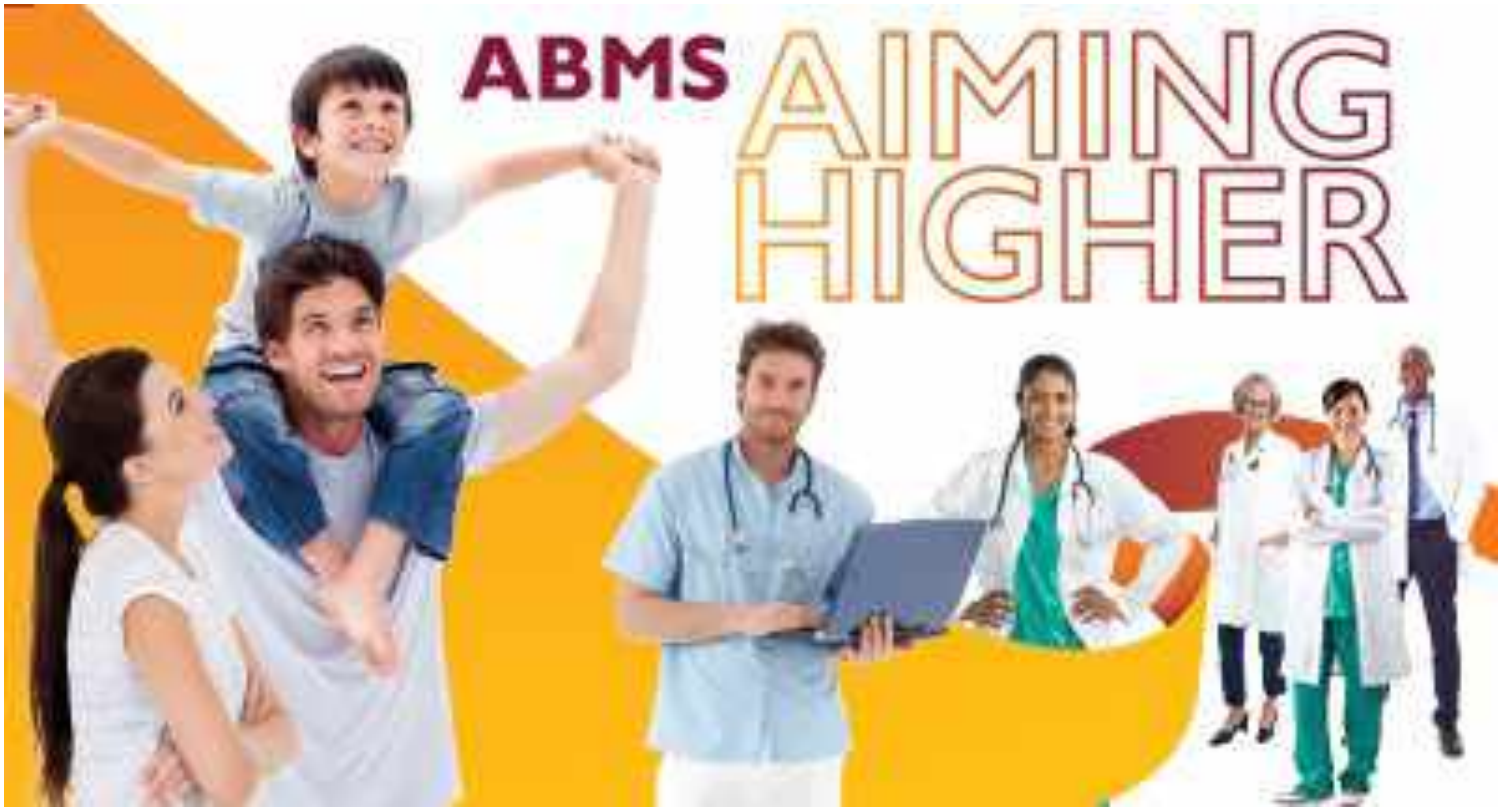
(https://www.facebook.com/AmericanBoardAnesthesiology/?fref=photo)
(https://twitter.com/abaphysicians)
(https://www.linkedin.com/company/the-american-board-of-anesthesiology)

About the American Board of Medical Specialties

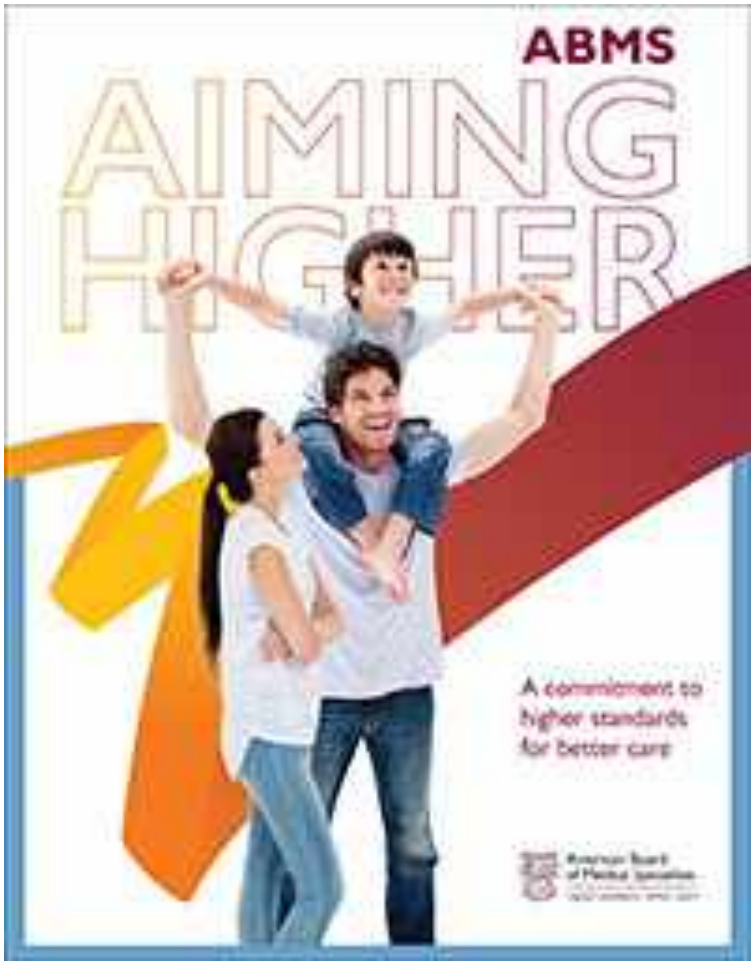


The American Board of Medical Specialties (ABMS) is an independent, not-for-profit organization founded in 1933 to set professional standards for physician practice and board certification. ABMS and its 24 Member Boards are aiming higher to improve the quality of health care by elevating the discipline of specialty medicine through board certification.

Patients and their families place an extraordinary level of trust in their physician specialists. They expect their physicians to meet high standards. Through board certification, physicians retain that trust by demonstrating they are keeping their knowledge current to provide the best possible care to their patients.

At the heart of board certification is an ongoing assessment process, helping physicians identify areas for further study and connect with resources to refresh their skills throughout their career. This continuous focus on assessment and learning helps board certified physicians drive advancements in medicine to diagnose, treat and prevent illness, disease or injury — bringing the highest standards of care into the practices and health systems where they work.

The mission of the American Board of Medical Specialties (ABMS) is to serve the public and the medical profession by improving the quality of health care through setting professional standards for lifelong certification in partnership with Member Boards.



The ABMS mission is realized by helping physicians achieve their potential as providers of quality health care in one or more of the 40 specialties and 87 subspecialties offered by an ABMS Member Board. Working with the Member Boards, ABMS is always evolving and advancing our standards to keep the more than 900,000 ABMS Member Board certified physicians practicing at the forefront of medicine.

We invite others who value the ABMS certification framework to work with us in connecting physician specialists with discipline-specific learning modules, patient safety programs, quality improvement activities, and other educational and practice-based initiatives to support their professional development.

Looking ahead, we continue to work toward the promise of higher standards and better care. In doing so, we are creating an environment of better-informed communities, highly competent specialists and quality health care.

Download the ABMS Aiming Higher brochure[PDF] (best viewed in Adobe Acrobat).

ABMS Member Portal

LOGIN →

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Media

Board Certification Requirements

The information below provides an overview of the requirements for initial board certification and continuing certification. To learn more about the requirements for a specific specialty, please contact the particular ABMS Member Board.

Medical Education and Licensure

After completing medical school, medical students must pass the United States Medical Licensing Examination to receive a license to practice medicine in a particular state.

Residency/Fellowship (3 to 7 years)

Following graduate medical training, physicians can identify themselves as board eligible. They have three to seven years, depending on the ABMS Member Board, to take a specialty certification exam.

All application and exam requirements defined by the Member Board must be met before a physician can take the exam in a specialty or subspecialty.

ABMS Board Certification (Career Entry)

Upon successfully completing a rigorous exam, physicians receive specialty certification and are considered diplomates of that Member Board.

ABMS Continuing Certification (Professional Practice: 30+ years)

Through a process of ongoing assessment and learning, physicians demonstrate their commitment to high-quality patient care. Physicians can become more specialized to better reflect their practice, patient population, and interests through focused practice designation.

Initial Certification

Before physician specialists can practice medicine, they must meet the requirements for medical licensure. Licensure is a mandatory credential granted by a state providing legal permission to practice medicine. Physicians must have a license in the state(s) they intend to practice.

Before physicians can become board certified, however, they must first:

- Finish four years of premedical education in a college or university;
- Earn a medical degree (MD, DO or other credential approved by an ABMS Member Board) from a qualified medical school;
- Complete three to seven years of full-time experience in a residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME);
- Provide letters of attestation from their program director and/or faculty;
- Obtain an unrestricted medical license to practice medicine in the United States or Canada; and
- Pass a written and, in some cases, an oral examination created and administered by an ABMS Member Board.

Continuing Certification

Physicians are intrinsically motivated to enhance the efficiency and efficacy of their practice. The higher standards of board certification reflect the spirit of quality improvement — inspiring creative thinking, modern ingenuity, healthy curiosity and a sincere desire to help every patient. They help physicians maintain up-to-date knowledge,

enhance clinical outcomes and promote patient safety.

The career-long process of ABMS board certification encourages physicians to uphold the dignity and honor of their profession by integrating knowledge, skill and ethical choices in ways that shape their professional lives and help them provide optimal patient care. The ongoing assessment process fosters a community of learners, helping physicians renew their knowledge, identify areas for learning, and connect with resources to retool their skills.

The many programs and initiatives offered by ABMS and our collaboration with a variety of health care organizations support physicians by connecting quality/safety goals and staff evolvement with the aims of certification.

POLICY BOOK

THE AMERICAN BOARD OF ANESTHESIOLOGY

MEMBER BOARD OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES

4208 SIX FORKS ROAD, SUITE 1500 | RALEIGH, NC 27609-5765
WWW.THEABA.ORG

2020

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6. SUBSPECIALTY RECERTIFICATION PROGRAMS

7. BOARD POLICIES

8. REQUESTING ACCOMMODATIONS

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C. Philip Larson, Jr., M.D. 1973-1985
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Richard J. Kitz, M.D. 1974-1986
James F. Arens, M.D. 1975-1987
Wendell C. Stevens, M.D. 1975-1988
Alan D. Sessler, M.D. 1977-1989
Robert K. Stoelting, M.D. 1980-1992
Stephen Slogoff, M.D. 1981-1993
Judith H. Donegan, M.D., Ph.D. 1983-1991
Carl C. Hug, Jr., M.D., Ph.D. 1984-1996
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GENERAL INFORMATION

1.01 GENERAL INFORMATION

We publish our policy book to inform all interested individuals of the policies, procedures, regulations and requirements governing our certification programs. The Board reserves the right to amend the policy book from time to time without advance notice. There are several chapters in this book that apply to individuals in different situations:

- Traditional Examinations (Initial Certification in Anesthesiology)
- Staged Examinations (Initial Certification in Anesthesiology)
- Maintenance of Certification in Anesthesiology® (MOCA 2.0®) program
- Subspecialty Certification
- Subspecialty Recertification

The chair of the anesthesiology department is ultimately responsible for the residency program. We correspond officially about training matters with the department chair and the department chair's appointed program director. If the chair notifies us that a faculty member has been appointed as a designated official with responsibility for coordinating the administration of the program, we will correspond with the department chair, program director and designated official about training matters.

The program must ensure that each resident's/fellow's training fulfills all criteria for entering the ABA examination system. However, it is crucial that the resident/fellow know the requirements described in the policy book, since the resident/fellow ultimately holds responsibility for compliance with the requirements and bears the consequences if one or more aspects of training prove unacceptable. This is especially important when requests are made for special training sequences or sites, or for exemptions. If, after speaking with the program director, there is any question about the acceptability of any portion of training, the resident/fellow should write to the Secretary of the ABA at our office.

Physicians taking our examinations have the ultimate responsibility to know and comply with the Board's policies, procedures, requirements and deadlines regarding admission to and opportunities for examination.

1.02 MISSION AND PURPOSES

Our mission is to advance the highest standards of the practice of anesthesiology. The ABA exists to:

A. Advance the highest standards of practice by fostering lifelong education in anesthesiology, which we define as the practice of medicine dealing with but not limited to:

(1) Assessment of, consultation for, and preparation of patients for anesthesia.

(2) Relief and prevention of pain during and following surgical, obstetric, therapeutic and diagnostic procedures.

(3) Monitoring and maintenance of normal physiology during the perioperative or periprocedural period.

(4) Management of critically ill patients.

(5) Diagnosis and treatment of acute, chronic and cancer-related pain.

(6) Management of hospice and palliative care.

(7) Clinical management and teaching of cardiac, pulmonary and neurologic resuscitation.

(8) Evaluation of respiratory function and application of respiratory therapy.

(9) Conduct of clinical, translational and basic science research.

(10) Supervision, teaching and evaluation of performance of both medical and allied health personnel involved in perioperative or periprocedural care, hospice and palliative care, critical care and pain management.

(11) Administrative involvement in health care facilities and organizations, and medical schools as appropriate to our mission.

B. Establish and maintain criteria for the designation of a board-certified and subspecialty certified anesthesiologist as described in our policy book.

C. Inform the Accreditation Council for Graduate Medical Education (ACGME) concerning the training required of individuals seeking certification as such requirements relate to residency and fellowship training programs in anesthesiology.

D. Establish and conduct processes by which the Board may judge whether a physician who voluntarily applies should be issued a certificate indicating that the required standards for certification or maintenance of certification have been met.

A board-certified anesthesiologist is a physician who provides medical management and consultation during the perioperative period in pain medicine and in critical care medicine. A diplomate of the Board must possess knowledge, judgment, adaptability, clinical skills, technical facility and personal characteristics sufficient to carry out the entire scope of anesthesiology practice independently, without accommodation or with reasonable accommodation. An ABA diplomate must logically organize and effectively present rational diagnoses and appropriate treatment protocols to peers, patients, their families and others involved in the medical community. A diplomate can serve as an expert in matters related to anesthesiology, deliberate with others, and provide advice and defend opinions in all aspects of the specialty of anesthesiology. A board-certified anesthesiologist is able to function as the leader of the anesthesiology care team.

Because of the nature of anesthesiology, the ABA diplomate must be able to manage emergent life-threatening situations in an independent and timely fashion. The ability to independently acquire and process information in a timely manner is central to ensure individual responsibility for all aspects of anesthesiology care. Adequate physical and sensory faculties, such as eyesight, hearing, speech and coordinated function of the extremities, are essential to the independent performance of the board-certified anesthesiologist. Freedom from the influence of or dependency on chemical substances that impair cognitive, physical, sensory or motor function is also an essential characteristic of the board-certified anesthesiologist.

E. Serve the public, medical profession, health care facilities and organizations, medical schools and licensing boards by providing the names of physicians certified by the Board.

1.03 ABA TRADEMARKS AND CERTIFICATION MARKS

We are the owner of the following trademarks and certification marks:

A. The ABA certification mark and seal:

B. The American Board of Anesthesiology®

C. Maintenance of Certification in Anesthesiology® (MOCA®) program

D. MOCA®

E. MOCA Minute®

F. MOCA 2.0®

Each of these marks is a registered mark with the United States Patent and Trademark Office as shown.

1.04 FEES

We are a nonprofit organization. Fees are based on the cost of maintaining the functions of the ABA.

Registration fees vary by date received. Current fees are posted on our website at www.theABA.org. The Board reserves the right to change fees when necessary. All fees paid to the ABA are non-refundable except when:

- an individual withdraws from residency or fellowship training and has a fee on account.
- an individual passes away and has a fee on account.

1.05 STATUS OF INDIVIDUALS

We reserve the right to define an individual's status relative to our examination and certification system. Status is limited to the period of time the physician's certification or registration for certification is valid.

We define **clinically active** as spending, on average, at least one day per week during 12 consecutive months over the previous three years in the clinical practice of anesthesiology and/or related subspecialties. This activity must involve patients having a varied degree of systemic disease and who are undergoing surgery or diagnostic procedures requiring anesthetic care, and must be consistent with currently relevant knowledge of pharmacology, physiology and medicine.

We have defined the following **certification statuses**:

- Certified
- Certified – Not Clinically Active
- Certified – Retired
- Expired
- Retired
- Revoked

Diplomates designated as "Certified - Not Clinically Active" have attested that they do not meet our definition of clinical activity. Diplomates designated by the Board as "Certified – Retired" or "Retired" have attested that they do not meet our definition of clinical activity and do not plan to return to the practice of anesthesiology at any time in the future. **Diplomates with a certification status of "Retired" or "Revoked" have to register with us to re-attain "Certified" status (see Section 7.07).**

An individual's current status relative to our examination and certification system may be confirmed at no charge via the Diplomate and Candidate Directory on our website at www.theABA.org, which is the official source for verification of ABA certification status. **The fee for written confirmation of an individual's status is $35.00.**

Inquiries about the current status of individuals should be addressed to our office. In addition to the

physician's full name, inquiries should include other identification information if available. We respond to inquiries with one or more of the following statements:

- The physician is certified by the ABA.
- The physician is currently enrolled in the Maintenance of Certification in Anesthesiology® (MOCA®) program.
    - The physician is participating in MOC.
    - The physician is not participating in MOC.
    - The physician is not required to participate in MOC.
- The physician currently is not clinically active.
- The physician is retired from the practice of anesthesiology.
- The physician was certified by the ABA from (date of certification) to (date certification expired).
- The ABA revoked the physician's certification, which had been in effect from (date of certification) to (date of revocation).
- The physician is a candidate in the ABA examination system (see Sections 2.10, 3.06.A and 5.09.C for the definition of a "candidate").
- The physician has never been certified by the ABA.

We will affirm the status of physicians who are certified in a subspecialty by the Board.

We do not recognize "Board Eligible" as a physician status relative to the ABA examination system for initial certification in anesthesiology. Therefore, physicians should refrain from making any representations of being "Board Eligible."

The certification marks and trademarks identified in Section 1.03 are owned by The American Board of Anesthesiology, Inc., and only the ABA has any legal rights with respect to the ownership of such marks. In the event we have reason to believe that individuals have misappropriated our certification marks for the purpose of misrepresenting their ABA certification status or for some other purpose, we will aggressively defend the integrity of such marks, including but not limited to pursuing all legal remedies at law and in equity. After an investigation has been concluded and an individual has been determined to have committed such acts, we may impose any of its own restrictions on the eligibility of the individual to participate in the ABA examination system, including but not limited to permanent exclusion from entrance to the examination system; and we will notify any state medical licensure board known by it to have licensed the individual.

TRADITIONAL EXAMINATIONS (PART 1 & PART 2)

INITIAL CERTIFICATION IN ANESTHESIOLOGY

2.01 CERTIFICATION REQUIREMENTS

At the time of certification, the candidate must:

A. Hold an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the United States (U.S.) or province of Canada that is permanent, unconditional and unrestricted. Further, every U. S. and Canadian medical license the candidate holds must be free of restrictions.

Candidates for initial certification and ABA diplomates have the affirmative obligation to advise us of any and all restrictions placed on any of their medical licenses, and to provide complete information concerning such restrictions within 60 days after their imposition or notice, **whichever first occurs**. Such information shall include, but not be limited to, the identity of the State Medical Board imposing the restriction as well as the restriction's duration, basis, and specific terms and conditions. Candidates and diplomates discovered **not** to have made disclosure may be subject to sanctions on their candidate or diplomate status.

We must receive acceptable evidence of the candidate having satisfied the licensure requirement for certification by Nov. 15 of the Part 2 Examination administration year.

B. Have fulfilled all the requirements of the continuum of education in anesthesiology.

C. Have on file with the ABA a Certificate of Clinical Competence with an overall satisfactory rating covering the final six-month period of clinical anesthesia training in each anesthesiology residency program.

D. Have satisfied all Board examination requirements.

E. Have satisfactory professional standing (see Section 7.06).

F. Be capable of performing independently the entire scope of anesthesiology practice without accommodation or with reasonable accommodation (see Sections 1.02.A and 1.02.D).

Although admission into our examination system and success with the examinations are important steps in our certification process, they do not by themselves guarantee certification. The Board reserves the right to make the final determination of whether *each* candidate meets all of the requirements for certification, including A, E and F above, after successful completion of examinations for certification.

ABA certificates in anesthesiology issued on or after Jan. 1, 2000, are valid for 10 years after the year the candidate passes the examination for certification. ABA certificates are subject to our rules and regulations, including our policy book, all of which may be amended from time to time without further notice.

A person certified by the ABA is designated a diplomate in publications of the American Board of Medical Specialties (ABMS) and the American Society of Anesthesiologists (ASA).

2.02 THE CONTINUUM OF EDUCATION IN ANESTHESIOLOGY

The continuum of education in anesthesiology consists of four years of full-time training subsequent to the date that the medical or osteopathic degree has been conferred. To be eligible for appointment to an ACGME-accredited program at the time of enrollment, the residency training program will verify that a resident has graduated from a medical school in a state or jurisdiction of the U.S. or in Canada that was accredited at the date of graduation by the Liaison Committee of Medical Education, the Committee on Accreditation of Canadian Medical Schools, or the American Osteopathic Association. Graduates of medical schools outside the jurisdiction of the U.S. and Canada must have one of the following: a permanent (valid indefinitely) certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), comparable credentials from the Medical Council of Canada, or documentation of training for those who entered postdoctoral medical training in the U.S. via the Fifth Pathway as proposed by the American Medical Association.

The continuum consists of a clinical base year and 36 months of approved training in anesthesia (CA-1, CA-2 and CA-3 years). Prospective ABA approval is required for exceptions to our policies regarding the training planned for individual residents.

A. During the clinical base year, the physician must be enrolled and training as a resident in a transitional year or specialty training program in the U.S. or its territories that is accredited by the ACGME or approved by the American Osteopathic Association (AOA), or outside the U.S. and its territories in institutions affiliated with medical schools approved by the Liaison Committee on Medical Education from the date the training begins to the date it ends. **Training as a fellow in a subspecialty program is not an acceptable clinical base experience.**

The clinical base year must include at least six months of clinical rotations during which the resident has responsibility for the diagnosis and treatment of patients with a variety of medical and surgical problems, of which at most one month may involve the administration of anesthesia and one month of pain medicine. Acceptable clinical base experiences include training in internal medicine, pediatrics, surgery or any of their subspecialties, obstetrics and gynecology, neurology, family medicine or any combination of these as approved for residents by the directors of their training programs in anesthesiology. The clinical base year should also include rotations in critical care and emergency medicine, with at least one month, but no more than two months, devoted to each. Other rotations completing the 12 months of broad education should be relevant to the practice of anesthesiology.

The resident must complete the clinical base year before beginning CA-3 year clinical rotations.

B. **The three-year clinical anesthesia curriculum (CA 1-3)** consists of experience in basic anesthesia training, subspecialty anesthesia training and advanced anesthesia training. It is a graded curriculum of increasing difficulty and learning that is progressively more challenging of the resident's intellect and technical skills.

(1) **Experience in basic anesthesia training** is intended to emphasize basic and fundamental aspects of the management of anesthesia. It is recommended that at least 12 months of the CA-1 and CA-2 years be spent in basic anesthesia training with a majority of this time occurring during the CA-1 year.

(2) **Subspecialty anesthesia training** is required to emphasize the theoretical background, subject material and practice of subdisciplines of anesthesiology. These subdisciplines include obstetric anesthesia, pediatric anesthesia, cardiothoracic anesthesia, neuroanesthesia, anesthesia for outpatient surgery, recovery room care, perioperative evaluation, regional anesthesia and pain medicine. It is recommended that these experiences be subspecialty rotations and occur in the CA-1 and CA-2 years. The sequencing of these rotations in the CA-1 and CA-2 years is left to the discretion of the program director.

By the end of the CA-3 year, required experiences in perioperative care must include four months of distinct rotations in critical care medicine with progressive responsibility and three months in pain medicine that may include one month in an acute perioperative pain management rotation, one month in a rotation for assessment and treatment of inpatients and outpatients with chronic pain, and one month of regional analgesia experience in pain medicine. Experiences in these rotations must emphasize the fundamental aspects of anesthesia, preoperative evaluation and immediate postoperative care of surgical patients, and assessment and treatment of critically ill patients and those with acute and chronic pain. An acceptable critical care rotation should include active participation in patient care, active involvement by anesthesia faculty experienced in the practice and teaching of critical care and an appropriate population of critically ill patients. Experience in short-term, overnight post-anesthesia units, intermediate step-down units or emergency rooms does not fulfill this requirement.

(3) **Experience in advanced anesthesia training** constitutes the CA-3 year. The program director, in collaboration with the resident, will design the resident's CA-3 year of training. The CA-3 year is a distinctly different experience than the CA 1-2 years, requiring progressively more complex training experiences and increased independence and responsibility for the resident. Resident assignments in the CA-3 year should include the more difficult or complex anesthetic procedures and care of the most seriously ill patients. Residents must complete the clinical base and CA 1-2 years of training before they begin clinical rotations in fulfillment of the CA-3 year requirement.

CA-3 residents are required to complete a minimum of six months of advanced anesthesia training. They may spend the remaining months in advanced anesthesia training in one to three selected subspecialty rotations, or in research. Residents may train in one anesthesia subspecialty for at most six months during the CA-3 year and no more than 12 months during the CA 1-3 years. The training must culminate in sufficiently independent responsibility for clinical decision-making and patient care so that the graduating resident demonstrates sound clinical judgment in a wide variety of clinical situations and can function as a leader of perioperative care teams.

(4) **There are options for research during the anesthesiology residency.** Interested residents could spend approximately 25 percent of a three- or four-year training program, and 38 percent of a five-year program, engaged in scholarly activities. Suggested templates for research during the anesthesiology residency are posted at www.theABA.org. The program director must develop a plan with strict guidelines for research activity and "work product" oversight if a resident's research activities will be more than six months. The resident must be enrolled in an ACGME-accredited anesthesiology program and remain active in the educational component of the program while pursuing research.

Involvement in scholarly activities must result in the generation of a specific permanent "work product." Review of scholarly activity and the permanent work product will occur at the local level by a Scholarship Oversight Committee responsible for overseeing and assessing the trainee's progress and verifying to the ABA that the requirement has been met. The Scholarship Oversight Committee must consist of three or more faculty members. The program director may serve as a trainee's mentor and participate in the activities of the Scholarship Oversight Committee, but should not be a standing member.

The following exceptions will be considered by application to our Credentials Committee (at least four months in advance):

- Aggregating research time normally allocated across the clinical base and clinical anesthesia years into one or more years, allowing a significant amount of time to be used for research as a block.
- Leave of absence from the clinical program for research activities.
- Additional months in research, especially if the research is prospectively integrated in the training program.

A resident can receive credit for research activities, provided that the resident has at least six months of satisfactory clinical anesthesia (CA) training on file with the ABA prior to beginning research. If a resident receives an unsatisfactory Certificate of Clinical Competence Report immediately preceding any research activity, no credit will be given for the research activity unless prospectively approved by our Credentials Committee.

C. We grant a resident credit toward the CA 1-3 year requirements for clinical anesthesia training that satisfy **all four** of the following conditions:

(1) The CA 1-3 years of training are spent as a resident enrolled by no more than two ACGME-accredited anesthesiology residency programs in the U.S. or its territories. An ACGME-accredited program includes the sponsoring (parent) institution and major participating institutions (i.e., institutions that have an RRC-approved integration or affiliation agreement with the sponsoring institution). **All three years of CA training must occur in programs that are accredited by the ACGME for the entire period of training.**

(2) The period of clinical anesthesia training as an enrolled resident of any single program is at least six months of uninterrupted training.

(3) The six-month period of clinical anesthesia training in any one program ends with receipt of a satisfactory Certificate of Clinical Competence (CCC) report. To receive credit from the ABA for a six-month period of clinical anesthesia training that is not satisfactory, the resident must immediately complete an additional six months of uninterrupted clinical anesthesia training, not including research, in the same program with receipt of a satisfactory CCC report. A resident with an unsatisfactory training period reported with gaps in training (e.g. leave of absence) will not receive credit for any training reported prior to the gap in the period because it was not immediately followed by six months of uninterrupted clinical anesthesia training. **If a resident receives consecutive CCC reports that are not satisfactory, additional training is required.** When a resident receives a satisfactory CCC report immediately following consecutive periods of training that are not satisfactory, we will grant credit only for the period of satisfactory training and the most recent of the periods of unsatisfactory training immediately preceding it.

For residents who receive an unsatisfactory CCC report for a period of training completed in an integrated training program where clinical base year rotations are intermingled with clinical anesthesia rotations, our Credentials Committee will determine the amount of training credit granted for the unsatisfactory period.

(4) Residents have the option to complete training away from their ACGME-accredited anesthesiology programs. This option is not available during the last three months of residents' CA-3 year or until after they complete at least one year of clinical anesthesia training, unless the training will be in another ACGME-accredited anesthesiology program.

Current Residency Review Committee requirements limit training in institutions not integrated with the resident's ACGME-accredited program to a maximum of 12 months throughout the CA 1-3 years. We will accept no more than six of these months in institutions not affiliated with the ACGME-accredited program. Therefore, residents must complete a minimum of 24 months of clinical anesthesia training in their ACGME-accredited program's parent and integrated institutions and may complete at most six months of clinical anesthesia training away from their ACGME- accredited program.

Our Credentials Committee must prospectively approve all anesthesia training away from the ACGME-accredited program, even if the training will occur in another ACGME-accredited program (see Section 2.02.E). The request for approval must include a chronological description of the rotations, information about resident supervision, and assurances that residents will be in

compliance with the limits on training away from their ACGME-accredited programs. Further, residents must remain enrolled in their programs while training away from the ACGME-accredited programs, and their programs must report the training on the CCC report filed for the period involved.

D. Our Credentials Committee will assess individually requests for part-time training. Prospective approval is required for alteration in the number of hours per week of training or alteration in the temporal distribution of the training hours (e.g., substantially different night and weekend hours) from other residents in the program. It is expected that residents will take not more than twice the "standard time" to achieve the level of knowledge and clinical experience comparable to a full-time resident completing the program in standard time. Residents who train on a part-time basis are expected to meet all the program's didactic requirements before training is complete.

Requests for part-time training must be in writing from the program director and countersigned by the department chair (if that is another person), the hospital's Designated Institutional Officer (DIO), and the resident. The letter must include: (1) the reason for the part-time training request, (2) documentation about how all clinical experiences and educational objectives will be met, (3) assurance that the part-time training program will teach continuity-of-care and professionalism and (4) an explanation about how the part-time training program will maintain the overall quality, content and academic standards/clinical experiences of the training program required of a full-time trainee.

E. Prospective approval is required for exceptions to our policies regarding the training planned for individual residents [see Sections 2.02.B (3) and 2.02.C (4)]. Our Credentials Committee considers requests for prospective approval on an individual basis. Our office must receive the request from the program director on behalf of a resident at least **four months** before the resident begins the training in question. It is the responsibility of the program director and the resident to ensure that the request is received in a timely manner.

2.03 ABSENCE FROM TRAINING

The total of any and all absences may not exceed 60 working days (12 weeks) during the CA 1-3 years of training. Attendance at scientific meetings, not to exceed five working days per year, shall be considered a part of the training program. Duration of absence during the clinical base year may conform to the policy of the institution and department in which that portion of the training is served. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence. A lengthy interruption in training may have a deleterious effect upon the resident's knowledge or clinical competence. Therefore, when there is an absence for a period in excess of six months, our Credentials Committee will determine the number of months of training the resident will have to complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system.

2.04 CERTIFICATE OF CLINICAL COMPETENCE

We require every residency training program to electronically file an Evaluation of Clinical Competence in January and July on behalf of each resident who has spent any portion of the prior six months in clinical anesthesia training in or under the sponsorship of the residency program and its affiliates. **The program director or department chair must not chair the Clinical Competence Committee.**

Entry into the ABA examination system is contingent upon the registrant having a Certificate of Clinical Competence on file attesting to satisfactory clinical competence during the final period of clinical anesthesia training in or under the sponsorship of each program [see Section 2.02.C (3) for details]. We will deny entry into the ABA examination system until this requirement is fulfilled.

Residents who wish to appeal an Evaluation of Clinical Competence, and registrants who wish to appeal final recommendations from the program director or department chair, must do so through the reporting institution's grievance and due process procedures.

2.05 PROGRAM DIRECTOR'S REFERENCE FORM

We require every residency program director to electronically file a Program Director's Reference Form on behalf of each resident upon graduation from the residency program. Information is requested regarding the professional standing, abilities and character of the candidate.

Entry into the ABA examination system is contingent upon the program directors' recommendation. We will deny entry into the ABA examination system until this requirement is fulfilled. This reference evaluation will be used as part of the process by which the Board judges whether the candidate meets the standards of a board-certified anesthesiologist articulated in Section 1.02.D. Entrance into the ABA examination system may also be denied if the Board, in its discretion, is not satisfied with the recommendation based upon reasonable consideration of information known at the time.

We consider references to be confidential and will not disclose the contents or a copy to the candidate unless the person providing the reference consents in writing. Candidates should contact their references if more information is desired. Residents who wish to appeal a final recommendation from the program director or department chair must do so through the reporting institution's grievance and due process procedures.

2.06 OVERVIEW OF INITIAL CERTIFICATION EXAMINATIONS

The traditional examination system for initial certification in anesthesiology has two distinct parts, the Part 1 Examination and the Part 2 Examination. Each is designed to assess different qualities of a board-certified anesthesiologist as previously defined in Section 1.02.D. It is necessary for candidates to pass the Part 1 Examination to qualify for the Part 2 Examination.

Beginning in 2017, the new staged examinations process (BASIC, ADVANCED and APPLIED Examinations) will begin to replace the traditional Part 1 and Part 2 Examinations for candidates who began the four-year continuum of education in anesthesiology on or after July 2012 and will complete residency training on or after June 30, 2016. The Part 1 Examination will still be offered to eligible individuals (those who completed residency training before June 30, 2016) until it is passed, or until it is no longer possible to satisfy examination requirements within the defined duration of candidate status (see Section 2.10). Candidates who did not pass the Part 2 Examination in 2016 will take the Standardized Oral Examination (SOE) component of the APPLIED Examination in 2017 and later to satisfy the Part 2 Examination requirement. Candidates will have one examination appointment per calendar year to satisfy the examination requirements. Details of these examinations can be found in Sections 3.01 – 3.16.

A. Part 1 Examination

The Part 1 Examination is designed to assess the candidate's knowledge of basic and clinical sciences as applied to anesthesiology. The Part 1 Examination is held annually in locations throughout the U.S. and Canada. A passing grade, as determined by the Board, is required. The Part 1 Examination will be administered by computer through a third-party testing vendor.

Examination dates are available on the last page of this section. However, for the most current examination dates and fees, please visit our website at www.theABA.org.

B. Part 2 Examination

The Part 2 Examination assesses the candidate's ability to demonstrate the attributes of an ABA diplomate when managing patients presented in clinical scenarios. The attributes are sound judgment in decision making and management of surgical and anesthetic complications, appropriate application of scientific principles to clinical problems, adaptability to unexpected changes in the clinical situations, and logical organization and effective presentation of information. The Part 2 Examination emphasizes the scientific rationale underlying clinical management decisions. Examiners are Board Directors and other

ABA diplomates who assist as associate examiners. A passing grade, as determined by the Board, is required.

The Part 2 Examination is administered several times each year at the ABA Assessment Center in Raleigh, NC. Individuals who did not pass the Part 2 Examination in 2016 will take the Standardized Oral Examination (SOE) component of the APPLIED Examination in 2017 and later at the ABA Assessment Center; however, they can only schedule one examination appointment per calendar year. Descriptions of these examinations can be found in the Staged Examinations section.

Part 1 and Part 2 Examination dates are available on the last page of this section. However, for the most current examination dates, deadlines and fees, please visit our website at www.theABA.org.

We must receive acceptable evidence of the candidate having satisfied the licensure requirement for certification by Nov. 15 of the Part 2 Examination administration year (see Section 2.01.A). Training and expired licenses do not fulfill this licensure requirement for certification. Candidates must inform us of any conditions or restrictions in force on any active medical license they hold. When there is a restriction or condition in force on any of the candidate's medical licenses, our Credentials Committee will determine whether, and on what terms, the candidate will be permitted to take the Part 2 Examination.

We will not validate the results of candidates who take the Part 2 Examination and do not fulfill the licensure requirement by the deadline.

C. ABA examinations are administered to all candidates under the same standardized testing conditions. The Board will consider a candidate's complaint about the testing conditions under which an examination was administered only if the complaint is received within one week of the examination date.

2.07 REGISTRATION ELIGIBILITY REQUIREMENTS

At the time of registration for entrance to the ABA examination system, the registrant must:

A. Have evidence on file in the ABA office of having satisfactorily fulfilled all requirements of the continuum of education in anesthesiology before the date of the Part 1 Examination. Such evidence must include a satisfactory Certificate of Clinical Competence covering the final six months of clinical anesthesia training in each residency program [see Sections 2.02.C (3) for details]. A **grace period** will be permitted so that registrants completing this requirement by Sept. 30 may register for the immediately preceding the Part 1 Examination.

B. Have documentation on file with the Board attesting to the registrant's current privileges and evaluations of various aspects of their current practice of anesthesiology. Such evaluations will include verification that the registrants meet our clinical activity requirement by spending, on average, at least one day per week during 12 consecutive months over the previous three years in the clinical practice of anesthesiology and/or related subspecialties. We may solicit such documentation and evaluations from the residency program director or others familiar with the registrant's current practice of anesthesiology and use them in determining the resident's qualifications for admission to the ABA examination system. The CCC report from the department **and** the evaluation of the program director and others will be used as the basis for assessing admission qualifications.

C. Be capable of performing independently the entire scope of anesthesiology practice without accommodation or with reasonable accommodation (see Sections 1.02.A and 1.02.D).

We will not validate the results of registrants who take the Part 1 Examination and do not fulfill those conditions identified above by the deadlines.

We will determine that entry into our examination system is warranted when required information submitted

by and on behalf of the registrant is satisfactory. We will notify a registrant who is accepted as a candidate for certification after approval of all credentials.

Although admission into the ABA examination system and success with the examinations are important steps in the certification process, they do not by themselves guarantee certification. The Board reserves the right to make the final determination of whether *each* candidate meets all of the requirements for certification (see Section 2.01 and Section 2.11).

The Board, acting as a committee of the whole, reserves the right not to accept a registration. The registrant has the right to seek review of such decisions (see Section 7.05).

The Board reserves the right to correct clerical errors affecting its decisions.

2.08 REGISTRATION PROCEDURE

A. Registration for admission to the ABA examination system must be made using the Physician Portal, which can be accessed via our website at www.theABA.org.

B. Registration includes the following Acknowledgment and Release forms, which the registrant shall be required to sign by electronic signature:

(1) *I, the undersigned registrant ("registrant"), hereby agree to participate in the American Board of Anesthesiology, Inc.'s ("ABA") initial certification program. I acknowledge that my participation is subject to the ABA rules and regulations. I further acknowledge and agree that if I withdraw my registration or the ABA does not accept it, the ABA will retain the registration fee and any late fee.*

I represent and warrant to the ABA that all information I provide to the ABA is true, correct and complete in all material respects. I understand and acknowledge that any material misstatement or omission over the course of my initial certification program shall, at any time, constitute cause for disqualification from the ABA examination system or from the issuance of an ABA certificate or to forfeiture and redelivery of such ABA certificate to the ABA.

I agree that this acknowledgment, as submitted by me, shall survive the electronic submission of the registration, regardless of whether the information or data provided in the registration has been reformatted in any manner by the ABA. I also agree that this acknowledgment is a part of and incorporated into the registration, whether submitted along with the registration or not.

I acknowledge that I have read a copy of the ABA Policy Book. I agree to be bound by the policies, rules, regulations and requirements published in the book, in all matters relating to consideration of and action upon this registration and certification. I understand that ABA certificates are subject to ABA rules and regulations, all of which may be amended from time to time without further notice. I understand and acknowledge that in the event I have violated any of the ABA rules governing my registration and/or certification, such violations shall constitute cause for disqualification from the ABA examination system or from the issuance of an ABA certificate or for revocation of certification and indication of such action in the ABA Diplomate and Candidate Directory.

(2) *I, the undersigned registrant ("registrant"), hereby agree to participate in the American Board of Anesthesiology, Inc.'s ("ABA") initial certification program. I acknowledge that participation is subject to the ABA rules and regulations, all of which may be amended from time to time without further notice.*

In connection with my registration, I authorize all persons holding testimony, records, documents, opinions, information and data relevant to or pertaining to my professional competence and ethical conduct and/or behavior (the "Background Information") to release such Background Information to the ABA, its employees and agents. This authorization applies whether or not such persons are listed as a reference on my registration. The Background Information includes any information relating to any abusive use of alcohol and/or illegal use of drugs, and any medical or psychiatric treatment or rehabilitation related thereto. I

understand that such Background Information may be used to determine, verify or deny my qualifications for entrance into the ABA entrance examination and ABA certification. I understand that the ABA treats this information as confidential and will not release the content or a copy of any references to me unless the person providing the reference consents in writing. A copy of this release may accompany any request made by the ABA for such Background Information.

I authorize the ABA to: (1) report my status in the examination system, including the results of any examination, to the director and department chair of the program from which I received my clinical training; (2) use any score in psychometric analyses to confirm observations and reports of suspected irregularities in the conduct of an examination; and (3) respond to any inquiry about my status in the ABA examination system. I understand and agree that once my examination registration is completed and granted, this consent cannot be withdrawn.

I also authorize the ABA to record the video and audio of my performance during the ABA examinations at the ABA Assessment Center for educational, quality and scoring purposes. Such recordings will be used for ABA internal purposes only and will be retained in accordance with ABA retention policies. I understand that any use of a mobile or recording device during the examination may result in my examination being invalidated and the loss of my registration fee. Furthermore, if I attempt to record, transmit or transcribe any portion of the examination, my examination will be invalidated and I will forfeit my registration fee.

I also understand that the ABA may use any and all Background Information for the purpose of conducting longitudinal studies to assess the ABA certification process. I further understand that the ABA, alone or in collaboration with other researchers, may use information from the registration, testing, assessment and certification process (the "Assessment Information") to conduct scientific research relating to anesthesiologists, the practice of anesthesiology and/or or the education of anesthesiologists. Any and all information used for research may be reported or released to the public only in the aggregate without any individual identification.

Use of any Background Information or Assessment Information for analysis or research will not impact in any way my individual registration, test results or certification status. I understand and agree that should I not wish for my information to be used for research purposes, prior to taking the exam I must notify the ABA in writing to the attention of researchoptout@theABA.org to opt out and withdraw consent for my information to be used as part of research studies. I cannot opt out and consent cannot be withdrawn once my information has been de-identified and/or aggregated as part of any research study.

I release and agree to hold harmless each person from any liability to me arising out of the giving or releasing of information to the ABA. This release and agreement includes liability for the inaccuracy or untruth of the Information, so long as such Information is provided in good faith. I also release and agree to hold harmless the ABA and its agents and employees, including but not limited to its directors, officers and examiners, from any liability to me as a result of any acts or proceedings undertaken or performed in connection with my registration, provided such acts or proceedings are made or conducted in good faith.

C. Registrants must also attest to their clinical activity every three years while in the examination system.

2.09 EXAMINATION REGISTRATION, SCHEDULING & CANCELLATION

It is necessary for candidates to pass the Part 1 Examination to qualify for the Part 2 Examination.

A. Part 1 Examination

Candidates will register for the examination in the year of the examination and pay a single fee upon registration. We notify candidates of their eligibility to register for a Part 1 Examination via emails sent to their email address on file. Candidates who register for an examination by the established deadline must pay the registration fee at that time. Current fees are posted at www.theABA.org.

After candidates register for an examination and pay the fee via their portal account, they will be **notified**

via email with instructions on how to schedule an examination appointment with the examination vendor.

B. Part 2 Examination

When a physician passes the Part 1 Examination, they will receive notification in their official result letter that they are eligible to register for the Part 2 Examination.

Registration for the Part 2 Examinations is continuous, so there are no registration deadlines. Candidates will select an examination week from the list of available weeks posted within their portal accounts. Once a Part 2 Examination week reaches its capacity of appointments, candidates can no longer schedule appointments for that week. We assign specific examination dates and times within the selected week to each candidate. Two months prior to an examination, we will email candidates the exact date, time and location of their examination and the rules of examination conduct.

- **Candidates who have not been assigned an exam date, time and location** may request to change their Part 2 Examination week within the same calendar year; however, we cannot guarantee that a change will be made. To request a change, candidates must send a written request to our office with a check for the Part 2 Examination change fee. Current fees are posted at www.theABA.org.

- **Candidates who have been assigned an exam date, time and location** may not request to change their Part 2 Examination week. If they do not plan to attend their scheduled exam, they must cancel their examination as defined in Section 2.09.C (1).

C. Notification and Cancellation of Examination Appointments

(1) **A candidate who cancels a scheduled examination appointment must submit a written request to us to cancel at least one week prior to the examination administration week.** A cancellation fee must accompany the candidate's request in order to retain the registration fee for the next examination appointment. Current cancellation fees are posted at www.theABA.org.

(2) **A candidate who misses a scheduled examination appointment** because of an unavoidable or catastrophic event must submit a written request with explanation and independent documentation of the event. We must receive the candidate's request and the cancellation fee no later than three days after the examination date to retain the registration fee for the next examination appointment.

(3) **A candidate who misses a scheduled examination appointment and does not cancel the scheduled examination appointment forfeits the examination fee.**

(4) **A candidate who cancels or misses a scheduled Part 2 Examination may not schedule another Part 2 Examination in the same calendar year.**

D. Our office is not responsible for an interruption in communication with a candidate that is due to circumstances beyond its control. Candidates must immediately notify us of a mailing or email address change via their portal account or by writing the ABA office. Candidates must email us at exams@theABA.org if they do not receive an examination notice they are expecting within the time frames described above. The candidate's ABA identification number should be included on all correspondence to the Board solely for identification purposes.

2.10 DURATION OF CANDIDATE STATUS

A. The duration of candidate status is limited as follows:

(1) Candidates who completed residency training **prior to Jan. 1, 2012**, had until Dec. 31, 2018, to satisfy all requirements for certification.

(2) Candidates who complete residency training **on or after Jan. 1, 2012**, must satisfy all requirements for certification within seven years of the last day of the year in which residency training was completed. Candidates have one examination appointment per calendar year until seven years of the last day of the year in which residency training was completed to successfully complete both the Part 1 and Part 2 Examinations and satisfy all other requirements for ABA certification.

Physicians will be considered candidates in the ABA examination system when their first registration for initial certification in anesthesiology is accepted. Physicians with two or more prior voided registrations will not be considered candidates in the ABA examination system, regardless of registration status, until they pass the Part 1 Examination.

We do not recognize “Board Eligible” as a physician status relative to the ABA examination system. Therefore, physicians should refrain from making any representations of being “Board Eligible.” (see Section 1.05.)

2.11 REESTABLISHING ELIGIBILITY FOR INITIAL CERTIFICATION

If a candidate does not satisfy all requirements for certification within the initial seven-year prescribed time period specified in Section 2.10, we will declare the candidate’s registration void. Physicians whose registrations have been voided may submit a new registration after reestablishing eligibility for initial certification. Such registration shall be subject to the fees, rules, privileges and entrance requirements that apply at the time of reregistration. Physicians will only be allowed to reestablish eligibility for initial certification once.

To reestablish eligibility for certification, physicians must take and pass the BASIC Examination to re-enter the ABA examination system. After reestablishing eligibility, candidates must satisfy all requirements for certification, including successfully completing the ADVANCED Examination and both the Standardized Oral Examination and Objective Structured Clinical Examination components of the APPLIED Examination, by Dec. 31 of the fourth year following the successful completion of the BASIC Examination. Physicians will be considered candidates in the ABA examination system when their registration for the ADVANCED Examination is accepted.

TRADITIONAL EXAMINATIONS DEADLINES & EXAMINATION DATES

2020 PART 1 EXAMINATION	
Examination Dates	July 24 – 25, 2020

2020 PART 2 EXAMINATIONS	
Registration is continuous.	
March 2 - 5, 2020	May 18 - 21, 2020
March 16 - 19, 2020	June 8 - 11, 2020
March 30 - April 2, 2020	Sept. 14 - 17, 2020
April 20 - 23, 2020	Sept. 28 - Oct. 1, 2020
May 4 - 7, 2020	

STAGED EXAMINATIONS (BASIC, ADVANCED & APPLIED)

INITIAL CERTIFICATION IN ANESTHESIOLOGY

3.01 CERTIFICATION REQUIREMENTS

At the time of certification by the ABA, the candidate must:

A. Hold an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the United States or province of Canada that is permanent, unconditional and unrestricted. Further, every United States and Canadian medical license a candidate holds must be free of restrictions.

Candidates for initial certification and ABA diplomates have the affirmative obligation to advise us of any and all restrictions placed on any of their medical licenses, and to provide complete information concerning such restrictions within 60 days after their imposition or notice, whichever first occurs. Such information shall include, but not be limited to, the identity of the State Medical Board imposing the restriction as well as the restriction's duration, basis, and specific terms and conditions. Candidates and diplomates discovered **not** to have made disclosure may be subject to sanctions on their candidate or diplomate status.

We must receive acceptable evidence of the candidate having satisfied the licensure requirement for certification by Nov. 15 of the APPLIED Examination administration year.

B. Have fulfilled all the requirements of the continuum of education in anesthesiology.

C. Have a Certificate of Clinical Competence on file with the ABA with an overall satisfactory rating covering the final six-month period of clinical anesthesia training in each anesthesiology residency program.

D. Have satisfied all examination requirements of the Board.

E. Have satisfactory professional standing (see Section 7.06).

F. Be capable of performing independently the entire scope of anesthesiology practice without accommodation or with reasonable accommodation (see Sections 1.02.A, 1.02.D and 8.09).

Although admission into the ABA Examination System and success with the examinations are important steps in the certification process, they do not by themselves guarantee certification. The Board reserves the right to make the final determination of whether *each* candidate meets all of the requirements for certification, including A, E and F above, after successful completion of examinations for certification.

ABA certificates in anesthesiology issued on or after Jan. 1, 2000, are valid for 10 years after the year the candidate passes the examination for certification. ABA certificates are subject to our rules and regulations, including our policy book, all of which may be amended from time to time without further notice.

A person certified by the ABA is designated as a "diplomate" in publications of the American Board of Medical Specialties (ABMS) and the American Society of Anesthesiologists (ASA).

3.02 THE CONTINUUM OF EDUCATION IN ANESTHESIOLOGY

The continuum of education in anesthesiology consists of four years of full-time training subsequent to the date that the medical or osteopathic degree has been conferred. To be eligible for appointment to an ACGME-accredited program, at the time of enrollment the training program will verify that a resident has graduated from a medical school in a state or jurisdiction of the U.S. or in Canada that was accredited at the date of graduation by the Liaison Committee of Medical Education, the Committee on Accreditation of Canadian Medical Schools, or the American Osteopathic Association (AOA). Graduates of medical schools outside the jurisdiction of the U.S. and Canada must have one of the following: a permanent (valid indefinitely) certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), comparable credentials from the Medical Council of Canada, or documentation of training for those who entered postdoctoral medical training in the U.S. via the Fifth Pathway as proposed by the American Medical Association.

The continuum consists of a clinical base year and 36 months of approved training in anesthesia (CA-1, CA-2 and CA-3 years). Prospective approval is required for exceptions to our policies regarding the training planned for individual residents.

A. During the clinical base year, the physician must be enrolled and training as a resident in a transitional year or specialty training program in the U.S. or its territories that is accredited by the ACGME or approved by the AOA, or outside the U.S. and its territories in institutions affiliated with medical schools approved by the Liaison Committee on Medical Education from the date the training begins to the date it ends. **Training as a fellow in a subspecialty program is not an acceptable clinical base experience.**

The clinical base year must include at least six months of clinical rotations during which the resident has responsibility for the diagnosis and treatment of patients with a variety of medical and surgical problems, of which at most one month may involve the administration of anesthesia and one month of pain medicine. Acceptable clinical base experiences include training in internal medicine, pediatrics, surgery or any of their subspecialties, obstetrics and gynecology, neurology, family medicine or any combination of these as approved for residents by the directors of their training programs in anesthesiology. The clinical base year should also include rotations in critical care and emergency medicine, with at least one month, but no more than two months, devoted to each. Other rotations completing the 12 months of broad education should be relevant to the practice of anesthesiology.

The resident must complete the clinical base year before beginning CA-3 year clinical rotations.

B. **The three-year clinical anesthesia curriculum (CA 1-3)** consists of experience in basic anesthesia training, subspecialty anesthesia training and advanced anesthesia training. It is a graded curriculum of increasing difficulty and learning that is progressively more challenging of the resident's intellect and technical skills.

(1) **Experience in basic anesthesia training** is intended to emphasize basic and fundamental aspects of the management of anesthesia. It is recommended that at least 12 months of the CA-1 and CA-2 years be spent in basic anesthesia training with a majority of this time occurring during the CA-1 year.

(2) **Subspecialty anesthesia training** is required to emphasize the theoretical background, subject material and practice of subdisciplines of anesthesiology. These subdisciplines include obstetric anesthesia, pediatric anesthesia, cardiothoracic anesthesia, neuroanesthesia, anesthesia for outpatient surgery, recovery room care, perioperative evaluation, regional anesthesia and pain medicine. It is recommended that these experiences be subspecialty rotations and occur in the CA-1 and CA-2 years. The sequencing of these rotations in the CA-1 and CA-2 years is left to the discretion of the program director.

By the end of the CA-3 year, required experiences in perioperative care must include four months of distinct rotations in critical care medicine with progressive responsibility and three months in pain

medicine that may include one month in an acute perioperative pain management rotation, one month in a rotation for assessment and treatment of inpatients and outpatients with chronic pain, and one month of regional analgesia experience in pain medicine. Experiences in these rotations must emphasize the fundamental aspects of anesthesia, preoperative evaluation and immediate postoperative care of surgical patients, and assessment and treatment of critically ill patients and those with acute and chronic pain. An acceptable critical care rotation should include active participation in patient care, active involvement by anesthesia faculty experienced in the practice and teaching of critical care and an appropriate population of critically ill patients. Experience in short-term overnight post-anesthesia units, intermediate step-down units or emergency rooms does not fulfill this requirement.

(3) **Experience in advanced anesthesia training** constitutes the CA-3 year. The program director, in collaboration with the resident, will design the resident's CA-3 year of training. The CA-3 year is a distinctly different experience than the CA 1-2 years, requiring progressively more complex training experiences and increased independence and responsibility for the resident. Resident assignments in the CA-3 year should include the more difficult or complex anesthetic procedures and care of the most seriously ill patients. Residents must complete the clinical base and CA 1-2 years of training before they begin clinical rotations in fulfillment of the CA-3 year requirement.

CA-3 residents are required to complete a minimum of six months of advanced anesthesia training. They may spend the remaining months in advanced anesthesia training in one to three selected subspecialty rotations, or in research. Residents may train in one anesthesia subspecialty for at most six months during the CA-3 year, with a total of no more than 12 months during the CA 1-3 years. The training must culminate in sufficiently independent responsibility for clinical decision-making and patient care so that the graduating resident demonstrates sound clinical judgment in a wide variety of clinical situations and can function as a leader of perioperative care teams.

(4) **There are options for research during the anesthesiology residency.** Interested residents could spend approximately 25 percent of a three- or four-year training program, and 38 percent of a five-year program, engaged in scholarly activities. Suggested templates for research during the anesthesiology residency are posted on our website at www.theABA.org. The program director must develop a plan with strict guidelines for research activity and "work product" oversight if a resident's research activities will be more than six months. The resident must be enrolled in an ACGME-accredited anesthesiology program and remain active in the educational component of the program while pursuing research.

Involvement in scholarly activities must result in the generation of a specific permanent "work product." Review of scholarly activity and the permanent work product will occur at the local level by a Scholarship Oversight Committee responsible for overseeing and assessing the trainee's progress and verifying to the ABA that the requirement has been met. The Scholarship Oversight Committee must consist of three or more faculty members. The program director may serve as a trainee's mentor and participate in the activities of the Scholarship Oversight Committee, but should not be a standing member.

The following exceptions will be considered by application to our Credentials Committee (at least four months in advance):

- Aggregating research time normally allocated across the clinical base and clinical anesthesia years into one or more years, allowing a significant amount of time to be used for research as a block.
- Leave of absence from the clinical program for research activities.
- Additional months in research, especially if the research is prospectively integrated in the training program.

A resident can receive credit for research activities, provided that the resident has at least six months of satisfactory clinical anesthesia (CA) training on file with the ABA prior to beginning research. If a resident receives an unsatisfactory Certificate of Clinical Competence (CCC) report immediately preceding any research activity, no credit will be given for the research activity unless prospectively approved by our Credentials Committee.

C. We grant a resident credit toward the CA 1-3 year requirements for clinical anesthesia training that satisfy **all four** of the following conditions:

(1) The CA 1-3 years of training are spent as a resident enrolled with the ABA by no more than two ACGME-accredited anesthesiology residency programs in the U.S. or its territories. An ACGME-accredited program includes the sponsoring (parent) institution and major participating institutions (i.e., institutions that have an RRC-approved integration or affiliation agreement with the sponsoring institution). **All three years of CA training must occur in programs that are accredited by the ACGME for the entire period of training. All physicians who graduate from an AOA-approved anesthesiology residency program on or after the date the program receives full ACGME accreditation will receive ABA credit for the CA 1-3 years of satisfactory training in the newly accredited program.**

(2) The period of clinical anesthesia training as an enrolled resident of any single program is at least six months of uninterrupted training.

(3) The six-month period of clinical anesthesia training in any one program ends with receipt of a satisfactory CCC report (see Section 3.04). To receive credit for a six-month period of clinical anesthesia training that is not satisfactory, the resident must immediately complete an additional six months of uninterrupted clinical anesthesia training, not including research, in the same program with receipt of a satisfactory CCC report. A resident with an unsatisfactory training period reported with gaps in training (e.g. leave of absence) will not receive credit for any training reported prior to the gap in the period because it was not immediately followed by six months of uninterrupted clinical anesthesia training. **If a resident receives consecutive CCC reports that are not satisfactory, additional training is required.** When a resident receives a satisfactory CCC report immediately following consecutive periods of training that are not satisfactory, we will grant credit only for the period of satisfactory training and the most recent of the periods of unsatisfactory training immediately preceding it.

For residents who receive an unsatisfactory CCC report for a period of training completed in an integrated training program where clinical base year rotations are intermingled with clinical anesthesia rotations, our Credentials Committee will determine the amount of training credit granted for the unsatisfactory period.

A resident who fails the BASIC Examination (see Section 3.06.A) for the **first** time may take the examination again at the next opportunity. A resident who fails the BASIC Examination a **second** time will automatically receive an unsatisfactory for the CCC reporting period during which the examination was taken. After a **third** failed attempt at the BASIC Examination, a resident will be required to complete six months of additional training. After a **fourth** failed attempt a resident will be required to complete an additional 12 months of residency training. A resident will continue to receive an unsatisfactory for each CCC reporting period until the exam is passed, regardless of whether the resident takes the exam during the reporting period. Continuation of residency training is at the discretion of the individual training program. A resident cannot graduate from residency training without passing the BASIC Examination. We strongly encourage residents to register and take the BASIC Examination as soon as they meet the eligibility requirements defined in Section 3.07.

(4) Residents have the option to complete training away from their ACGME-accredited anesthesiology programs. This option is not available during the last three months of residents' CA-3 year or until after

they complete at least one year of clinical anesthesia training, unless the training will be in another ACGME-accredited anesthesiology program.

Current Residency Review Committee requirements limit training in institutions not integrated with the resident's ACGME-accredited program to a maximum of 12 months throughout the CA 1-3 years. The ABA will accept no more than six of these months in institutions not affiliated with the ACGME-accredited program. Therefore, residents must complete a minimum of 24 months of clinical anesthesia training in their ACGME-accredited program's parent and integrated institutions and may complete at most six months of clinical anesthesia training away from their ACGME-accredited program.

Our Credentials Committee must prospectively approve all anesthesia training away from the ACGME-accredited program even if the training will occur in another ACGME-accredited program (see Section 3.02.E). The request for approval must include a chronological description of the rotations, information about resident supervision, and assurances that residents will be in compliance with the limits on training away from their ACGME-accredited programs. Further, residents must remain enrolled in their programs while training away from the ACGME-accredited programs, and their programs must report the training on the Clinical Competence Committee report filed for the period involved.

D. Our Credentials Committee will assess individually requests for part-time training. Prospective approval is required for alteration in the number of hours per week of training or alteration in the temporal distribution of the training hours (e.g., substantially different night and weekend hours) from other residents in the program. It is expected that residents will take not more than twice the "standard time" to achieve the level of knowledge and clinical experience comparable to a full-time resident completing the program in standard time. Residents who train on a part-time basis are expected to meet all the program's didactic requirements before training is complete.

Requests for part-time training must be in writing from the program director and countersigned by the department chair (if that is another person), the hospital's Designated Institutional Officer (DIO), and the resident. The letter must include: (1) the reason for the part-time training request, (2) documentation about how all clinical experiences and educational objectives will be met, (3) assurance that the part-time training program will teach continuity-of-care and professionalism and (4) an explanation about how the part-time training program will maintain the overall quality, content and academic standards/clinical experiences of the training program required of a full-time trainee.

E. Prospective approval is required for exceptions to our policies regarding the training planned for individual residents (see Sections 3.02.B (3) and 3.02.C (4)). Our Credentials Committee considers requests for prospective approval on an individual basis. We must receive the request from the program director on behalf of a resident at least **four months** before the resident begins the training in question. It is the responsibility of the program director and the resident to assure that the request is received in a timely manner.

3.03 ABSENCE FROM TRAINING

We have established certain training requirements for a candidate to enter our examination system. The following outlines permissible absences that will not result in delay in a candidate being eligible to enter the examination system:

- Without prior approval from the ABA, a candidate may be absent from training up to a total of 60 working days (12 weeks) during the CA 1-3 years of training.

- Attendance at scientific meetings, not to exceed five working days per year, shall be considered part of the training program and not count toward the absence calculation.

- Candidates should also comply with the policy of the institution and department in which that portion of the training is served for the duration of any absence during the clinical base year.

- We will consider requests for up to 40 additional days (8 weeks) away from training (over and above the 60 working days). Such additional leave of absence time must be approved by the ABA as follows:

    - Any request for such leave must be received by our office within four weeks of the resident's resumption of the residency program.
    - The request shall be in writing from the program director, countersigned by the department chair (if that person is different than the program director), and the resident.
    - The request must include: (1) the reason for the absence training request (as an example, serious medical illness, parental or family leave that are covered under the Family and Medical Leave Act would be reasons acceptable to the ABA) and (2) documentation about how all clinical experiences and educational objectives will be met.

Absences in excess of those described above will require lengthening of the total training time to compensate for the additional absences from training. The additional training days required will be equal to the total number of working days missed beyond (1) the 60 working days (without need for ABA approval); and (2) the additional 40 working days (approved by the ABA).

Residents who have their residency extended may take the Summer ADVANCED Examination if they complete all requirements by Sept. 30 of the same year. They may take the Winter ADVANCED Examination if they complete all requirements by March 30 of the same year.

A lengthy interruption in training may have a deleterious effect upon the resident's knowledge or clinical competence. Therefore, when there is an absence for a period more than six months, our Credentials Committee shall determine the number of months of training the resident must complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system.

3.04 CERTIFICATE OF CLINICAL COMPETENCE

The Board requires every residency training program to file, on forms provided by the Board, an Evaluation of Clinical Competence in January and July on behalf of each resident who has spent any portion of the prior six months in clinical anesthesia training in or under the sponsorship of the residency program and its affiliates. **The program director or department chair must not chair the Clinical Competence Committee.**

Entry into the ABA examination system is contingent upon the registrant having a Certificate of Clinical Competence on file with the Board attesting to satisfactory clinical competence during the final period of clinical anesthesia training in or under the sponsorship of each program [see Section 3.02.C (3) for details]. We will deny entry into the ABA examination system until this requirement is fulfilled.

Residents who wish to appeal an Evaluation of Clinical Competence must do so through the reporting institution's grievance and due process procedures.

3.05 PROGRAM DIRECTOR'S REFERENCE FORM

We require every residency program director to electronically file a Program Director's Reference Form on behalf of each resident upon graduation from the residency program. Information is requested regarding the professional standing, abilities and character of the resident.

Entry into the ABA examination system is contingent upon the program director's recommendation. We will deny entry into the ABA examination system until this requirement is fulfilled. This reference evaluation will be used as part of the process by which the Board judges whether the candidate meets the standards of a board-certified

anesthesiologist articulated in Section 1.02.D. Entrance into the ABA examination system may also be denied if the Board in its discretion is not satisfied with the recommendation based upon reasonable consideration of information known at the time.

We consider references to be confidential and will not disclose the contents or a copy to the candidate unless the person providing the reference consents in writing. Candidates should contact their references if more information is desired. Residents who wish to appeal a final recommendation from the program director or department chair must do so through the reporting institution's grievance and due process procedures.

3.06 OVERVIEW OF STAGED EXAMINATIONS

The staged examinations were designed to better support the movement toward competency-based training in graduate medical education. The staged examinations consist of three distinct parts: the BASIC Examination, the ADVANCED Examination and the APPLIED Examination. Each is designed to assess different qualities of a board-certified anesthesiologist as defined in Section 1.02.D.

Individuals who began the continuum of education in anesthesiology on or after July 2012 and are scheduled to complete residency training on or after June 30, 2016, will take staged examinations. Residents are automatically enrolled in the staged examination process when their anesthesiology residency program submits a resident enrollment form. Residents must then register for each examination when they meet the registration eligibility criteria for that examination.

A. The BASIC Examination, which will be administered at the end of a resident's CA-1 year, focuses on the scientific basis of clinical anesthetic practice including content areas such as pharmacology, physiology, anatomy, anesthesia equipment and monitoring. The content outline, available at www.theABA.org, provides a detailed description of the covered topics. The examination is offered twice each year. Residents must pass the BASIC Examination to qualify for the ADVANCED Examination. We strongly encourage residents to register and take the BASIC Examination as soon as they meet the eligibility requirements defined in Section 3.07.

B. The ADVANCED Examination, which will be administered after graduation from residency training, focuses on clinical aspects of anesthetic practice including subspecialty-based practice and advanced clinical issues. The content outline provides a detailed description of the topics covered, which is inclusive of the topics covered in the BASIC Examination. The ADVANCED Examination is administered twice each year. Candidates must pass the ADVANCED Examination to qualify for the APPLIED Examination.

C. The APPLIED Examination is designed to assess the candidate's ability to demonstrate the attributes of an ABA diplomate when managing patients presented in clinical scenarios, with an emphasis on the rationale underlying clinical management decisions. These attributes include sound judgment in making decisions, proper management of surgical and anesthetic complications, appropriate application of scientific principles to clinical problems, adaptability to unexpected changes in the clinical situations, and logical organization and effective presentation of information.

The APPLIED Examination includes two components: a Standardized Oral Examination (SOE) and an Objective Structured Clinical Examination (OSCE). The SOE is an oral assessment using realistic patient cases with two Board-certified anesthesiologist examiners questioning an examinee in a standardized manner. These examinations assess clinical decision-making and the application or use of medical knowledge with realistic patient scenarios. The OSCE is a series of short, simulated clinical situations in which a candidate is evaluated on skills such as history taking, physical exam, procedural skills, clinical decision-making, counseling, professionalism and interpersonal skills. Both components are administered by directors of the Board and other ABA diplomates who assist as associate examiners.

For the OSCE component, candidates will participate in a seven-station circuit to evaluate their proficiency in the skills listed in the OSCE Content Outline, which is available on the ABA website. Each OSCE

encounter will be eight minutes long, and candidates will have four minutes between stations to review the next scenario. The OSCE portion of the APPLIED Exam will take 84 minutes from start to finish.

Candidates will interact with a standardized patient actor as part of the scenario in some exam rooms. In others, candidates will interact directly with an examiner. Examiners will not be in most exam rooms. Instead, the sessions will be recorded for grading purposes.

The APPLIED Examination will be administered multiple times each year.

- **Candidates who complete residency training between June 30 and Sept. 30, 2016**, will not be required to take the OSCE component of the APPLIED Examination. They will only be required to pass the SOE component to satisfy the APPLIED Examination requirement.

- **Candidates who complete residency training on or after Oct. 1, 2016**, will be required to pass both the SOE and the OSCE to satisfy the APPLIED Examination requirement. Candidates will receive a separate score for each component of the APPLIED Examination - the SOE and the OSCE. If one component is failed, the candidate will retake only the failed component. Candidates must pass both components.

D. Our examinations are administered to all residents and candidates under the same standardized testing conditions. The Board will consider a resident's/candidate's complaint about the testing conditions under which an examination was administered only if the complaint is received within one week of the examination date.

E. Individuals will be considered candidates in the ABA Examination System when their first registration for the ADVANCED Examination is accepted.

F. The registration deadlines and examination dates for staged examinations are available on the last page of this section. However, for the most current examination dates and registration deadlines, please visit our website at www.theABA.org.

G. Once candidates pass all of the staged examinations, meet other requirements for certification, and are awarded a certificate, they are automatically enrolled into the Maintenance of Certification in Anesthesiology® (MOCA®) program. A description of the program can be found in the MOCA 2.0® section.

3.07 BASIC EXAMINATION REGISTRATION ELIGIBILITY REQUIREMENTS

Residents are automatically enrolled in the staged examinations process when their anesthesiology residency program submits a resident enrollment form. We will determine that entry into the examination system is warranted when required information submitted by and on behalf of the resident is satisfactory. We will notify residents of their eligibility to register for the BASIC Examination after we have approved of all their credentials. The notification is sent to residents at their email address on file in the ABA office.

At the time of registration for the BASIC Examination, the resident must:

A. Have evidence on file in the ABA office of having satisfactorily completed 18 months of training, including clinical base and clinical anesthesiology training. Residents who will complete this requirement before March 31 may register for the following summer BASIC Examination. Residents who will complete this requirement before Sept. 30 may register for the following winter BASIC Examination.

B. We will not validate the results to residents who take the BASIC Examination and do not fulfill the conditions identified above.

3.08 BASIC EXAMINATION REGISTRATION

We must receive all required documentation to make a decision about a resident's qualifications for registration to the BASIC Examination. Registration will not be accepted if the required documentation is not received by each registration deadline (please see the Registration Deadlines and Examination Dates available on the last page of this section). It is ultimately the responsibility of every resident to ensure that we receive all required documentation in a timely manner.

A. Approximately three months prior to each BASIC Examination administration, we notify residents of their eligibility to register for an examination. The notification is sent to residents' email address on file. Residents who register for an examination must pay the registration fee at that time. Current fees and deadlines are posted at www.theABA.org.

B. Registration for the BASIC Examination must be made via the Physician Portal, which is accessible through our website at www.theABA.org.

C. Registration includes the following Acknowledgment and Release forms, which the registrant shall be required to sign by electronic signature:

(1) *I, the undersigned registrant ("registrant"), hereby agree to participate in the American Board of Anesthesiology, Inc.'s ("ABA") initial certification program. I acknowledge that my participation is subject to the ABA rules and regulations. I further acknowledge and agree that if I withdraw my registration or the ABA does not accept it, the ABA will retain the registration fee and any late fee.*

I represent and warrant to the ABA that all information I provide to the ABA is true, correct and complete in all material respects. I understand and acknowledge that any material misstatement or omission over the course of my initial certification program shall, at any time, constitute cause for disqualification from the ABA examination system or from the issuance of an ABA certificate or to forfeiture and redelivery of such ABA certificate to the ABA.

I agree that this acknowledgment, as submitted by me, shall survive the electronic submission of the registration, regardless of whether the information or data provided in the registration has been reformatted in any manner by the ABA. I also agree that this acknowledgment is a part of and incorporated into the registration whether submitted along with the registration or not.

I acknowledge that I have read a copy of the ABA Policy Book. I agree to be bound by the policies, rules, regulations and requirements published in the book, in all matters relating to consideration of and action upon this registration and certification. I understand that ABA certificates are subject to ABA rules and regulations, all of which may be amended from time to time without further notice. I understand and acknowledge that in the event I have violated any of the ABA rules governing my registration and/or certification, such violations shall constitute cause for disqualification from the ABA examination system or from the issuance of an ABA certificate or for revocation of certification and indication of such action in the ABA Diplomate and Candidate Directory.

(2) *I, the undersigned registrant ("registrant"), hereby agree to participate in the American Board of Anesthesiology, Inc.'s ("ABA") initial certification program. I acknowledge that my participation is subject to the ABA rules and regulations, all of which may be amended from time to time without further notice.*

In connection with my registration, I authorize all persons holding testimony, records, documents, opinions, information and data relevant to or pertaining to my professional competence and ethical conduct and/or behavior (the "Background Information") to release such Background Information to the ABA, its employees and agents. This authorization applies whether or not such persons are listed as a reference on my registration. Background Information includes any information relating to any abusive use of alcohol and/or illegal use of drugs, and any medical or psychiatric treatment or rehabilitation related thereto. I understand that such Background Information may be used to determine, verify or deny my qualifications for entrance

into the ABA entrance examination and ABA certification. I understand that the ABA treats this information as confidential and will not release the content or a copy of any references to me unless the person providing the reference consents in writing. A copy of this release may accompany any request made by the ABA for such Background Information.

I authorize the ABA to: (1) report my status in the examination system, including the results of any examination, to the director and department chair of the program from which I received my clinical training; (2) use any score in psychometric analyses to confirm observations and reports of suspected irregularities in the conduct of an examination; and (3) respond to any inquiry about my status in the ABA examination system. I understand and agree that once my examination registration is completed and granted, this consent cannot be withdrawn.

I also authorize the ABA to record the video and audio of my performance during the ABA examinations at the ABA Assessment Center for educational, quality and scoring purposes. Such recordings will be used for ABA internal purposes only and will be retained in accordance with ABA retention policies. I understand that any use of a mobile or recording device during the examination may result in my examination being invalidated and the loss of my registration fee. Furthermore, if I attempt to record, transmit or transcribe any portion of the examination, my examination will be invalidated and I will forfeit my registration fee.

I understand that the ABA may use any and all Background Information for the purpose of conducting longitudinal studies to assess the ABA certification process. I further understand that the ABA, alone or in collaboration with other researchers, may use information from the registration, testing, assessment and certification process (the "Assessment Information") to conduct scientific research relating to anesthesiologists, the practice of anesthesiology and/or the education of anesthesiologists. Any and all information used for research may be reported or released to the public only in the aggregate without any individual identification.

Use of any Background Information or Assessment Information for analysis or research will not impact in any way my individual registration, test results or certification status. I understand and agree that should I not wish for my information to be used for research purposes, prior to taking the exam I must notify the ABA in writing to the attention of researchoptout@theABA.org to opt out and withdraw consent for my information to be used as part of research studies. I cannot opt out and consent cannot be withdrawn once my information has been de-identified and/or aggregated as part of any research study.

I release and agree to hold harmless each person from any liability to me arising out of the giving or releasing of information to the ABA. This release and agreement includes liability for the inaccuracy or untruth of the Information, so long as such information is provided in good faith. I also release and agree to hold harmless the ABA and its agents and employees, including but not limited to its directors, officers and examiners, from any liability to me as a result of any acts or proceedings undertaken or performed in connection with my registration, provided such acts or proceedings are made or conducted in good faith.

3.09 ADVANCED EXAMINATION REGISTRATION ELIGIBILITY REQUIREMENTS

At the time of registration for the Advanced Examination, a resident must:

A. Have passed the BASIC Examination.

B. Have evidence on file in the ABA office of having satisfactorily fulfilled all requirements of the continuum of education in anesthesiology before the date of the ADVANCED Examination. Such evidence must include a satisfactory Certificate of Clinical Competence covering the final six months of clinical anesthesia training in each residency program [see Sections 2.02.C (3) for details].

Registrants completing the full training requirement by Sept. 30 may register for the summer ADVANCED Examination. Registrants who will complete this requirement after Sept. 30 may register for the winter ADVANCED Examination.

Registrants completing the full training requirement by March 31 may register for the winter ADVANCED Examination. Registrants who will complete this requirement after March 31 may register for the summer ADVANCED Examination.

C. Have documentation on file with the Board attesting to the registrant's current privileges and evaluations of various aspects of their current practice of anesthesiology. Such evaluations will include verification that the registrants meet our clinical activity requirement by spending, on average, at least one day per week during 12 consecutive months over the previous three years in the clinical practice of anesthesiology and/or related subspecialties. We may solicit such documentation and evaluations from the residency program director or others familiar with the registrant's current practice of anesthesiology and use them in determining the resident's qualifications for admission to the ABA examination system.

D. Be capable of performing independently the entire scope of anesthesiology practice without accommodation or with reasonable accommodation (see Sections 1.02A, 1.02D and 8.09).

E. We will not validate the results of registrants who take the ADVANCED Examination and do not fulfill those conditions identified in Section 3.09 by the deadlines.

3.10 ADVANCED EXAMINATION REGISTRATION

We must receive all required documentation to make a decision about a candidate's qualifications for registration to the ADVANCED Examination. Registration will not be accepted if the required documentation is not received by the registration deadline. It is ultimately the responsibility of every candidate to ensure that we receive all required documentation in a timely manner.

A. Approximately three months prior to each ADVANCED Examination administration, we notify residents of their eligibility to register for an examination. The notification is sent to residents at their email address on file. Residents who register for an examination must pay the registration fee at that time. Current fees and deadlines are posted at www.theABA.org.

B. Registration for the ADVANCED Examination must be made via the Physician Portal, which is accessible through our website at www.theABA.org.

C. Candidates must attest to their clinical activity every three years while in the examination system.

3.11 APPLIED EXAMINATION REGISTRATION ELIGIBILITY REQUIREMENTS

At the time of registration for the APPLIED Examination, the candidate must:

A. Have passed the ADVANCED Examination.

B. Provide evidence of having satisfied the licensure requirement for certification. A **grace period** will be permitted so that candidates may complete this requirement by Nov. 15 of the APPLIED Examination administration year. Training and expired licenses do not fulfill this licensure requirement for certification. Candidates must inform us of any conditions or restrictions in force on any active medical license they hold. When there is a restriction or condition in force on any of the candidate's medical licenses, our Credentials Committee will determine whether, and on what terms, the candidate will be admitted to the ABA Examination System.

C. We will not validate the results to candidates who take the APPLIED Examination and do not fulfill the licensure requirement by the deadline identified above.

3.12 APPLIED EXAMINATION REGISTRATION

We must receive all documentation required to make a decision about a candidate's qualifications for registration to the APPLIED Examination by the registration deadline. Registration will not be accepted if the required documentation is not received by the deadline. It is ultimately the responsibility of every candidate to assure that we receive all required documentation in a timely manner.

A. Physicians who have graduated from residency, passed the ADVANCED Examination, and met all eligibility requirements will be eligible to take the APPLIED Examination. When a physician passes the ADVANCED Examination, they will receive notification in their official result letter that they are eligible to register for the APPLIED Examination.

B. The APPLIED Examination will be administered multiple times each year. To schedule an APPLIED Examination, candidates will select an examination week from the list of available weeks posted within their portal account. Once an APPLIED Examination week reaches its capacity of appointments, candidates can no longer schedule appointments for that week. We will assign specific examination dates and times within the selected week. Two months prior to an examination, we will notify candidates of the exact date, time and location of their examination and the rules of examination conduct.

- **Candidates who have not been assigned an exam date, time and location** may request to change their APPLIED Examination week within the same calendar year; however, we cannot guarantee that a change will be made. To request a change, candidates must send a written request to our office with a check for the APPLIED Examination change fee. Current fees are posted at www.theABA.org.

- **Candidates who have been assigned an exam date, time and location** may not request to change their APPLIED Examination week. If they do not plan to attend their scheduled exam, they must cancel their examination as defined in Section 3.13.A.

C. Candidates who do not take or do not pass the APPLIED Examination for which they are scheduled, for whatever reason, may schedule their next APPLIED Examination no earlier than four months following the current scheduled examination.

3.13 NOTIFICATION AND CANCELLATION OF EXAMINATIONS

Our office is not responsible for an interruption in communication with a resident or candidate that is due to circumstances beyond its control. Residents and candidates must immediately notify us of a mailing or email address change via their portal account at www.theABA.org, or by writing to our office. Residents and candidates must email us at exams@theABA.org if they do not receive an examination notice they are expecting within the time frames described above. The resident's and candidate's ABA identification number should be included on all correspondence to the Board solely for identification purposes.

A. A resident or candidate who cancels a scheduled examination appointment must submit a written request to cancel at least one week prior to the examination administration week. A cancellation fee must accompany the request in order to retain the registration fee for the next examination appointment. Current fees are posted at www.theABA.org.

B. A resident or candidate who misses a scheduled examination appointment because of an unavoidable or catastrophic event must submit a written request with explanation and independent documentation of the event. To retain the registration fee for the next examination appointment, we must receive the request and the cancellation fee no later than one week after the examination date. If a scheduled appointment is missed for a reason that does not represent an unavoidable or catastrophic event, the registration fee will be forfeited. Forfeiting of the registration fee is solely at the discretion of the Board.

C. A resident or candidate who misses a scheduled examination appointment and does not cancel the scheduled examination appointment forfeits the registration fee.

D. A candidate who cancels or misses a scheduled APPLIED Examination may not schedule another APPLIED Examination sooner than four months following the cancelled or missed appointment.

3.14 DURATION OF CANDIDATE STATUS

The duration of candidate status is limited. Candidates who complete residency training on or after Jan. 1, 2012, must satisfy all requirements for certification within seven years of the last day of the year in which residency training was completed. If a candidate does not satisfy all requirements for certification within the prescribed time period, the candidate must reestablish eligibility for the ABA examination system (see Section 3.15).

We do not recognize "Board Eligible" as a physician status relative to the ABA Examination System. Therefore, physicians should refrain from making any representations of being "Board Eligible" (See Section 1.05).

3.15 REESTABLISHING ELIGIBILITY FOR CERTIFICATION

If a candidate does not satisfy all requirements for certification within the prescribed time period specified in Section 3.14, we will declare the candidate's registration void. Physicians whose registrations have been voided may submit a new registration after reestablishing eligibility for certification. Such registration shall be subject to the fees, rules, privileges and entrance requirements that apply at the time of reregistration. Physicians will only be allowed to reestablish eligibility for certification once.

To reestablish eligibility for certification, physicians must take and pass the BASIC Examination to reenter the ABA examination system for initial certification. After reestablishing eligibility, candidates must satisfy all requirements for certification, including successfully completing the ADVANCED Examination and both the Standardized Oral Examination and Objective Structured Clinical Examination components of the APPLIED Examination, by Dec. 31 of the fourth year following the successful completion of the BASIC Examination. Physicians will be considered candidates in the ABA examination system when their registration for the ADVANCED Examination is accepted.

Physicians who completed residency training prior to Jan. 1, 2012, who will not satisfy all of the traditional requirements for certification (Part 1 and Part 2 Examinations) by Dec. 31, 2018, must take and pass the BASIC Examination to re-enter the ABA examination system for initial certification. After reestablishing eligibility, candidates must satisfy all requirements for certification, including successfully completing the ADVANCED Examination and both the Standardized Oral Examination and Objective Structured Clinical Examination components of the APPLIED Examination, by Dec. 31 of the fourth year following the successful completion of the BASIC Examination. Physicians will be considered candidates in the ABA examination system when their registration for the ADVANCED Examination is accepted. See the last page of this section for examination dates and deadlines.

3.16 REESTABLISHING ELIGIBILITY (FORMER DIPLOMATES)

MOCA PARTICIPATION EXCEEDING 13 YEARS FOR TIME-LIMITED CERTIFICATE HOLDERS

Former diplomates who do not complete all MOCA requirements within three years of the expiration of their most recent certificate in anesthesiology or certificate for Maintenance of Certification in the specialty of Anesthesiology must complete the following steps to reestablish their status as an ABA diplomate. Physicians will only be allowed to reestablish eligibility for the ABA examination system once.

- Meet the requirements for entering the examination system of the ABA (see Section 2.09);

- Register for admission to the examination system of the ABA; and
- Pass the ADVANCED Examination; and
- Pass both the Standardized Oral Examination and Objective Structured Clinical Examination components of the APPLIED Examination under the new registration.

Candidates must successfully complete the requirements for certification in anesthesiology within seven years of the last day of the year in which their registration was accepted.

STAGED EXAMINATIONS DEADLINES & EXAMINATION DATES

SUMMER 2020 BASIC EXAMINATION	
Examination Dates	June 12 – 13, 2020

FALL 2020 BASIC EXAMINATION	
Examination Dates	Nov. 13 – 14, 2020

WINTER 2020 ADVANCED EXAMINATION	
Examination Dates	Jan. 24 – 25, 2020

SUMMER 2020 ADVANCED EXAMINATION	
Examination Dates	July 24 – 25, 2020

2020 APPLIED EXAMINATIONS		
March 2 - 5, 2020	May 4 - 7, 2020	Sept. 14 - 17, 2020
March 16 - 19, 2020	May 18 - 21, 2020	Sept. 28 - Oct. 1, 2020
March 30 - April 2, 2020	June 8 - 11, 2020	
April 20 - 23, 2020	July 18 - 19, 2020	

MOCA 2.0®

MAINTENANCE OF CERTIFICATION IN ANESTHESIOLOGY PROGRAM

(ANESTHESIOLOGY AND SUBSPECIALTY CERTIFICATIONS)

Beginning in 2017, there is only one set of MOCA 2.0 requirements, no matter how many certificates a diplomate is maintaining (See Section 4.03).

- All diplomates with current time-limited certificates in anesthesiology or an anesthesiology subspecialty can register for MOCA 2.0 in their ABA portal account, as can diplomates with non-time limited certificates in anesthesiology (those certified before 2000) and/or non-time limited certificates in critical care medicine who are participating in MOCA.

- Diplomates with non-time limited certificates in anesthesiology or critical care medicine who are not enrolled in MOCA can voluntarily register for MOCA 2.0.

- Newly certified diplomates can register for MOCA 2.0 in their portal account immediately after we award them certification.

- Time-limited certificate holders whose subspecialty certificates in pain medicine or critical care medicine expired on or before Dec. 31, 2016, must reestablish eligibility for subspecialty certification and successfully complete the subspecialty certification exam before being eligible to register for MOCA 2.0 (See Section 5.12).

- Time-limited anesthesiology certificate holders whose certificates expired from Dec. 31, 2011 to Dec. 31, 2016, must complete a portion of the staged examinations requirements before being eligible to register for MOCA 2.0 (see Section 4.04.A).

4.01 MAINTAINING SPECIALTY AND SUBSPECIALTY CERTIFICATION

ABA diplomates who choose to maintain both initial certification in anesthesiology and subspecialty certification will benefit from one set of program requirements for all parts of MOCA 2.0.

4.02 MAINTAINING ONLY SUBSPECIALTY CERTIFICATION

ABA diplomates may choose to maintain their subspecialty certification without maintaining their initial certification in anesthesiology (once they are both obtained). However, when a time-limited anesthesiology certification expires, the physician is no longer board certified in the specialty. Should this occur, the information on our Diplomate and Candidate Directory will indicate that their certification in anesthesiology is no longer valid. We will also advise the American Board of Medical Specialties (ABMS) that the physician no longer holds a valid certificate in anesthesiology.

Although diplomates may choose to maintain only their subspecialty certification, we strongly encourage them to maintain their initial certification in anesthesiology. We do not recommend maintaining only a subspecialty certificate and wants diplomates to consider any imponderable repercussions before choosing to let their certification in anesthesiology expire.

4.03 MOCA 2.0® REQUIREMENTS

A. ANNUAL MOCA 2.0 REGISTRATION

All eligible diplomates will complete an annual registration process to participate in MOCA 2.0, and to gain access to MOCA Minute questions.

To register, diplomates must complete the following activities within their portal accounts:

- Confirm their personal contact information
- Verify their medical licenses
- Electronically sign the following forms:

    - **Acknowledgment and Release**

      I, the undersigned registrant ("registrant"), hereby agree to participate in the American Board of Anesthesiology, Inc.'s (ABA) Maintenance of Certification in Anesthesiology® (MOCA®) program. I acknowledge that my participation is subject to the ABA rules and regulations, all of which may be amended from time to time without further notice. I further acknowledge and agree that all MOCA fees paid to the ABA are non-refundable.

      I represent and warrant to the ABA that all information I provide to the ABA is true, correct and complete in all material respects. I understand and acknowledge that any material misstatement or omission over the course of my MOCA cycle shall, at any time, constitute cause for disqualification from the MOCA program or from the issuance of an ABA certificate or to forfeiture and redelivery of such ABA certificate to the ABA.

      I agree that this acknowledgment, as submitted by me, shall survive the electronic submission of the registration, regardless of whether or not the information or data provided during my participation in the program has been reformatted in any manner by the ABA. I also agree that this acknowledgment is a part of and incorporated into the annual registration, whether submitted along with the registration or not.

      I acknowledge that I have read a copy of the ABA Policy Book. I agree to be bound by the policies, rules, regulations and requirements published in the book, in all matters relating to consideration of and action upon my participation in the MOCA program, and certification should it be granted. I understand that ABA certificates are subject to ABA rules and regulations, all of which may be amended from time to time without further notice. In addition, I understand and acknowledge that in the event I have violated any of the ABA rules governing my registration and/or certification, such violations shall constitute cause for disqualification from the ABA MOCA program or from the issuance of an ABA certificate or for revocation of certification and indication of such action in the ABA Diplomate and Candidate Directory.

      In connection with my status in the MOCA program, I authorize all persons holding testimony, records, documents, opinions, information and data relevant to or pertaining to my professional competence and ethical conduct and/or behavior (the "Background Information") to release such Background Information to the ABA, its employees and agents. This authorization applies whether or not such persons are listed as a reference on my registration. Background Information includes anything relating to any abusive use of alcohol and/or illegal use of drugs, and any medical or psychiatric treatment or rehabilitation related thereto. I understand that such Background Information may be used to determine, verify or deny my qualifications as a diplomate in the ABA MOCA program. I understand that the ABA treats this information as confidential and will not release the content or a copy of any references to me unless the person providing the reference consents in writing. A copy of this release may accompany any request made by the ABA for such Background Information.

      I authorize the ABA to: (1) report my participation status in the MOCA program, and (2) use a pattern of responses in psychometric analyses to confirm observations and reports of suspected

irregularities on the answering of MOCA Minute questions. I understand and agree that once I elect to participate in the MOCA program, my consent cannot be withdrawn for prior obtained and reported information. To withdraw from the MOCA program and the prospective reporting of information, I understand that I must notify the ABA in writing to the attention of MOCA@theABA.org.

I also understand that the ABA may use any and all Background Information for the purpose of conducting longitudinal studies to assess the ABA certification process or the Maintenance of Certification program. I further understand that the ABA, alone or in collaboration with other researchers, may use information from the registration, testing, assessment, and certification process, including my participation in the MOCA program (the "Assessment Information"), to conduct scientific research relating to anesthesiologists, the practice of anesthesiology and/or the education of anesthesiologists. Any and all information used for research may be reported or released to the public only in the aggregate without any individual identification.

Use of any Background Information or Assessment Information for analysis or research will not impact in any way my registration, MOCA participation or certification status. I understand and agree that should I not wish for my information to be used for research purposes, I must notify the ABA in writing to the attention of researchoptout@theABA.org to opt out and withdraw consent for my information to be used as part of research studies. I cannot opt out and consent cannot be withdrawn once my information has been de-identified and/or aggregated as part of any research study.

I release and agree to hold harmless each person from any liability to me arising out of the giving or releasing of information to the ABA. This release and agreement includes liability for the inaccuracy or untruth of the information, so long as such Information is provided in good faith. I also release and agree to hold harmless the ABA and its agents and employees, including but not limited to its directors, officers and examiners, from any liability to me as a result of any acts or proceedings undertaken or performed in connection with my participation in the MOCA program, provided such acts or proceedings are made or conducted in good faith.

- **CME Release**

  In connection with the American Board of Anesthesiology® Inc.'s (ABA) Maintenance of Certification in Anesthesiology® (MOCA®) program, the ABA allows certain continuing medical education (CME) providers to electronically submit verification of a Diplomate's program participation in order to make it easier for ABA Diplomates to document fulfillment of their CME requirements. CME activities submitted to the ABA from a CME provider are NOT subject to audit by the ABA.

  On occasion, the ABA is contacted by CME providers to obtain or verify certain Diplomate identifying information to submit program participation data to the ABA. Before the ABA may provide this information to a CME provider, the ABA must obtain authorization directly from the physician.

  I hereby authorize the ABA to release my name, date of birth, date of medical school graduation, and ABA unique identification number to ABA registered CME providers. Please note that the ABA identification number is not my Social Security number.

  I understand that the ABA does not review, evaluate, or monitor data received from registered CME providers.

- **Copyright Policy**

  MOCA Minute questions are proprietary information of the American Board of Anesthesiology (ABA) and are the ABA's copyrighted material. By your registration for MOCA, you agree not to share, copy, create derivative works, or otherwise distribute the questions to any third party for profit without the ABA's explicit written consent. MOCA Minute questions are the sole property of the ABA.

Diplomates are expected to participate in MOCA Minute with the highest level of professionalism and integrity, and as such are required to answer their own MOCA Minute questions and not assist other diplomates in answering theirs or seek the assistance of others.

Diplomates found to have violated the copyright protection by engaging in the aforementioned activities,received or gave assistance in the answering of MOCA Minute questions, or in some other conduct or manner, will be subject to disciplinary actions by the ABA, which may include permanent disqualification from MOCA.

- **Independent Practice Requirement**

  Although admission into the MOCA program and success with components of the program are important steps in the ABA maintenance of certification process, they do not by themselves guarantee maintenance of certification. The Board reserves the right to make the final determination of whether each diplomate meets all of the requirements for maintenance of certification, including Professional Standing and the ability to perform independently in the specialty or subspecialty, with or without reasonable accommodation for disabilities, before awarding maintenance of certification.

- Request nonstandard accommodations (if applicable)
- Answer substance abuse statement
- Complete their practice profiles by selecting a practice location and practice areas by topic
- Pay the annual MOCA 2.0 fee ($210 for the first certificate maintained and $100 for each additional certificate maintained)

B. PART I: PROFESSIONALISM AND PROFESSIONAL STANDING (MEDICAL LICENSURE)

We assess a diplomate's professional standing continually as one means to assess professionalism. Acceptable professional standing to be designated as participating in MOC includes, at minimum, holding an active, unrestricted license to practice medicine in at least one jurisdiction of the United States or Canada. Further information regarding professionalism and professional standing requirements is found in Section 7.06.

Diplomates have the affirmative obligation to advise us of any and all restrictions placed on any of their medical licenses and to provide complete information concerning such restrictions within 60 days after their imposition. Such information shall include, but not be limited to, the identity of the medical board imposing the restriction as well as the restriction's duration, basis, and specific terms and conditions. Diplomates discovered not to have made disclosure may be subject to sanctions on their diplomate status.

C. PART II: LIFELONG LEARNING AND SELF-ASSESSMENT (CME ACTIVITIES)

ABA diplomates should continually seek to improve the quality of their clinical practice and patient care through self-directed professional development. This should be done through self-assessment and learning opportunities designed to meet the diplomate's needs and the MOCA requirement for Lifelong Learning and Self-Assessment (LLS).

The LLS requirement is 250 credits for continuing medical education (CME) activities.

(1) All credits must be:
   a. ACCME/AMA PRA-approved Category 1
   b. American Osteopathic Association Category 1-A
   c. Accredited CPD credits issued by the Royal College of Physicians of Canada and the Association of Faculties of Medicine of Canada

(2) During the period from 2006 to 2012, no more than 70 credits for CME programs and activities may be completed in the same calendar year. Effective as of 2013, no more than 60 credits for CME programs and activities may be completed in the same calendar year. Some CME activity must be

completed in at least five years of each 10-year MOCA cycle. Participants are encouraged to complete some CME activity in each of the six general competencies for physicians.

(3) Half of the CME requirement (125 credits) must be completed by the end of Year 5 of the diplomates' 10-year cycles (see Section 4.01.F).

(4) **Beginning in 2016, self-assessment CMEs are no longer required** for Part II: Lifelong Learning and Self-Assessment. However, diplomates who previously completed self-assessment CMEs or who wish to in the future will receive credit for them in MOCA 2.0.

Patient Safety CME Credit Requirements

(1) All diplomates and non-time limited diplomates who register for MOCA 2.0 are required to complete 20 Category 1 credits of patient safety CME. A list of the approved activities is available on our website and on physicians' portal accounts.

CME sponsors may submit CME activities and credits to us electronically for our diplomates. Diplomates may self-report their CME activities and credits to us electronically. Whereas provider-reported CME activities do not require verification, self-reported CME activities are subject to audit and verification within three years of their submission. Therefore, diplomates must keep documentation of every self-reported CME activity for at least three years after their submission.

D. PART III: ASSESSMENT OF KNOWLEDGE, JUDGMENT, AND SKILLS (MOCA MINUTE)

MOCA Minute® replaces the MOCA and MOCA-SUBS exams as the Part III: Assessment of Knowledge, Judgment, and Skills. MOCA Minute questions are multiple-choice questions with a single best answer, like those presented on previous MOCA and subspecialty recertification exams. MOCA Minute allows diplomates to assess their knowledge, gauge whether they have retained knowledge over time and demonstrate their proficiency continuously throughout their 10-year MOCA cycle.

Diplomates must complete 30 MOCA Minute questions per calendar quarter (120 per year by 11:59 p.m. EST on Dec. 31) and maintain an MDT p-value of ≥ 0.10 every year. Diplomates can answer all 30 questions at once; however, they cannot answer more than 30 questions per day. Diplomates who miss answering questions in the first three quarters of the year can make up the missed questions in subsequent quarters. Diplomates who answer questions incorrectly will receive similar questions on the same topic over time to gauge whether they have learned the material.

We will waive as many as two calendar quarters of MOCA Minute questions (60 questions) when:

- Active military diplomates personally submit a written request to the ABA Secretary attesting to their deployment and lack of computer access or
- Diplomates have a current severe illness and personally submit a written request to the ABA Secretary including a letter from their treating physician substantiating their illness.

Other reasonable requests or justifiable hardships will be reviewed on a case-by-case basis.

MOCA Minute questions are based on the certificates diplomates are maintaining.

- **Diplomates only maintaining anesthesiology certification** will receive general anesthesia questions that represent the base of knowledge every physician anesthesiologist should know and questions about new knowledge areas that the Board believes diplomates need to learn quickly (i.e., Ebola). Additionally, they will receive questions based on the areas of practice they select in their practice profile during the MOCA 2.0 annual registration.

- **Diplomates only maintaining critical care medicine, pain medicine or pediatric anesthesiology certification** will receive some subspecialty-specific questions representative of what certified diplomates should know and some questions based on the areas of practice they

select in their practice profile during the MOCA 2.0 annual registration.

- **Diplomates maintaining multiple certifications in anesthesiology, critical care medicine, pain medicine and/or pediatric anesthesiology** will receive questions related to each certification area.

- **Diplomates maintaining hospice and palliative medicine or sleep medicine certification** will receive questions based on general anesthesia knowledge as well as areas selected in their practice profile. MOCA Minute is optional for these diplomates as they have to take and pass the subspecialty recertification exam to fulfill the MOCA Part III requirement.

Diplomates may access MOCA Minute questions via their portal account, weekly email reminders, or the MOCA Minute mobile app. Once diplomates access a question, they have one minute to answer it and will learn immediately whether they answered correctly or not. Diplomates will receive the questions' rationale, a critique and associated references and educational materials. Participants may also submit feedback to us on the question and the question's relevancy to their practice. Questions not answered within the time allotted will be counted as incorrect answers.

We are using Measurement Decision Theory (MDT) to evaluate diplomates' MOCA Minute performance. MDT is a statistical model that estimates the likelihood or probability that diplomates are keeping their specialty-specific knowledge up-to-date based on their pattern of responses to MOCA Minute questions. **Diplomates who maintain an MDT probability or p-value of ≥ 0.10 are meeting the standard for MOCA Part III.**

- Diplomates must answer 120 MOCA Minute questions each year by 11:59 p.m. EST on Dec. 31 and maintain an MDT p-value of ≥ 0.10 every year.

  OR

- Answer less than 120 MOCA Minute questions each year by 11:59 p.m. EST on Dec. 31 and maintain an MDT p-value of ≥ 0.10 every year. Any unanswered MOCA Minute questions will be considered incorrect and will negatively impact diplomates' MDT p-value.

Diplomates will be informed on a continuous basis in their portal account whether they are meeting the standard for Part III. We will use the MOCA Minute data to make judgments about diplomates who fall below a minimum standard for too long or too frequently. Diplomates who do not meet the standard should use the MOCA Minute Knowledge Assessment Report and the CME Explorer to create a remediation plan. If after remediation, a diplomate still does not meet the criteria for certification, we may not issue the diplomate a new certificate when the current one expires. We will make decisions about diplomates' certification status based on their performance in all four components of the MOCA 2.0 program, not just MOCA Minute.

Anesthesiology Special Purpose Exam (ASPEX)
Diplomates who are not meeting the MOCA Minute standard in the year their certification expires can take the ASPEX as a secondary assessment for the certificate(s) they are maintaining (anesthesiology, critical care medicine and/or pain medicine). We will notify diplomates via email of their eligibility for ASPEX.

Diplomates certified in anesthesiology in 2006, 2007 or 2008:

- Diplomates who passed the MOCA Examination will not be required to participate in MOCA Minute until their current certificates expire and will not have to pay the annual MOCA 2.0 fee until 2026. However, they will still need to register annually for MOCA 2.0 beginning in 2016.

- Diplomates who failed their most recent MOCA Examination will be required to register annually for MOCA 2.0 and participate in MOCA Minute starting in January 2016, but will not be required to pay the annual MOCA 2.0 fee until 2026.

Diplomates whose subspecialty certification in pain medicine or critical care medicine expires in 2017, 2018 or 2019:

- Diplomates who took and passed the pain medicine or critical care medicine recertification examination in 2014, 2015 or 2016, will not be required to complete any MOCA 2.0 requirements for their subspecialty certification, including participating in MOCA Minute and paying the MOCA 2.0 annual fee, until their certificate expires in 2017, 2018 or 2019. However, if these diplomates are also maintaining their initial certificate in anesthesiology that expires on or after Dec. 31, 2016, they will need to complete MOCA 2.0 requirements for that certificate.

- Diplomates with non-time limited initial certification in anesthesiology and time-limited subspecialty certification must complete all MOCA 2.0 requirements before their current subspecialty certificate expires. These diplomates must pay the annual MOCA 2.0 fee every year they participate in the program.

E. PART IV: IMPROVEMENT IN MEDICAL PRACTICE (QUALITY IMPROVEMENT)

ABA diplomates should be continually engaged in a self-directed program of Improvement in Medical Practice (IMP). We made changes to the requirements based on diplomate feedback and changes to the ABMS standards that allow for greater flexibility to provide diplomates with options to participate in activities that are most relevant to their practice.

Beginning in 2016, simulation is an optional Part IV activity. We developed a point system for Part IV that weighs activities based on the time and effort associated with completing them. Diplomates must earn **25 points per five-year period for a total of 50 points during the 10-year MOCA cycle**. They may choose activities from the Part IV activity list to accumulate points. Diplomates may not receive credit for more than 25 points in one year, therefore diplomates may not complete all IMP requirements in one year. Part IV activity submissions are subject to audit.

The list of Part IV activities is available at www.theABA.org. This list is subject to change.

F. PARTICIPATING IN MOC REQUIREMENTS

We will report the status of **all diplomates** as it relates to their participation in one or more Maintenance of Certification (MOC) program (Anesthesiology, Critical Care Medicine, Hospice and Palliative Medicine, Pain Medicine, Pediatric Anesthesiology, Sleep Medicine) based on the below criteria. Diplomates certified prior to the year 2000 have certificates that are not time-limited, and are not required to participate in MOCA.

"Participating in MOC"

Diplomates are considered to be participating in MOC if they are making continuous progress toward completing all of the requirements as measured by:

(1) Maintaining satisfactory professionalism and professional standing , which includes:
   a. Holding an active, unrestricted license to practice medicine in at least one jurisdiction of the United States (U.S.) or Canada. Further, all U.S. and Canadian medical licenses that a diplomate holds must be unrestricted.
   b. Updating the current expiration date(s) of their medical license(s) no later than 60 days after renewal via our website.
   c. Informing us of any actions taken against their medical license(s) within 60 days of the final action.

(2) Actively participating in Lifelong Learning and Self-Assessment (LLS) activities, which includes:
   a. Completing and reporting to us one half (125 credits) of the total LLS requirement by the end of Year 5 of the 10-year MOCA cycle.
   b. Completing and reporting to us the total LLS requirement of 250 credits by the end of Year 10.

(3) Actively participating in Assessment of Knowledge, Judgment, and Skills, which includes:
   a. Answering 120 MOCA Minute questions per calendar year and/or maintaining an MDT probability or p-value of ≥ 0.10.
   b. Answering a total of 1,200 questions by the end of Year 10 and/or maintaining an MDT probability or p-value of ≥ 0.10.

(4) Actively participating in Improvement in Medical Practice (IMP) activities, which includes:
   a. Satisfactory completion of 25 points of Part IV: IMP activities by the end of Year 5.
   b. Satisfactory completion of 25 points of Part IV: IMP activities by the end of Year 10.

"Not Participating in MOC"

Diplomates are considered to not be participating in MOC if they are unable to complete the above requirements in the specified timeframes. If diplomates are unable to complete the program requirements by the expiration date of their current time-limited certificate, then they will be classified as "Expired" and "Not Board Certified."

"Not Required to Participate in MOC"

Diplomates certified prior to the year 2000 have certificates that are not time-limited. These diplomates **are not required** to recertify or participate in the MOCA program or its subspecialties, but are strongly encouraged to do so. The Diplomate and Candidate Directory on the ABA website will note that these diplomates are not required to participate in MOC.

G. MOCA REQUIREMENTS FOR CANDIDATES WHOSE INITIAL CERTIFICATION IN ANESTHESIOLOGY HAS BEEN DEFERRED

Despite passing the initial certification examinations, some candidates will not receive initial ABA certification because their certification has been deferred. For candidates whose certification has been deferred, MOCA requirements shall be determined as follows:

- Candidate's 10-year MOCA cycle will now begin once certification has been awarded; not at the time the candidate passes the Part 2 Examination.
- Candidates will not be allowed to participate in MOCA Minute until certification is awarded.
- Candidates will be allowed to accumulate as many as five years of MOCA Part II CME credit and as many as 25 points of MOCA Part IV activities that were accumulated prior to their certification date.
- Additional requirements may be determined by our Credentials Committee.

H. MOCA REQUIREMENTS FOR DIPLOMATES WHO ARE NOT CLINICALLY ACTIVE

Diplomates who are not clinically active and hold time-limited certificates in anesthesiology or a related subspecialty can maintain their certification(s) by completing the following MOCA requirements:

- Part I: Maintain satisfactory Professionalism and Professional Standing
- Part II: Complete the required Lifelong Learning and Self-Assessment activities
- Part III: Demonstrate proficiency by participating in MOCA Minute for the Assessment of Knowledge, Judgment, and Skills.

The MOCA Part IV requirement is waived for diplomates who are designated as "Certified – Not Clinically Active."

I. EXPIRED TIME-LIMITED CERTIFICATES

(1) Time-limited certificate holders who fail to meet the MOCA requirements by the expiration of their most recent certificate in anesthesiology or certificate for Maintenance of Certification in the specialty of

Anesthesiology will have their certification status changed to “expired.” To regain their certification status of “diplomate,” they must complete all MOCA requirements as described below:

a. We will move their 10-year MOCA cycle forward one year. Any activities that were completed in the original Year 1 (i.e., CME) are removed and they are required to redo those activities. If the Part III requirement was not completed, diplomates can be re-certified after answering 30 questions per quarter for four consecutive quarters.

b. Upon successful completion of all MOCA requirements (which are defined by their original MOCA cycle), we will issue that physician a certificate for Maintenance of Certification in the specialty of Anesthesiology valid for 10 years from the date of completion of the program.

c. If the physician fails to complete the requirements within a year after the expiration of their certificate, then their MOCA cycle moves forward another year and they lose the activities that were completed in the original Year 2.

d. We will move a MOCA cycle forward, one year at a time, for up to three years.

(2) **Reinstatement Fee:** Effective Jan. 1, 2014, all former diplomates with time-limited certificates who wish to complete the MOCA program in Years 11, 12 and 13 will be charged a fee for each year they continue in the program. The fee is cumulative, so former diplomates who do not pay until Year 12 will pay the fee for Years 11 and 12. Current fees for MOCA are posted at www.theABA.org. The Board reserves the right to change fees when necessary. All fees paid are non-refundable.

4.04 REESTABLISHING ELIGIBILITY FOR INITIAL CERTIFICATION

A. MOCA PARTICIPATION EXCEEDING 13 YEARS FOR TIME-LIMITED CERTIFICATE HOLDERS

Former diplomates who do not complete all MOCA requirements within three years of the expiration of their most recent certificate in anesthesiology or certificate for Maintenance of Certification in the specialty of Anesthesiology must complete the following steps to reestablish their status as an ABA diplomate. Physicians will only be allowed to reestablish eligibility for the ABA examination system once.

- Meet the requirements for entering the ABA Examination System; provided in the Staged Examinations section
- Register for admission to the ABA Examination System; and
- Pass the ADVANCED Exam;
- Pass both the Standardized Oral Examination and Objective Structured Clinical Examination components of the APPLIED Examination under the new registration.

Candidates must successfully complete the requirements for certification in anesthesiology within seven years of the last day of the year in which their registration was accepted.

B. MOCA PARTICIPATION EXCEEDING 10 YEARS FOR NON-TIME LIMITED CERTIFICATE HOLDERS

Effective Dec. 31, 2020, all diplomates with non-time limited certificates who do not meet all MOCA program requirements by the end of their 10-year cycle will have their current cycle voided and will be required to re-register if they wish to continue in the MOCA program.

4.05 REESTABLISHING ELIGIBILITY FOR SUBSPECIALTY CERTIFICATION

Time-limited certificate holders whose subspecialty certificates in pain medicine or critical care medicine expired on or before Dec. 31, 2016, must reestablish eligibility for subspecialty certification and successfully complete the subspecialty certification exam before being eligible to register for MOCA 2.0 (See Section 6.03).

4.06 MOCA 2.0® EDUCATIONAL ACTIVITIES

Medical societies and other healthcare organizations offering quality educational activities to enable

physicians to fulfill the MOCA requirements may submit a proposal for their educational activities to be considered by for approval.

We may also consider collaborating with medical societies and healthcare organizations to provide activities designed to help our diplomates fulfill the following requirements of the MOCA program: Part II: Lifelong Learning and Self-Assessment and Part IV: Improvement in Practice.

Educational activity requirements and applications are available at www.theABA.org.

SUBSPECIALTY CERTIFICATION

CRITICAL CARE MEDICINE, PAIN MEDICINE, HOSPICE AND PALLIATIVE MEDICINE, SLEEP MEDICINE & PEDIATRIC ANESTHESIOLOGY

5.01 SUBSPECIALTY CERTIFICATIONS

The ABMS has authorized the ABA and other ABMS Member Boards to award certification in the subspecialties of critical care medicine, pain medicine, hospice and palliative medicine, sleep medicine and pediatric anesthesiology.

A. The discipline of **critical care medicine (CCM)** has evolved over the last few decades in parallel with the development of techniques and technology for acute and long-term life support of patients with multiple organ system derangement. Because problems encountered in the critically ill patient encompass aspects of many different specialties, critical care medicine is a multidisciplinary endeavor that crosses traditional department and specialty lines.

The critical care medicine physician is a specialist whose knowledge is broad, involving all aspects of management of the critically ill patient, and whose primary base of operation is the intensive care unit (ICU). This physician has completed training in a primary specialty and has received additional training in critical care medicine aspects of many disciplines. This background enables the physician to work in concert with the various specialists on the patient care team in the ICU; to utilize recognized techniques for vital support; to teach other physicians, nurses and health professionals the practice of intensive care; and to foster research.

B. **Pain medicine (PM)** is the medical discipline concerned with the diagnosis and treatment of the entire range of painful disorders. Because of the vast scope of the field, pain medicine is a multidisciplinary subspecialty. The expertise of several disciplines is brought together in an effort to provide the maximum benefit to each patient. Although the care of patients is heavily influenced by the primary specialty of physicians who subspecialize in pain medicine, each member of the pain treatment team understands the anatomical and physiological basis of pain perception, the psychological factors that modify the pain experience and the basic principles of pain medicine.

C. **Hospice and palliative medicine (HPM)** is based on expanding scientific knowledge about symptom control when a cure is not possible, and on appropriate care during the last stages of life. Research, teaching and practice efforts in this field have led to a vast increase in knowledge in the effort to relieve suffering of seriously ill patients and their families. Physicians who acquire subspecialist-level knowledge and skills in hospice and palliative medicine largely practice in one of two distinct professional roles: 1) hospice medical director, and 2) institution-based palliative care practice.

The competencies emphasized in the subspecialty of hospice and palliative medicine are needed so that the health care system can better respond to the steadily increasing number of patients with life-threatening illnesses characterized by prolonged courses during which the burden of illness increases, quality of life declines, suffering from multiple sources becomes manifest, and caregivers experience increasing burden and distress. Many in this population pose complex problems, which the specialist in hospice and palliative medicine is uniquely trained to address. Subspecialists may take on the primary management of patients, during which they will work with a team to address patient and family problems in multiple domains, typically including the management of active dying. Subspecialists also function as consultants, working with the attending physician to accomplish the same goals by providing expertise, particularly where symptoms, ethical issues or communication issues are complex.

D. Sleep medicine (SM) is the medical discipline concerned with the care of patients with sleep problems and specific sleep disorders. Sleep medicine encompasses a multidisciplinary body of knowledge regarding the anatomy, physiology, biochemistry, pathophysiology and pharmacology of sleep and wakefulness, and their disorders.

E. Pediatric anesthesiology (PA) is a discipline of anesthesiology that includes the evaluation, preparation and management of pediatric patients undergoing diagnostic and therapeutic procedures in operative and critical care settings. In addition, this discipline also entails the evaluation and treatment of children with acute and chronic painful disorders.

5.02 CERTIFICATION REQUIREMENTS

At the time of initial subspecialty certification by the ABA, the candidate must:

A. Be an ABA diplomate.

B. Fulfill the licensure requirement for certification as follows: Hold an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the U.S. or province of Canada that is permanent, unconditional and unrestricted. Further, every U.S. and Canadian medical license the registrant holds must be free of restrictions.

ABA diplomates have the affirmative obligation to advise us of any and all restrictions placed on any of their medical licenses, and to provide complete information concerning such restrictions within 60 days after their imposition or notice, **whichever first occurs**. Such information shall include, but not be limited to, the identity of the State Medical Board imposing the restriction as well as the restriction's duration, basis, and specific terms and conditions. Candidates and diplomates discovered **not** to have made disclosure may be subject to sanctions on their candidate or diplomate status.

C. Have fulfilled the subspecialty training requirement.

D. Have satisfied the subspecialty examination requirement.

E. Have satisfactory professional standing (see Section 7.06).

F. Be capable of performing independently the entire scope of subspecialty practice without accommodation or with reasonable accommodation.

G. For initial subspecialty certification, diplomates must be meeting MOCA® requirements. (Please see the MOCA 2.0 section.)

Although admission into the ABA examination system and success with the examination are important steps in the certification process, they do not by themselves guarantee certification. The Board reserves the right to make the final determination of whether *each* candidate meets all of the requirements for certification, including B, E and F above, after successful completion of examinations for subspecialty.

The Board, acting as a committee of the whole, reserves the right not to accept an exam registration. The registrant has the right to seek review of such a decision (see Section 7.05). The Board reserves the right to correct clerical errors affecting its decisions.

We award subspecialty certification only to qualified ABA diplomates who do not hold a valid certificate in the same subspecialty from another ABMS Member Board. ABA subspecialty certificates are valid for 10 years after the year the candidate passes the subspecialty examination. Diplomates with a time-limited certificate in sleep medicine and hospice and palliative medicine may take the subspecialty recertification examination as early as the seventh year of their most recent certification.

ABA subspecialty certificates are subject to our rules and regulations, including our policy book, all of which may be amended from time to time without further notice.

5.03 FELLOWSHIP REQUIREMENT

A. The **continuum of education** in an anesthesiology subspecialty consists of 12 months of full-time training. The training must be in a subspecialty program in the United States or its territories accredited by the ACGME from the date the training begins to the date it ends. The training must follow completion of the continuum of education in anesthesiology (i.e., clinical base and CA 1-3 years) unless our Credentials Committee prospectively approves a different training sequence for the fellow (see below for details).

We grant a fellow credit toward our subspecialty training requirements in two successive six-month increments, each of which ends with a satisfactory Certificate of Clinical Competence (CCC) report. To receive credit for a period of subspecialty training that is not satisfactory, the fellow must immediately complete six months of uninterrupted subspecialty training in the same program with receipt of a satisfactory CCC report. If more than one six-month period of subspecialty training ends with a CCC report that is not satisfactory, our Credentials Committee will determine the number of months of additional training the fellow will have to complete to satisfy the training required for admission to the ABA examination system.

We grant credit for subspecialty fellowship training in more than one ACGME-accredited training program within a single subspecialty under the following conditions:

- The training occurs in no more than two ACGME-accredited subspecialty training programs.
- The period of training as an enrolled fellow of any single program is at least six months of uninterrupted training.
- The six-month period of subspecialty training in any one program must end with receipt of a satisfactory CCC report.

We will accept no more than two months of training in institutions not recognized by the ACGME as part of the accredited subspecialty program. Therefore, we require that fellows complete a minimum of 10 months of training in their ACGME-accredited subspecialty program.

Our Credentials Committee will assess individually requests for part-time training. Prospective approval is required for alteration in the number of hours per week of training or alteration in the temporal distribution of the training hours (e.g., substantially different night and weekend hours) from other fellows in the program. It is expected that fellows will take not more than twice the “standard time” to achieve the level of knowledge and clinical experience comparable to a full-time fellow completing the program in standard time. Fellows who train on a part-time basis are expected to meet all the program’s didactic requirements before training is complete.

B. **Requests for part-time training** must be in writing from the program director and countersigned by the department chair (if that is another person), the hospital’s designated institutional officer (DIO), and the fellow. The letter must include: (1) the reason for the part-time training request, (2) documentation about how all clinical experiences and educational objectives will be met, (3) assurance that the part-time training program will teach continuity-of-care and professionalism and (4) an explanation about how the part-time training program will maintain the overall quality, content and academic standards/clinical experiences of the training program required of a full-time trainee.

5.04 ABSENCE FROM TRAINING

The total of any and all absences during a subspecialty fellowship may not exceed the equivalent of 20 working days (four weeks) per year. Attendance at scientific meetings, not to exceed five working days during the year of training, shall be considered part of the training program. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence.

Training in an anesthesiology subspecialty must not be interrupted by frequent or prolonged periods of absence. When there is an absence for a period in excess of two months, the Credentials Committee of the

ABA shall determine the number of months of training subsequent to resumption of the program that are necessary to satisfy the training requirement for admission to the ABA subspecialty examination system.

5.05 CERTIFICATE OF CLINICAL COMPETENCE

We require every anesthesiology subspecialty training program to electronically file an Evaluation of Clinical Competence in January and July on behalf of each fellow who has spent any portion of the prior six months in subspecialty anesthesia training in or under the sponsorship of the fellowship program and its affiliates. **The program director or department chair must not chair the Clinical Competence Committee.**

Entry into the ABA examination system is contingent upon the registrant having a Certificate of Clinical Competence on file with the Board attesting to satisfactory clinical competence during the final period of fellowship training in or under the sponsorship of each program. We will deny entry into the ABA examination system until this requirement is fulfilled.

Fellows who wish to appeal an Evaluation of Clinical Competence must do so through the reporting institution's grievance and due process procedures.

5.06 PROGRAM DIRECTOR'S REFERENCE FORM

We require every fellowship program director to electronically file a Program Director's Reference Form on behalf of each fellow upon graduation from the fellowship program. Information is requested regarding the professional standing, abilities and character of the fellow.

Entry into the ABA examination system is contingent upon the program directors' recommendation. We will deny entry into the ABA examination system until this requirement is fulfilled. This reference evaluation will be used as part of the process by which the Board judges whether the candidate meets the standards of a board-certified anesthesiologist articulated in Section 1.02.D. Entrance into the ABA examination system may also be denied if the Board in its discretion is not satisfied with the recommendation based upon reasonable consideration of information known at the time.

We consider references to be confidential and will not disclose the contents or a copy to the candidate unless the person providing the reference consents in writing. Candidates should contact their references if more information is desired. Fellows who wish to appeal a final recommendation from the program director or department chair must do so through the reporting institution's grievance and due process procedures.

5.07 OVERVIEW OF SUBSPECIALTY CERTIFICATION EXAMINATIONS

The examination in an anesthesiology subspecialty is designed to test for the presence of knowledge that is considered essential for the ABA diplomate to function as a practitioner of the subspecialty. The examination analyzes the cognitive and deductive skills as well as the clinical judgment of the candidates.

A. Examination Administration

(1) Examination dates are available on the last page of this section. However, for the most current examination dates and deadlines, please visit our website at www.theABA.org.

a. The Critical Care Medicine Examination is administered once each year.

b. The Pain Medicine Examination is administered once each year.

c. The Hospice and Palliative Medicine Examination is administered once every other year.

d. The Sleep Medicine Examination is administered once every other year.

e. The Pediatric Anesthesiology Examination is administered once each year.

(2) Our examinations are administered to all candidates under the same standardized testing conditions at computer-based testing centers located throughout the U.S. and Canada. We will consider a candidate's complaint about the testing conditions under which an examination was administered only if the complaint is received within one week of the examination date.

(3) Our policies regarding irregular examination behavior, unforeseeable events and examination under nonstandard conditions may be found at Sections 7.11, 7.12, and 8.01, respectively.

5.08 REGISTRATION ELIGIBILITY REQUIREMENTS

At the time of registration to enter the subspecialty examination system of the ABA, the registrant must:

A. Be certified by the ABA.

B. Have fulfilled the licensure requirement for certification (see Section 5.02.B). Registrants must inform us of any conditions or restrictions in force on any active medical licenses they hold. Registrants who have a medical license restriction will be permitted to register for and take a subspecialty certification examination; however, certification will be deferred until the nature of the restriction is reviewed by our Credentials Committee.

C. Have documentation on file in the ABA office of having satisfactorily fulfilled the subspecialty training requirement or, if applicable, Temporary Criteria in lieu of formal training in an accredited subspecialty program. A **grace period** will be permitted so that registrants completing the subspecialty training requirement by Dec. 31 may register for the immediately preceding subspecialty certification examination.

D. Have documentation on file with the Board attesting to the registrant's current privileges and evaluations of various aspects of the registrant's current practice of the subspecialty. Such evaluations will include verification that the registrant meets our clinical activity requirement by practicing the subspecialty, on average, at least one day per week during 12 consecutive months over the previous three years. We may use such documentation and evaluations as part of its assessment of the registrant's qualifications for admission to its subspecialty examination system. We may solicit such documentation and evaluations from the fellowship program director or others familiar with the registrant's current practice of the subspecialty and use them in determining the registrant's qualifications for admission to the examination system. The CCC report from the department and the evaluation from the program director and others will be used as the basis for assessing admission qualifications.

E. Be capable of performing independently the entire scope of anesthesiology subspecialty practice without accommodation or with reasonable accommodation.

F. Be meeting our MOCA program requirements. (Please see the MOCA 2.0 section.)

We will determine that entry into the subspecialty examination system is warranted when required information submitted by and on behalf of the registrant is satisfactory. We will notify a registrant who is accepted as a candidate for subspecialty certification via email after approval of all requirements.

5.09 REGISTRATION PROCEDURE

A. Registration for admission to the ABA examination system must be made using the Physician Portal, which can be accessed via our website at www.theABA.org.

B. Registrations may be completed at any time during the registration period. (Please see the Deadlines and Examination Dates available on the last page of this section.) Current fees are published at www.theABA.org.

The registration deadlines are absolute. Regardless of the reason, we will not consider a registration for a subspecialty certification examination that is received after the deadline.

C. We must receive all documentation required to make a decision about a registrant's qualifications for admission to a subspecialty certification examination by the decision deadline. This includes, but is not limited to, references and verification that the training requirement is met. A registration will not be accepted if the required documentation is not received by that date. It ultimately is the responsibility of every registrant to ensure that we receive all required documentation in a timely manner. Physicians will be considered candidates in the ABA examination system when their registration for a subspecialty examination is accepted.

D. Registration includes the following Acknowledgment and Release forms, which the registrant shall be required to sign by electronic signature:

(1) *I, the undersigned registrant ("registrant"), hereby agree to participate in the American Board of Anesthesiology, Inc.'s (ABA) subspecialty certification program. I acknowledge that my participation is subject to the ABA rules and regulations. I further acknowledge and agree that if I withdraw my registration or the ABA does not accept it, the ABA will retain the registration fee and any late fee.*

I represent and warrant to the ABA that all information I provide to the ABA is true, correct and complete in all material respects. I understand and acknowledge that any material misstatement or omission over the course of my subspecialty certification program shall, at any time, constitute cause for disqualification from the ABA examination system or from the issuance of an ABA certificate or to forfeiture and redelivery of such ABA certificate to the ABA.

I agree that this acknowledgment, as submitted by me, shall survive the electronic submission of the registration, regardless of whether or not the information or data provided in the registration has been reformatted in any manner by the ABA. I also agree that this acknowledgment is a part of and incorporated into the registration whether submitted along with the registration or not.

I acknowledge that I have read a copy of the ABA Policy Book. I agree to be bound by the policies, rules, regulations and requirements published in the book, in all matters relating to consideration of and action upon this registration and certification. I understand that ABA certificates are subject to ABA rules and regulations, all of which may be amended from time to time without further notice. I understand and acknowledge that in the event I have violated any of the ABA rules governing my registration and/or certification, such violations shall constitute cause for disqualification from the ABA examination system or from the issuance of an ABA certificate or for revocation of certification and indication of such action in the ABA Diplomate and Candidate Directory.

(2) *I, the undersigned registrant ("registrant"), hereby agree to participate in the American Board of Anesthesiology, Inc.'s (ABA) subspecialty certification program. I acknowledge that my participation is subject to the ABA rules and regulations, all of which may be amended from time to time without further notice.*

In connection with my registration, I authorize all persons holding testimony, records, documents, opinions, information and data relevant to or pertaining to my professional competence and ethical conduct and/or behavior (the "Background Information") to release such Background Information to the ABA, its employees and agents. This authorization applies whether or not such persons are listed as a reference on my registration. Background Information includes any information relating to any abusive use of alcohol and/or illegal use of drugs, and any medical or psychiatric treatment or rehabilitation related thereto. I understand that such Background Information may be used to determine, verify or deny my qualifications for entrance into the ABA entrance examination and ABA certification. I understand that the ABA treats this information as confidential and will not release the content or a copy of any references to me unless the person providing the reference consents in writing. A copy of this release may accompany any request made by the ABA for such Background Information.

I authorize the ABA to: (1) report my status in the examination system; (2) use any score in psychometric

analyses to confirm observations and reports of suspected irregularities in the conduct of an examination; and (3) respond to any inquiry about my status in the ABA examination system. I understand and agree that once my examination registration is completed and granted, this consent cannot be withdrawn.

I understand that the ABA may use any and all Background Information for the purpose of conducting longitudinal studies to assess the ABA certification process. I further understand that the ABA, alone or in collaboration with other researchers, may use information from the registration, testing, assessment and certification process (the "Assessment Information") to conduct scientific research relating to anesthesiologists, the practice of anesthesiology and/or the education of anesthesiologists. Any and all information used for research may be reported or released to the public only in the aggregate without any individual identification.

Use of any Background Information or Assessment Information for analysis or research will not impact in any way my individual registration, test results or certification status. I understand and agree that should I not wish for my information to be used for research purposes, prior to taking the exam I must notify the ABA in writing to the attention of researchoptout@theABA.org to opt out and withdraw consent for my information to be used as part of research studies. I cannot opt out and consent cannot be withdrawn once my information has been de-identified and/or aggregated as part of any research study.

I release and agree to hold harmless each person from any liability to me arising out of the giving or releasing of information to the ABA. This release and agreement includes liability for the inaccuracy or untruth of the information, so long as such Information is provided in good faith. I also release and agree to hold harmless the ABA and its agents and employees, including but not limited to its directors, officers and examiners, from any liability to me as a result of any acts or proceedings undertaken or performed in connection with my registration, provided such acts or proceedings are made or conducted in good faith.

E. Registrants must also attest to their clinical activity every three years while in the examination system.

5.10 EXAMINATION REGISTRATION, SCHEDULING & CANCELLATION

(1) Examination Registration and Scheduling

Candidates will register for the examination in the year of the subspecialty certification examination and will pay a single fee upon registration. Registration for subspecialty examinations begins March 1 of each year. See Deadlines and Examination Dates on the last page of this section**.**

We will notify candidates of their eligibility to register for a subspecialty examination via their email address on file. Candidates who register for an examination by the established deadline must pay the registration fee at that time. Current fees are posted at www.theABA.org.

Once candidates have registered for an examination and paid the fee via their portal account, they will be **notified via email** with instructions on how to schedule examination appointments with the examination administration vendor.

(2) Notification and Cancellation of Examination Appointments

(1) **A candidate who cancels a scheduled examination appointment** must submit a written request to cancel at least one week prior to the examination administration week. A cancellation fee must accompany the candidate's request to retain the examination fee for the next examination appointment. Current fees are posted at www.theABA.org.

(2) **A candidate who misses a scheduled examination appointment** because of an unavoidable or catastrophic event must submit a written request with explanation and independent documentation of the event. We must receive the candidate's request and the cancellation fee no later than three days after the examination date to retain the examination fee for the next examination appointment. If a scheduled appointment is missed for a reason that does not represent an unavoidable or catastrophic event, the examination fee will be forfeited. Forfeiting of the examination fee is solely at the discretion

of the Board.

(3) **A candidate who misses an examination appointment and does not cancel the scheduled examination appointment forfeits the examination fee.**

Our office is not responsible for an interruption in communication with a candidate that is due to circumstances beyond its control. Candidates must immediately notify us of a mailing or email address change via the ABA website at www.theABA.org, or by writing to our office. The candidate's ABA identification number should be included on all correspondence to the Board solely for identification purposes.

5.11 DURATION OF CANDIDATE STATUS

The duration of candidate status is limited as follows:

(1) We will no longer limit the number of opportunities candidates will be given to satisfy an examination requirement.

(2) Candidates who completed subspecialty training prior to Jan. 1, 2012, had until Dec. 31, 2018, to satisfy all requirements for subspecialty certification.

(3) Candidates who complete subspecialty training on or after Jan. 1, 2012, must satisfy all requirements for certification within seven years of the last day of the year in which subspecialty training was completed.

(4) Candidates who registered for the Pediatric Anesthesiology Examination with temporary criteria had until Dec. 31, 2018 to satisfy all requirements for subspecialty certification.

5.12 REESTABLISHING ELIGIBILITY FOR SUBSPECIALTY CERTIFICATION

If a candidate does not satisfy all requirements for subspecialty certification within the initial seven-year prescribed time (as described in Section 5.11), we will declare the candidate's registration void. Physicians whose registrations have been voided may submit a new registration for the subspecialty certification examination. At the time of registration, the registrant must meet the eligibility requirements (as described in Section 5.08).

In addition to meeting the requirements in Section 5.08, the physician must complete the following prior to submitting a new registration:

- **For Critical Care Medicine, Pain Medicine or Pediatric Anesthesiology Certification:** Take and pass the relevant subspecialty Anesthesiology Special Purpose Exam (ASPEX), which are offered beginning immediately for critical care medicine and pain medicine and beginning in mid-2020 for pediatric anesthesiology. Physicians who do not pass ASPEX must wait a minimum of four months before retaking the examination.

- **For Hospice and Palliative Medicine or Sleep Medicine:** Complete four additional consecutive months of training in the subspecialty. The training must be in an ACGME-accredited subspecialty program and must be completed satisfactorily before the physician can register to enter the subspecialty examination system.

Physicians reestablishing eligibility for subspecialty certification must satisfy all requirements for subspecialty certification by Dec. 31 of the fourth year following the successful completion of the applicable ASPEX (for critical care medicine, pain medicine or pediatric anesthesiology) or the four consecutive months of training (for hospice and palliative medicine or sleep medicine). Physicians will only be allowed to reestablish eligibility for the subspecialty certification once. *Physicians who qualified previously by Temporary Criteria must meet all eligibility requirements (as described in Section 5.08) at the time of registration to reestablish eligibility for subspecialty certification.*

SUBSPECIALTY CERTIFICATION DEADLINES & EXAMINATION DATES

2020 EXAMINATIONS	
Critical Care Medicine	Oct. 10, 2020
Pain Medicine	Sept. 12, 2020
Hospice and Palliative Medicine	Oct. 19, 2020
Sleep Medicine	-
Pediatric Anesthesiology	Oct. 31, 2020

SUBSPECIALTY RECERTIFICATION

CRITICAL CARE MEDICINE, PAIN MEDICINE & PEDIATRIC ANESTHESIOLOGY

6.01 SUBSPECIALTY RECERTIFICATION

The subspecialty recertification program has transitioned to MOCA 2.0® for all ABA diplomates with current certificates (see the MOCA 2.0 section).

6.02 DURATION OF CANDIDATE STATUS

The duration of candidate status is limited as follows:

(1) Candidates whose subspecialty recertification expired on or before Dec. 31, 2016, had until Dec. 31, 2018, to satisfy all requirements for subspecialty recertification.

If a candidate did not satisfy all requirements for recertification within the prescribed time period, as described above, we declared the candidate's registration void. Physicians whose registrations for subspecialty recertification were voided will be required to reestablish eligibility for subspecialty certification (see Section 6.03).

6.03 REESTABLISHING ELIGIBILITY FOR SUBSPECIALTY CERTIFICATION

Formerly subspecialty certified physicians whose registrations were voided due to the duration of candidate status policy must reestablish eligibility for subspecialty certification (as defined in Section 5.08).

After reestablishing eligibility, physicians must satisfy all requirements for certification including successfully completing the initial subspecialty certification examination by Dec. 31 of the seventh year following registration. Physicians will only be allowed to reestablish eligibility for the subspecialty certification once.

BOARD POLICIES

7.01 ALCOHOL AND SUBSTANCE USE DISORDER

The Americans with Disabilities Act (ADA) protects individuals with a history of alcohol or substance use disorder who are not currently abusing alcohol or using drugs illegally. We support the intent of the ADA.

We will admit qualified physicians with a history of alcohol abuse to our examination system and to the examination if, in response to inquiries, we receive acceptable documentation that they are not currently abusing alcohol.

We will admit qualified physicians with a history of illegal use of drugs to our examination system and to the examination if, in response to inquiries, we receive acceptable documentation that they are not currently engaged in the illegal use of drugs.

After a physician with a history of alcohol abuse or illegal use of drugs satisfies the examination requirements for certification, we will determine whether we should defer awarding its certification to the physician for a period of time to avoid certifying a physician who poses a direct threat to the health and safety of others. If we determine that deferral of the physician's certification is appropriate because the physician does currently pose a threat to the health and safety of others, we will assess the specific circumstances of the physician's history of alcohol abuse or illegal use of drugs to determine when the physician should request issuance of our certification.

7.02 REVOCATION OF CERTIFICATION

A certificate is issued by the Board with the understanding that it remains our property. Any certificate issued by the Board shall be subject to revocation in the event that:

A. The issuance of such certificate or its receipt by the person so certified shall have been contrary to, or in violation of, any rule or regulation of this Board; or

B. The person certified shall not have been eligible to receive such certificate whether the facts making him or her ineligible were known to, or could have been ascertained by, the Board or any of its Directors at the time of issuance of such certificate; or

C. Persons certified shall have made any misstatement or omission of fact in their registration for such certificate or in any other statement or representation to the Board or its representatives; or

D. The person certified shall fail to maintain satisfactory professional standing (see Section 7.06).

We will be the sole judge of whether the evidence or information before it is sufficient to require or permit revocation of any certificate issued, and the decision shall be final. The individual has the right to seek review of such a decision (see Section 7.05).

7.03 CERTIFICATION BY OTHER ORGANIZATIONS

We will make no statement about the comparability of the Board certificate and another organization's certificate. We will not accept certification by another entity as meeting the requirements for entrance into the ABA examination system for initial certification in anesthesiology or subspecialty certification or recertification.

7.04 RECORDS RETENTION

We retain certain documents pertaining to an individual's residency and fellowship training, registration for certification, examination opportunities, and examination results for the sole purpose of determining that the requirements for admission to the ABA examination system, certification, recertification, or maintenance of certification are fulfilled.

The following is a summary of the Records Retention Policy:

(1) The following records regarding physicians' successful completion of residency and fellowship programs are retained for 75 years:
- Certificate of Clinical Competence
- Program Directors Reference Forms
- Training Away from Program Administrative Approval
- Resident/Fellow Feedback
- Resident Enrollment Form

(2) Records corroborating the results (pass/fail) of a physician's examination are retained indefinitely.
- Part 2 and APPLIED Examination result letters are retained for 75 years. All other examination result letters are retained for 10 years following the examination.
- Physicians' score records and performance reports are retained for 10 years following the examination.

(3) Records pertaining to adverse Board actions, including Board sanctions, are retained indefinitely.

(4) The following records regarding the Maintenance of Certification in Anesthesiology® (MOCA®) program are retained for 75 years:
- Annual MOCA Registration
- Part I: Professionalism and Professional Standing (Medical Licensure)
- Part II: Lifelong Learning and Self-Assessment Records (CME)
- Part IV: Improvement in Medical Practice (Quality Improvement)

(5) Records pertaining to results of MOCA Part III: Assessment of Knowledge, Judgment, and Skills (MOCA Minute®) are retained for four years.

(6) Certification records for candidates issued an ABA certification are retained indefinitely.

(7) Records pertaining to requests for examination/assessment under nonstandard testing conditions, including any supporting documentation, evaluations, medical records or expert reports, are retained indefinitely.

We see to the secure destruction of the documents in its file for an individual when the period specified for retention of the documents has expired.

7.05 REQUESTS FOR RECONSIDERATION

The ABA, being dedicated to the principles of fairness and consistency in its dealings with its registrants, candidates and diplomates, has established a policy for review of certain Board decisions. The only actions that are reviewable are a decision to deny exam registration, a denial of assessment under nonstandard conditions, or revocation of a certificate issued. When we make such a decision, we will notify the physician in writing. Such notice shall contain a concise statement of the reasons for the decision, including copies or references to pertinent policies, procedures and deadlines; the established criteria and procedure for seeking reconsideration; and a clear statement that any right to reconsideration will be waived if not exercised by the stated deadline.

Reconsideration requests for denials of exam registration will not be considered if the original denial was due to an incomplete registration, non-payment of applicable fees, or failure to meet the requirements for continuum of education, satisfactory professional standing (i.e., medical licensure) or clinical activity. A Board decision to revoke certification is not subject to reconsideration if the revocation was due to unsatisfactory professional standing which remains unresolved (i.e., the physician's medical license(s) remain revoked, suspended or surrendered in lieu of revocation). Satisfactory professional standing is a requirement for initial certification, subspecialty certification, and maintenance of certification. The only basis on which we may consider your request for reconsideration of a decision to revoke certification based on unsatisfactory professional standing is if you provide written documentation that your medical license(s) has been restored without restrictions. Such documentation must be provided within the 30-day timeframe for submitting the request for reconsideration.

Physicians may exercise their right to request reconsideration by submitting a *Request for Reconsideration Form* within 30 days of receipt of the notice of the ABA decision in question. All requests for reconsideration will incur a $500 administration fee. If the form and fee are not received within the time and in the manner prescribed, the decision of the Board is considered final and not subject to further review. The form should be sent via email to credentialing@theABA.org to the attention of "ABA Case Administration." The form should include the reason(s) justifying reconsideration; including a concise rationale for why the physician believes our decision was inconsistent with its policies and/or not supported by the evidence available to the Board at the time the decision was made. Upon receipt of the required form within the time and in the manner prescribed, the request will be evaluated by the appropriate Committee. The Committee, in its discretion, may affirm, reverse or modify the initial decision. The ruling of the Committee will be final and not subject to further review.

7.06 PROFESSIONAL STANDING

Satisfactory professional standing is a requirement for initial certification, subspecialty certification, and maintenance of certification.

Individuals with a medical license that is revoked, suspended or surrendered in lieu of revocation or suspension may be permitted to take ABA examinations under some circumstances. Candidates with less severe restrictions on a medical license will be permitted to take ABA examinations. In both instances, certification may be deferred until the Board reviews and approves awarding certification.

We assess the professional standing of residents, candidates, and diplomates continually. These individuals have the affirmative obligation to advise us of any and all restrictions placed on any of their medical licenses, and to provide complete information concerning such restrictions within 60 days after their imposition. Such information shall include, but not be limited to, the identity of the medical board imposing the restriction as well as the restriction's duration, basis, and specific terms and conditions.

We will initiate proceedings to revoke the certification(s) of diplomates with a medical license that is revoked, suspended or surrendered in lieu of revocation, suspension, inquiry or investigation, upon notice of such action. We have the authority and may decide to undertake proceedings to take action against diplomates with other, less severe medical licensure restrictions (e.g., probation, reprimands or "conditions"), which may include revocation of the certification. Failure to respond to ABA communications regarding the initiation of revocation proceedings constitutes grounds for action to revoke diplomates' certification(s).

We incorporate the AMA Code of Medical Ethics, Opinion E-2.06 (June 2000), regarding physician participation in capital punishment into our own professional standing policy. Specifically, it is our position that an anesthesiologist should not participate in an execution by lethal injection and that violation of this policy is inconsistent with the professional standing criteria required for ABA certification and Maintenance of Certification in Anesthesiology or any of its subspecialties. As a consequence, ABA certificates may be revoked if we determine that a diplomate participates in an execution by lethal injection.

7.07 RE-ATTAINING CERTIFICATION STATUS

We established a registration procedure for diplomates with the designation of "Certified – Not Clinically Active," "Certified – Retired," or "Retired" to re-attain "Certified" status. There is also a procedure for physicians whose ABA certification is revoked to register with us to re-attain certification. Interested physicians should contact our office for details about these registration procedures.

We consider registrations for re-attaining certification on an individualized, case-by-case basis. We may require the registrant to do one or more of the following in order to re-attain certification:

- Pass the BASIC Examination.
- Pass the ADVANCED Examination.
- Pass both the Standardized Oral Examination and Objective Structured Clinical Examination components of the APPLIED Examination.
- Undertake continuing medical education.
- Complete additional training.
- Complete other activities as deemed necessary.

We may choose to allow a registrant who has been certified in both anesthesiology and one or more anesthesia subspecialties, and who has changed their certification status to "Certified - Not Clinically Active," "Certified – Retired," "Retired" or who has had the certificates "Revoked," to re-attain those certifications at different times. If a registrant had qualified under temporary criteria for a certificate, the status of which the diplomate has changed to either "Certified - Not Clinically Active," "Certified – Retired," "Retired" or which has been "Revoked," we may require the registrant to complete additional training or satisfy other additional conditions.

Certifications that are re-attained are subject to the requirements for maintenance of certification and to the our rules and regulations, including our policy book, all of which may be amended from time to time without further notice.

7.08 ALTERNATE ENTRY PATH TO INITIAL CERTIFICATION

The Alternate Entry Path (AEP) program allows international medical graduates who are certified by the national anesthesiology organization in the country where they trained and practicing anesthesiology in the U.S. to qualify for entrance into the ABA examination system for initial certification in anesthesiology. The objective of the program is to encourage outstanding internationally trained and certified anesthesiologists to become productive members of U.S. academic anesthesiology programs. A record of documented achievement in teaching and/or scholarship, rather than the potential for future success, is critical to acceptance into the AEP program, as is the ability of the sponsoring department to provide an outstanding academic environment.

AEP program participants will spend four years in an academic anesthesiology training program as fellows, researchers or faculty members. Participants are expected to actively participate in departmental educational activities and to otherwise retain or gain basic anesthesiology knowledge and experience that would help them to attain ABA certification.

When the anesthesiology department enrolls the international medical graduate in the AEP program through either the clinician educator pathway or the research and fellowship pathway described below, the department must have an anesthesiology residency or fellowship training program with "continued full" ACGME accreditation status. **Anesthesiology departments may have as many as four international medical graduates enrolled in the AEP program at one time.**

A. CLINICIAN EDUCATOR PATHWAY

To be considered for entry into the AEP Clinician Educator Pathway, physicians must:

- Be internationally trained in an ABA-approved training program with 4+ years (3+ years of anesthesiology-specific training) of post-graduate education in anesthesiology

- Have a letter of support from the sponsoring program's chair and program director

- Be board certified in anesthesiology from an ABA-approved certifying body

- Be clinically active with a faculty appointment for four continuous years in an ACGME-accredited anesthesiology program, not specifically the program that nominated the physician

- Hold an academic rank of assistant professor or higher at the time of application

- Have the sponsoring program's department chair and program director submit a four-year mentoring plan for future academic development as a clinician educator, co-signed by the physician, for prospective approval by our Credentials Committee. We must receive the four-year plan no later than four months before the department enrolls the internationally certified anesthesiologist in the AEP program and the four-year period of continuous experience commences. For the portion of the four-year experience that will be spent as a clinician educator, please address these items:

    - Describe how the contributions from the candidate will enhance the department's educational program.

    - Describe the educational facilities available to the candidate over the course of the four-year plan.

    - Describe the department infrastructure available for the candidate to develop as a clinician educator.

    - Identify the specific individuals within the department or institution available to support the candidate's development as a clinician educator.

    - Identify the specific mentors or colleagues who will collaborate with the candidate in their development as a clinician educator over the four years; also, describe their roles in supporting the development of the candidate as an educator.

    - Document the tangible results expected from the candidate over the four years of the plan (e.g., book chapters, electronic educational media, manuscripts, grants, lectures, new curriculum development, trainees mentored by the candidate, national educational presentations, etc.).

- Demonstrate excellence in teaching and excellence in clinical anesthesiology during the four-year period specifically designed and identified for the physician.

B. RESEARCH & FELLOWSHIP PATHWAY

To be considered for entry into the AEP Research and Fellowship Pathway, physicians must:

- Be internationally trained and certified anesthesiologists practicing in the U.S.

- Be internationally trained in an ABA-approved training program with 4+ years (3+ years of anesthesiology-specific training) of post-graduate education in anesthesiology.

- Have a pre-existing track record of scholarship as represented by the scholarship of discovery, dissemination and application. The scholarship of discovery is accomplished by obtaining peer-reviewed funding or by publication of original research in peer-reviewed journals. The scholarship of dissemination is accomplished by publication of review articles in peer-reviewed journals or chapters in text books. The scholarship of application is accomplished by publication of case reports or clinical

series at local, regional, or national professional and scientific society meetings. High-quality ongoing scholarship is critical to acceptance into the AEP program.

- Be clinically active with a faculty appointment for four continuous years in one ACGME-accredited anesthesiology program.

- Have the chair of the anesthesiology department that sponsors them submit a four-year plan, co-signed by the physician, for prospective approval by our Credentials Committee. We must receive the four-year plan no later than four months before the department enrolls the physician in the AEP program and the four-year period of continuous experience commences.

- Demonstrate discovery of new knowledge in the specialty, excellence in teaching and excellence in clinical anesthesiology during the four-year period specifically designed and identified for the physician.

C. PROSPECTIVE APPROVAL AND ENROLLMENT PROCESSES

We must receive the four-year plan with the application no later than four months before the department enrolls the internationally certified anesthesiologist with the ABA and the four-year period of continuous experience commences. The experiences planned for the internationally certified anesthesiologist will consist of four years of fellowship training, research or faculty experience, or a combination thereof. During the four-year period, these anesthesiologists shall demonstrate discovery of new knowledge in the specialty, excellence in teaching and excellence in clinical anesthesiology. The four-year experience must be in the same institution in which the anesthesiology program resides. The four-year plan should be specifically designed and identified for the candidate.

All applications for the AEP program will incur a $2,500 fee. This fee must be mailed by the training program immediately following the application submission.

The department chair must submit the following documents with the application and the request for prospective approval of a four-year plan:

(1) Documentation of the physician's anesthesiology certification in a foreign country preceded by postgraduate training in anesthesiology that is comparable in duration to training in the specialty provided by ACGME-accredited anesthesiology programs in the U.S.

(2) Written verification of the physician's anesthesiology certification from the certifying body.

(3) Evidence that the physician has been awarded a medical or osteopathic degree.

(4) Evidence of *one* of the following:
   a. A permanent (valid indefinitely) certificate from the Educational Commission for Foreign Medical Graduates; or
   b. Comparable credentials from the Medical Council of Canada; or
   c. An active license to practice medicine or osteopathy in one state of the U.S. or in Canada that is permanent, unconditional and unrestricted.

D. PERIODIC EVALUATION REPORTS

At six-month intervals, the department chair must submit attestations that the physician is a fellow or faculty member with a full-time primary appointment in an ACGME-accredited program, or is still actively engaged in research. At the same time, the department chair will provide an assessment of the physician's performance during the preceding six months relative to the ABMS- and ACGME-approved six general physician competencies.

E. ENTRANCE REQUIREMENTS FOR THE ABA INITIAL CERTIFICATION EXAMINATION SYSTEM

Approved AEP participants will be enrolled in the staged examinations process for initial certification in anesthesiology. Participants must complete satisfactorily the approved four-year program of continuous experience in one anesthesiology department before we will allow them to register and take any of the initial certification examinations. We will permit physicians to register for the BASIC Examination when they meet the eligibility requirements for registration (see Section 3.07). Participants must pass the BASIC Examination to qualify for the ADVANCED Examination. Upon completion of the four-year program, an AEP participant will be permitted to register for the ADVANCED Examination (see Section 3.10). Upon successful completion of the ADVANCED Examination participants may register for the APPLIED Examination (see Section 3.12).

The internationally trained and certified anesthesiologist must register for each examination. In addition to submitting the registration electronically, we require that the physician:

(1) Have attestations on file in the ABA office from the department chair that the physician completed satisfactorily the four-year program planned by the department chair and prospectively approved by our Credentials Committee.

(2) Provide evidence of having an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the U.S. or province of Canada that is permanent, unconditional and unrestricted. Further, every U.S. and Canadian medical license the physician holds must be free of restrictions. Physicians must inform us of any conditions or restrictions in force on any active medical license they hold. When there is a restriction or condition in force on any of the physician's medical licenses, our Credentials Committee will determine whether, and on what terms, the physician will be admitted to the ABA examination system (see Section 3.01.A).

(3) Have documentation on file with the Board attesting to the physicians' current privileges and evaluations of various aspects of their current practice of anesthesiology. Such evaluations will include verification that the physician meets our clinical activity requirement by spending, on average, at least one day per week during 12 consecutive months over the previous three years in the clinical practice of anesthesiology and/or related subspecialties. We may solicit such documentation and evaluations from the chair of the anesthesiology department that enrolled the physician in the alternate entry path program and use them in determining the physician's qualifications for admission to the examination system. The department's assessment of the physician's performance relative to the ABMS- and ACGME-approved six general physician competencies at six-month intervals and the evaluation of the anesthesiology department chair will be used as the basis for assessing admission qualifications.

7.09 INDEPENDENT PRACTICE REQUIREMENT

Physicians must be capable of performing independently the entire scope of practice in the specialty or subspecialty, with or without reasonable accommodation for disabilities.

We will investigate, examine and attempt to resolve any issues regarding a physician's ability to meet the Independent Practice Requirement by investigating and examining relevant information in our record, including any information provided by the physician, or submitted by the program director in the physician's final evaluation.

We routinely remind all program directors that they will be required to attest to whether a physician meets all of the criteria for admission to the ABA examination system, including the independent practice requirement, at the time they complete their residency and/or fellowship training program.

As part of the registration process for ABA examinations and MOCA, we present all registrants with our definition of independent practice and asks whether they satisfy the requirement, without accommodation or with reasonable accommodation.

We routinely advise all physicians that after successful completion of the certification examinations and MOCA, we will make the final determination of whether the physician meets all the criteria for certification, including the independent practice requirement. The Board may, at its discretion, gather additional information to assist in making this determination.

7.10 DATA PRIVACY AND SECURITY POLICY

During registration, examination, certification, recertification and maintenance of certification processes (collectively, “certification processes”), the American Board of Anesthesiology, Inc. (“the ABA”, "us", "we", or "our") must collect and utilize personal and professional information pertaining to its registrants, candidates and diplomates. The ABA has issued this Data Privacy and Security Policy to govern the collection, use and disclosure of such information. The Policy’s purpose is to help protect the security and privacy of information provided during the certification processes.

The ABA requires that registrants, candidates and diplomates provide certain personal information to be used during the certification processes. We work diligently to keep such information confidential and protected and to limit such disclosures to those who “need to know” the information to properly perform an ABA function or operation relating to the certification processes.

The ABA maintains physical, electronic and procedural safeguards to protect and secure all personal information in its possession. The ABA’s security measures endeavor to protect the confidentiality of online communications, examination results and other data related to the certification processes. Examination results and sensitive registrant, candidate and diplomate data transmissions are encrypted and stored in secure areas of ABA systems accessible only by authorized Board personnel with a unique ID and password. ABA database servers used for transactions and communication with registrants, candidates and diplomates are located in a restricted, secure area accessible only by authorized personnel. Firewalls and monitoring devices are utilized to seek to prevent unauthorized access via the Internet. The ABA endeavors to take reasonable precautions to ensure that personal information is not exposed to unauthorized persons. In the unlikely event that an unauthorized party gains access to personal information stored in the ABA’s computer systems, the Board will notify the affected person(s) without unreasonable delay and consistent with the legitimate needs of law enforcement. In this event, the ABA will take steps to determine the scope of the breach and restore our systems to a reasonable level of security.

The Service
The ABA operates the web domain theaba.org, which publishes several websites, including www.theaba.org, portal.theaba.org, and rtid.theaba.org (the "Service").

In addition to informing you of our policies regarding the collection, use, and disclosure of personal data when you use our Service, this policy also informs you of the choices you have associated with that data. The ABA may share relevant personal information with third-party vendors for them to provide services for you, such as publishing certification information, verifying Continuing Medical Education course completions, deploying informational emails or payment processing. Third-party vendors are required to keep your personal information confidential.

The ABA may also disclose certain registrant, candidate or diplomate personal information to third parties in response to lawful processes (such as a subpoena or court order) and make disclosures to the public regarding the registrant’s, candidate’s or diplomate’s certification status. In making such external disclosures to third parties, the ABA will only disclose information that is minimally necessary to accomplish the purposes described above and require any receiving party to take proper security precautions, unless such information is already in the public domain. The ABA also may disclose certain registrant, candidate or diplomate information to research partners approved by the Board to conduct studies to assess ABA certification processes or scientific research relating to anesthesiologists, the practice of anesthesiology and/or the education of anesthesiologists. Such research partners are required to keep information confidential.

The ABA takes great care to protect physicians’ personal information. However, if you leave our domains while managing your ABA account and share information, including your personally identifiable information,

with third parties, we will not have control over how the third party uses and secures your information. We use your data to provide and improve the Service. By using the Service, you agree to the collection and use of information in accordance with this policy.

Definitions

- Personal Data: Personal Data means data about a living individual who can be identified from such data (or from data and other information either in our possession or likely to come into our possession).

- Usage Data: Usage Data is data collected automatically from use of the Service or from the Service infrastructure itself (e.g., the duration of a page visit).

- Data Controller: The Data Controller is someone who (either alone, jointly or in conjunction with a group) determines the purposes for which and the manner in which any personal data are processed. For the purpose of this Privacy Policy, we are a Data Controller.

- Data Processor (or Service Provider): The Data Processor (or Service Provider) is any person (other than an employee of the Data Controller) who processes the data on behalf of the Data Controller. We may use the services of various Service Providers to process your data more effectively.

- Data Subject: The Data Subject is any living individual who is the subject of Personal Data, including Users and others.

- User: The User is the individual using our Service (e.g., physicians). The User corresponds to the Data Subject, who is the subject of Personal Data.

- Information Collection and Use: We collect several different types of information for various purposes to provide and improve our Service to you.

Types of Data Collected

- Personal Data: While using our Service, we may ask you to provide personally identifiable information that can be used to contact or identify you ("Personal Data"). Personally identifiable information may include, but is not limited to:
  - Email address
  - First name and last name
  - Phone number
  - Address, State, Province, ZIP/Postal code, City
  - Medical Licensure History and Status
  - Education History and Status

- Cookies and Usage Data: We may use your Personal Data to contact you with information regarding your certification status, programmatic updates, and other news of the Board that may be of interest to you.

- Usage Data: We may also collect information on how the Service is accessed and used ("Usage Data"). Usage Data may include information such as your computer's Internet Protocol address (e.g. IP address), browser type, browser version, the pages of our Service that you visit, the time and date of your visit, the time spent on those pages, unique device identifiers and other diagnostic data.

- Tracking & Cookies Data: We use cookies and similar tracking technologies to monitor activity on our Service and store certain information.

  Cookies are files with small amounts of data that are stored on a User’s device and may include an anonymous unique identifier. Cookies are sent to your browser from a website and stored on your device. Tracking technologies also used are beacons, tags, and scripts that collect and track

information to analyze and improve our Service.

You can instruct your browser to refuse all cookies or to indicate when a cookie is being sent. However, if you do not accept cookies, you may not be able to use some portions of our Service.
Examples of Cookies we use:
Session Cookies: We use Session Cookies to operate our Service. Session cookies are stored in temporary memory and are not retained after the browser is closed.

Preference Cookies: We use Preference Cookies to remember your preferences and various settings. Security Cookies. We use Security Cookies for security purposes.

Use of Data
The ABA uses the collected data for various purposes:

- To provide and maintain our Service
- To notify you about changes to our Service
- To allow you to participate in interactive features of our Service when you choose to do so
- To provide customer support
- To gather and analyze valuable information so that we can improve our Service
- To monitor the usage of our Service
- To detect, prevent and address technical issues
- To provide you with news, programmatic information and general updates about services and events that we offer that may be of interest to you
- To conduct research, in which case your data will be decoupled from your personal identity

Retention of Data
The ABA will retain your Personal Data only for as long as is necessary for the purposes set out in this Privacy Policy. We will retain and use your Personal Data to the extent necessary to comply with our legal obligations (for example, if we are required to retain your data to comply with applicable laws), resolve disputes, and enforce our legal agreements and policies.

The ABA will also retain Usage Data for internal analysis purposes. Usage Data is generally retained for a shorter period of time, except when this data is used to strengthen the security or to improve the functionality of our Service, or we are legally obligated to retain this data for longer time periods.

Transfer of Data
Your information, including Personal Data, may be transferred to – and maintained on – computers located outside of your state, province, country or other governmental jurisdiction where the data protection laws may differ.

- International Users: If you are an International User located outside of the United States and choose to provide personal information to us, please note that we transfer the data, including Personal Data, to the United States for processing.

  Your consent to this Privacy Policy followed by your submission of such information represents your agreement to that transfer.

  The ABA endeavors to take reasonable steps to treat your data securely and in accordance with this Privacy Policy. We will not knowingly transfer your Personal Data to an organization or a country that does not have adequate security controls in place to avoid theft, misuse or other abuses.

Disclosure of Data

- Disclosure for Law Enforcement: Under certain circumstances, the ABA may be required to disclose your Personal Data if required to do so by law or in response to valid requests by public authorities (e.g., a subpoena).

- Legal Requirements: The ABA may disclose your Personal Data if we reasonably believe such action is necessary to:
  - To comply with a legal obligation
  - To protect and defend the rights or property of the ABA
  - To prevent or investigate possible wrongdoing in connection with the Service
  - To protect the personal safety of the Service users or the public
  - To protect against legal liability

Security of Data
The security of your data is of the utmost importance to us. However, no method of data transmission using the Internet or electronic storage is 100% secure. While we strive to use commercially acceptable means to protect your Personal Data, we cannot guarantee its absolute security.

"Do Not Track" Function
We do not support Do Not Track ("DNT"). Do Not Track is a preference you can set in your web browser to inform websites that you do not want to be tracked. This functionality does not work on our sites and our sites will not acknowledge, respond to, or accept a Do Not Track request.

Your Rights
The ABA aims to take reasonable steps to allow you to correct, amend, delete or limit the use of your Personal Data. You can update your Personal Data directly within your Account Settings in your portal account. You are encouraged to change your personal information when necessary. The ABA generally does not make changes to physicians' personal information in their portal accounts. The only change that requires intervention by the ABA is a name change, which requires documentation of the change.

If you wish to be informed what Personal Data we hold about you and/or want it to be removed from our systems, or have any concerns regarding the accuracy or completeness of it, please contact our Communications Center at (866) 999-7501 or at coms@theABA.org.

In certain circumstances, you have the right:
- To access and receive a copy of the Personal Data we hold about you
- To rectify any Personal Data held about you that is verified as inaccurate
- To request the deletion of Personal Data held about you

You have the right to data portability for the information you provide to the ABA. You can request a copy of your Personal Data in a commonly used electronic format so that you can manage and move it. Please note that your identity must be verified before responding to such requests.

Service Providers
We may employ third party companies and individuals to facilitate our Service ("Service Providers"), to provide the Service on our behalf, to perform related services or to assist us in analyzing how our Service is used. These third parties have access to your Personal Data only to perform these tasks on our behalf and are obligated not to disclose or use it for any other purpose.

Analytics
We may use third-party Service Providers to monitor and analyze the use of our Service.

Google Analytics: Google Analytics is a web analytics service offered by Google that tracks and reports website traffic. Google uses the data collected to track and monitor use of our Service. This data is shared with other Google services. Google may use the collected data to contextualize and personalize the ads of its own advertising network.

You can opt-out of having made your activity on the Service available to Google Analytics by installing the Google Analytics opt-out browser add-on. The add-on prevents the Google Analytics JavaScript (ga.js, analytics.js, and dc.js) from sharing information about your activity related to our Service. For more information on Google privacy practices, please visit the Google Privacy & Terms web page:

http://www.google.com/intl/en/policies/privacy/

Payments
We may provide paid products and/or services within the Service. In that case, we use third-party services for payment processing (e.g. payment processors).

We will not store or collect your credit card information. That information is provided directly to our third-party payment processors whose use of your personal information is governed by their Privacy Policy. These payment processors adhere to the standards set by PCI-DSS as managed by the PCI Security Standards Council, which is a joint effort of brands like Visa, MasterCard, American Express and Discover. PCI-DSS requirements help ensure the secure handling of payment information.

The payment processor we work with is Authorize.net. For information on the Authorize.net, visit their Privacy Policy web page: https://www.authorize.net/company/privacy/

Links to Other Sites
Our Service may contain links to other sites that we do not operate. If you click on a third party link, you will be directed to that third party's site. We strongly advise you to review the Privacy Policy of every site you visit.

We have no control over and assume no responsibility for the content, privacy policies or practices of any third party sites or services.

Children's Privacy
Our Service does not address anyone under the age of 13 ("Children"). We do not knowingly collect personally identifiable information from anyone under the age of 13. If we become aware that we have collected Personal Data from Children without verification of parental consent, we take steps to remove that information from our servers.

Changes to this Privacy Policy
We may update our Privacy Policy from time to time. We will notify you via email and posted messages on our Service of any changes to the policy prior to the change becoming effective. We will update the "effective date" at the top of this Privacy Policy.

You are advised to review this Privacy Policy periodically for any changes. Changes to this Privacy Policy are effective when they are posted on this page.

Contact Us
If you have any questions about this Privacy Policy, please contact our Communications Center at (866) 999-7501 or at coms@theABA.org.

By using the ABA site and furnishing your data to us you acknowledge that you have read the foregoing ABA Privacy and Security Policy and consent to it in its entirety.

7.11 IRREGULAR EXAMINATION BEHAVIOR

The Board acts to maintain the integrity of our examination and certification process and to ensure the equitable and objective administration of its examinations to all candidates. Information about behavior that we consider a violation of the integrity of our examination and certification process is sent to all physicians scheduled for examination or participation in MOCA Minute. Statistical analyses may be conducted to verify observations and reports of suspected irregularities in the conduct of an examination or MOCA Minute. Those whose conduct, in the Board's judgment, violates or attempts to violate the integrity of its examination and certification process will be invalidated and no results will be reported. Furthermore, the candidate will be subject to punitive action as determined by the Board. In that event, the candidate would be informed of the reasons for our actions and could request an opportunity to present information deemed relevant to the issue and to petition to reconsider its decision.

Irregular examination/MOCA Minute behavior means any conduct that, in our sole discretion, may jeopardize the integrity or validity of any ABA examination process or result, including but not limited to cheating, misappropriating, copying or reproducing any element of an examination for personal use or the use of a third-party without our explicit and specific written consent. We consider that irregular examination/MOCA Minute behavior demonstrates unsatisfactory essential attributes related to the competency of professionalism.

A. For residents found to have engaged in irregular examination behavior on the In-Training Examination:

(1) We will give the resident an unsatisfactory rating for appropriate Essential Attributes and for overall clinical competence on the six-month Certificate of Clinical Competence report for the training period that included the examination date for the In-Training Examination.

(2) We will first consider a registration for examination and certification from individuals no sooner than two years after the initial examination for which they otherwise could have qualified.

B. For ABA candidates found to have engaged in irregular examination behavior on any other ABA examination:

(1) We will declare the candidate's registration void.

(2) We will not consider a registration from the individual for re-admission to the ABA examination system for at least two years.

C. For diplomates found to have engaged in irregular MOCA Minute behavior:

(1) We will declare the diplomate's responses void and will withdraw the diplomate from MOCA.

(2) We will not consider MOCA enrollment for at least two years.

The above statements do not limit our ability to impose more severe actions. In its sole discretion, the Board may require an individual who is found to have engaged in irregular examination/MOCA Minute behavior to wait a longer period of time to apply for re-examination/participation in MOCA Minute. These decisions are final and not subject to review.

7.12 UNFORSEEABLE EVENTS

In the event of a natural disaster, war, government regulations, strikes, civil disorders, curtailment of transportation facilities or other unforeseeable events which make it inadvisable, illegal or impossible for us to administer an examination to a candidate at the appointed date, time and location, or to conclude a candidate's examination, we are not responsible for any personal expense the candidate may have incurred to be present for the examination, nor for any such expense the candidate may incur for any subsequent examination.

7.13 ASSESSMENT SCORE VERIFICATION POLICY

We offer an exam score verification service to physicians who wish to have the accuracy of their reported scores verified. This service applies to all ABA certification assessments, including written and oral exams, the OSCEs and MOCA Minute.

- For written exams, the service is limited to verifying that the responses recorded and scored were those of the examinee and were correctly transformed into a scaled score.

- For oral exams and the OSCEs, the service is limited to verifying that the scores assigned by examiners to the examinee's performance were correctly recorded and transformed into a scaled score.

- For MOCA Minute, the service is limited to verifying that the Measurement Decision Theory (MDT) probability or p-value is correctly calculated based on the diplomate's responses to their MOCA Minute questions as of the end of the most recent full quarter (i.e., March 31, June 30, Sept. 30, or Dec. 31).

The score verification service is not a review of the content, what the correct answer or acceptable performance should be, the acceptability of testing site conditions or examiner style, or a reconsideration of the passing standard. In the case of oral examinations and OSCEs, examiners will not reevaluate the examinee performance.

We employ extensive and rigorous quality control procedures to ensure the accuracy of the assessment results reported to our candidates/diplomates and have no record of a discrepancy ever being detected; therefore, physicians are strongly discouraged from requesting this service.

Physicians who wish to request the exam score verification service should send a completed request form with the fee to us, postmarked within six weeks of the official release date of your exam results. We will communicate the exam score verification outcome within six weeks of receiving the request.

More information, including the request form and fee, is available on our website.

7.14 ELECTRONIC RECORDING DEVICE POLICY (APPLIED/PART 2 EXAMINATIONS)

We want an environment that optimizes the abilities of each candidate by providing a safe and secure environment. Also, we want to protect the privacy of candidates, examiners, and testing materials. Use of mobile phones and other electronic recording devices is prohibited during the APPLIED/Part 2 Examination.

Any use of mobile or other electronic recording device from the time of registration until departure from the building at the conclusion of the examination may result in candidates' examination being invalidated and loss of the registration fee.

Furthermore, if candidates attempt to record, transmit or transcribe any portion of the examination, their examination will be invalidated and they will forfeit their registration fee.

REQUESTING ACCOMMODATION

We support the intent of the Americans with Disabilities Act. To accommodate individuals with documented disabilities who demonstrate a need for accommodation, we will make reasonable and appropriate modifications to our assessment programs that do not impose an undue burden on its programs or fundamentally alter the measurement of skills or knowledge that the programs are intended to test. Emotional support, therapy, comfort or companion animals are not covered under our policy.

8.01 REQUESTING ACCOMMODATION

Individuals must request assessment accommodation by submitting the *Request for Accommodation* form for the assessment for which accommodation is sought. We only review and respond to one assessment accommodation request at a time. Individuals seeking accommodation on more than one assessment must submit a separate request form for each assessment type at the time that they are eligible to take that assessment.

Requests for accommodation on the APPLIED or Part 2 Examination should only be submitted after the candidate has passed the ADVANCED or Part 1 Examination. We will not consider a request for accommodation on the APPLIED or Part 2 Examination if the individual has not first satisfied the ADVANCED or Part 1 Examination requirement.

Request forms must be submitted by the request deadline as published at www.theABA.org. The request form must state the nature of the individual's disabilities and all the modifications or auxiliary aids being requested. Our office must receive all documentation and other evidence substantiating the individual's disabilities no later than the published documentation deadline. The request form and applicable deadline dates are available on the ABA website. **Individuals are highly encouraged to submit their request form and supporting documentation as early in the registration process as possible.**

All individuals requesting accommodations should read the *Guidelines for Requesting Accommodation*. The guidelines are provided for examinees, evaluators, faculty and others involved in the process of documenting an individual's request for accommodation. Individuals requesting accommodation are encouraged to share these guidelines with their evaluator, therapist, treating physician, etc., so that the appropriate documentation can be assembled to support the request for accommodation. The guidelines are available at www.theABA.org.

Documentation and other evidence of the nature, severity and impact of the individual's disability must include an evaluation report from the professional who assessed the individual's disability that explains why the testing results support the specific diagnosis and how the disability limits the individual's ability to take the examination under standard testing conditions.

Documentation of the individual's disability must include the results of tests performed when the individual is using mitigating measures (e.g., a medication, assistive device or prosthetic) or compensating behaviors that are available to control or correct the symptoms or limitations of the individual's disability.

The nature and severity of a disability and its impact on the individual's ability to take the assessment under standard testing conditions may change with time. Therefore, we require that the accompanying assessments of an individual's disability and resulting functional limitations be based on testing results and evaluations that are sufficiently recent (**i.e., generally performed within five years of the assessment for which accommodation is requested**) to demonstrate the current nature and severity of the disability and its impact on the individual's ability to take the assessment under standard testing conditions.

A prior history of accommodation does not, in and of itself, warrant accommodation. If a candidate has

previously been approved by the ABA for assessment under nonstandard conditions, we reserve the right to require the individual to provide additional or newer documentation to demonstrate a current need for accommodation.

We reserve the right to verify independently, at our own expense, the nature and severity of an individual's disabilities and their impact on the individual's ability to take the assessment under standard testing conditions.

All requests for accommodations, including any supporting documentation, evaluations, medical records or expert reports, will become part of, and retained indefinitely in, the individual's ABA file (see Section 3.04). We reserve the right to utilize these certification records in connection with our determination of whether the registrant or candidate meets the requirements for entrance into the ABA examination system, or the requirements for certification, recertification or maintenance of certification including the independent practice requirement (see Section 7.09).

8.02 CONSIDERING A REQUEST

An ABA committee will consider the individual's request and the documentation submitted to substantiate the basis for it, if the request and documentation are received by the appropriate deadline dates. If a request is received after our published deadline dates, the request will not be considered for the current examination cycle.

At its own expense, the committee may obtain the professional opinion of experts of its choosing regarding the documentation of the individual's disabilities and the accommodations requested.

The committee will make reasonable accommodations for individuals with disabilities when there is sufficient evidence of a disability that significantly impairs the individual's ability to take the examination under standard testing conditions. However, auxiliary aids and services, and modifications to the ABA assessment programs, can only be offered if they do not fundamentally alter the measurement of skills or knowledge that the programs are intended to test or result in an undue burden on our programs.

We reserve the right to require an individual to provide additional information to verify the existence of a disability and the need for any modification or aid. We will not delay an examination pending submission of any missing documentation.

We will send the individual a letter of notification of the committee's action. If the individual's request is not granted, the letter shall include the basis for the committee's action. The individual has the right to seek review of such decision (see Section 7.05).

GLOSSARY

Policy Book – Published to inform all interested individuals of the policies, procedures, regulations and requirements governing its certification programs.

Accreditation – A review and approval process of residency training programs that have met certain standards.

Accreditation Council for Continuing Medical Education (ACCME) – The organization that evaluates and accredits institutions and organizations offering Continuing Medical Education (CME) in the United States. ACCME is an Associate Member of ABMS.

Accreditation Council for Graduate Medical Education (ACGME) – The organization that evaluates and accredits post-MD medical residency training programs in the United States. ACGME is an Associate Member of ABMS.

ADVANCED Examination – The ADVANCED Examination focuses on clinical aspects of anesthetic practice and emphasizes subspecialty-based practice and advanced clinical issues.

APPLIED Examination – The APPLIED Examination includes two components: A Standardized Oral Examination (SOE) and an Objective Structured Clinical Examination (OSCE).

BASIC Examination – The BASIC Examination focuses on the scientific basis of clinical anesthetic practice and concentrates on content areas such as pharmacology, physiology, anatomy, anesthesia equipment and monitoring.

Candidate – An individual who has become eligible to register with the ABA for initial certification or subspecialty certification whose certification has not been granted yet.

Certificate of Clinical Competence – An assessment of a resident's performance submitted semi-annually to us by a training program over the course of residency.

Certification Status – An individual's status relative to the ABA's examination and certification system. "Status" is limited to the period of time the physician's certification or registration for certification is valid.

Clinical Base (CB) – A one-year curriculum consisting of clinical rotations during which a resident has responsibility for the diagnosis and treatment of patients with a variety of medical and surgical problems.

Clinical Anesthesia (CA) – A three-year curriculum consisting of experience in basic anesthesia training, subspecialty anesthesia training and advanced anesthesia training.

Clinical Competence Committee – A group comprised of active faculty members who review the progress of every resident in a training program.

Clinically Active – Physicians are considered clinically active if they spend on average, at least one day per week during 12 consecutive months over the previous three years in the clinical practice of anesthesiology and/or related subspecialties.

Continuum of Education – The continuum of education in anesthesiology consists of four years of full-time training subsequent to the date that the medical or osteopathic degree has been conferred. The continuum consists of a clinical base year and 36 months of approved training in anesthesia (CA-1, CA-2 and CA-3 years).

Credentials Committee – An ABA Committee responsible for determining whether residents' training is

acceptable, registrants meet requirements for admission to examination, candidates meet the requirements for certification and subspecialty certification, and diplomates meet requirements for recertification or maintenance of certification.

Decision Deadline – A time limit we establish for all documentation to be received to make a decision about admission into the examination system.

Diplomate – An ABA-certified physician.

Diplomate and Candidate Directory – The official source of verification for ABA certification status which can be found at www.theABA.org.

Duration of Candidate Status – The time frame in which a physician must complete the requirements for certification relative to the physician's satisfactory completion of an ACGME-accredited residency/fellowship program.

Eligibility Requirements – Necessary performance and information required to determine entry into the ABA examination system.

Independent Practice Requirement – Requires residents/fellows and candidates for initial ABA specialty and subspecialty certification to be capable of performing independently the entire scope of practice in the specialty or subspecialty without accommodation or with reasonable accommodation.

In-Training Examination (ITE) – Formative examination developed to evaluate resident/fellow progress in meeting the educational objectives of a residency/fellowship program. These examinations may be offered by certification boards or specialty societies.

Liaison Committee on Medical Education (LCME) – Accredits programs of medical education leading to the M.D. in the United States and in collaboration with the Committee on Accreditation of Canadian Medical Schools, in Canada.

Licensure Restriction – A candidate or diplomate has had his/her medical license revoked, suspended or surrendered in lieu of revocation or suspension.

Licensure Condition – A candidate or diplomate has a medical licensure restriction of less severe nature, such as special conditions or requirements imposed on the license (e.g., chaperoning, probation, supervision, or additional training).

Maintenance of Certification in Anesthesiology® (MOCA®) program– A program that includes continuing assessment of Professionalism and Professional Standing; ongoing Lifelong Learning and Self-Assessment; Assessment of Knowledge, Judgment, and Skills; and Improvement in Medical Practice, to assure that our diplomates demonstrate a commitment to quality clinical outcomes and patient safety.

Part 1 Examination – The Part 1 Examination is designed to assess the candidate's knowledge of basic and clinical sciences as applied to anesthesiology. Part 1 Examinations are held annually in locations throughout the United States and Canada. The Part 1 Examination is administered by computer through a third-party testing vendor. Passing the Part 1 Examination is required for initial certification.

Part 2 Examination – The Part 2 Examination is designed to assess the candidate's ability to demonstrate the attributes of an ABA diplomate when managing patients presented in clinical scenarios. The attributes are sound judgment in decision-making and management of surgical and anesthetic complications, appropriate application of scientific principles to clinical problems, adaptability to unexpected changes in the clinical situations, and logical organization and effective presentation of information. The Part 2 Examination emphasizes the scientific rationale underlying clinical management decisions. Examiners are Directors of the Board and other ABA diplomates who assist as associate examiners. Passing the Part 2 Examination is required for initial certification.

Program Director – The one physician designated with authority and accountability for the operation of a residency/fellowship program.

Program Director's (PDIR) Reference Form – A form that program directors are required to file regarding the professional standing, abilities, and character of a resident upon graduation.

Professional Standing – ABA diplomates must hold an active, unrestricted license to practice medicine in at least one jurisdiction of the United States or Canada.

Registration – The process a physician will complete prior to being allowed to take an examination.

Request for Accommodation – The form a physician submits to request taking an examination under nonstandard conditions to accommodate individuals with documented disabilities.

Resident – A physician in an accredited graduate medical education specialty or subspecialty program; also referred to as "intern."

Residency – A period of training in a specific medical specialty that typically occurs after graduation from medical school.

Residency Program – A program accredited to provide structured educational experience to train physicians in a particular medical specialty.

Rotation – An educational experience of planned activities in selected settings, over a specific time period, developed to meet goals and objectives of the program.

State Medical Licensing Board – Responsible for issuing licenses to physicians within their respective geographic jurisdiction. Each state has its own board, with its own set of requirements for licensure. A license may be obtained by taking an examination in a particular state; by endorsement if the physician is already licensed in another state; or by taking Steps 1, 2 and 3 of the United States Medical Licensing Exam (USMLE). A license is not always required during residency, although in some states it is necessary to have a license after the first year or two of training. All physicians must be licensed to practice, whether they are Board certified or not.

Status of Individuals – Defining an individual's status relative to our examination and certification system.

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Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners

While nurse practitioners are trained to emphasize health promotion, patient education, and disease prevention, they lack the broader and deeper expertise needed to recognize cases in which multiple symptoms suggest more serious conditions. The primary care physician is trained to provide complex differential diagnosis, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of the patient's overall health condition.

This expertise is earned through the deep, rigorous study of medical science in the classroom and the thousands of hours of clinical study in the exam room that medical students and residents must complete before being allowed to practice medicine independently.

Because primary care physicians throughout the United States follow the same highly structured educational path, complete the same coursework, and pass the same licensure examination, you know what you're getting with a physician. There is no such standard to achieve nurse practitioner certification, as their educational requirements vary from program to program and from state to state.

DEGREES REQUIRED AND TIME TO COMPLETION

	Undergraduate degree	Entrance exam	Post-graduate schooling	Residency and duration	TOTAL TIME FOR COMPLETION
Family physician (M.D. or D.O.)	Standard 4-year BA/BS	Medical College Admissions Test (MCAT)	4 years, doctoral program (M.D. or D.O.)	REQUIRED, 3 years minimum	**11 years**
Nurse practitioner	Standard 4-year BA/BS*	Graduate Record Examination (GRE) & National Council Licensure Exam for Registered Nurses (NCLEX-RN) required for MSN programs	1.5 – 3 years, master's program (MSN)	NONE	**5.5 – 7 years**

MEDICAL/PROFESSIONAL SCHOOL AND RESIDENCY/POST-GRADUATE HOURS FOR COMPLETION

	Lecture hours (pre-clinical years)	Study hours (pre-clinical years)	Combined hours (clinical years)	Residency hours	TOTAL HOURS
Family physician	2,700	3,000**	6,000	9,000 – 10,000	**20,700 – 21,700**
Doctorate of Nursing Practice	800 – 1,600	1,500 – 2,250**	500 – 1,500	0	**2,800 – 5,350**
Difference between FP and NP hours of professional training	1,100 – 1,900 more for FPs	750 – 1,500 more for FPs	4,500 – 5,500 more for FPs	9,000 – 10,000 more for FPs	**15,350 – 18,900 more for FPs**

* While a standard 4-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor's degree to enter some master's programs.

** Estimate based on 750 hours of study dedicated by a student per year.

Sources: Vanderbilt University Family Nurse Practitioner Program information, http://www.nursing.vanderbilt.edu/msn/fnp_plan.html, and the Vanderbilt University School of Nursing Handbook 2009-2010, http://www.nursing.vanderbilt.edu/current/handbook.pdf.
American Academy of Family Physicians, Primary Health Care Professionals: A Comparison, http://www.aafp.org/online/en/home/media/kits/fp-np.html.

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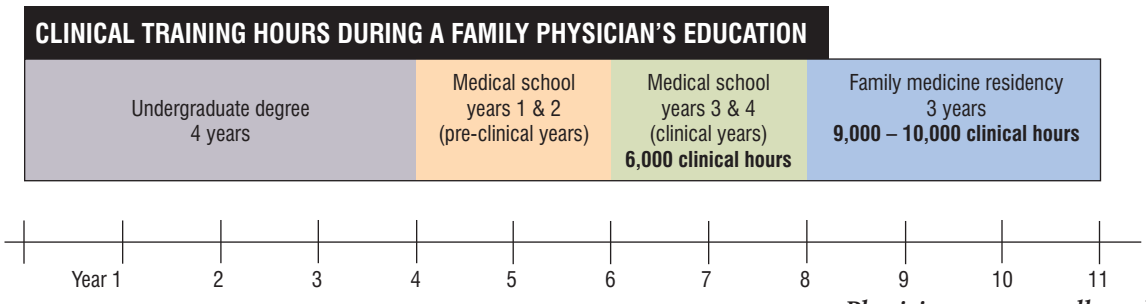

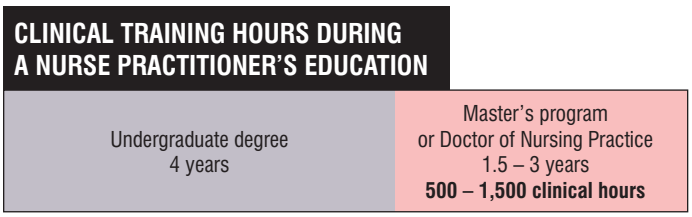

Physicians are not allowed to diagnose, treat, or prescribe independently until they have logged 15,000 to 16,000 clinical hours.

Nurse practitioner organizations argue that APNs are prepared to diagnose and prescribe independently after logging between 500 and 1,500 clinical hours.

Nurse practitioners can achieve certification by completing an associate's degree program or nursing diploma program, and go directly into a master's degree program—some of which can be completed online—or they can complete their Bachelor of Science degree in nursing. At the point of certification, a new nurse practitioner has acquired between 500 and 1,500 hours of clinical training, fewer than a third-year medical student. A new family physician has acquired more than 15,000 hours of clinical training.

- A 2004 survey of practicing nurse practitioners published in the Journal of the American Academy of Nurse Practitioners reported that in the area of pharmacology, 46% reported they were not "generally or well prepared."[1]
- From the study: "In no uncertain terms, respondents indicated that they desired and needed more out of their clinical education, in terms of content, clinical experience, and competency testing."[1]
- Also from the study: "Our results indicate that formal NP education is not preparing new NPs to feel ready for practice and suggests several areas where NP educational programs need to be strengthened."[1]

The complex chemistry and powerful therapeutics of modern pharmaceuticals require substantial expertise to carefully titrate dosages and account for the very real risks of toxicity, therapeutic failure, chemical dependency, adverse side effects from drug interactions, and simply wasting scarce health care resources through over- or under-prescribing. Pharmacology and pharmacotherapy are closely integrated into every aspect of medical training, providing an educational foundation that far exceeds the nominal exposure nurse practitioner programs offer.

- A study on antibiotic prescribing published in the American Journal of Medicine in 2005 found that non-physician clinicians were more likely to prescribe antibiotics than were practicing physicians (26.3% and 16.2%, respectively) in outpatient settings.[2]
- Another study suggested that many nurse practitioners had not received enough education in microbiology, knowledge integral to effective treatment for bacterial, fungal, as well as viral disease.[3]
- A six-year study published in 2006 found that rural nurse practitioners were writing more prescriptions than their urban nurse practitioner counterparts, physicians, and physician assistants.[4]

1. Hart A and Macnee C. "How well are nurse practitioners prepared for practice: results of a 2004 questionnaire study." Journal of the American Academy of Nurse Practitioners. 2007, Vol. 19, No. 1, p. 37.
2. Roumie C and Halasa N. "Differences in antibiotic prescribing among residents, physicians and non-physician clinicians." American Journal of Medicine. June 2005, Vol. 118, No. 6, pp. 641-648.
3. Sym D et al. "Characteristics of nurse practitioner curricula in the United States related to antimicrobial prescribing and resistance." Journal of the American Academy of Nurse Practitioners. September 2007, Vol. 19, No. 9, pp. 477-485.
4. Cipher D and Hooker R. "Prescribing trends by nurse practitioners and physician assistants in the United States." Journal of the Amercian Academy of Nurce Practitioners. June 2006, Vol. 18, No. 6, p.6.

ACGME Program Requirements for Graduate Medical Education In Anesthesiology

Editorial revision: effective July 1, 2019
Currently-in-Effect Program Requirements incorporated into the 2019 Common Program Requirements

Contents

ACGME Program Requirements for Graduate Medical Education in Anesthesiology

Common Program Requirements (Residency) are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. ***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.***

Graduate medical education transforms medical students into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

Int.B. **Definition of Specialty**

The Review Committee representing the medical specialty of anesthesiology exists in order to foster and maintain the highest standards of education and educational facilities in anesthesiology, which the Review Committee defines as the practice of medicine dealing with the peri-operative management of patients.

This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain. These goals are achieved through a thorough understanding of physiology and pharmacology, and the ability to conduct, interpret, and apply the results of medical research. Finally, the anesthesiologist is skilled in the leadership of health services delivery, prudent fiscal resource stewardship, and quality improvement, as well as the supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care.

Int.C. Length of Educational Program

The educational programs in anesthesiology are configured in 36-month and 48-month formats. The latter includes 12 months of education in fundamental clinical skills of medicine, and both include 36 months of education in clinical anesthesia (CA-1, CA-2, and CA-3 years). (Core)*

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

I.B.1. **The program, with approval of its Sponsoring Institution, must designate a primary clinical site.** (Core)

I.B.1.a) The sponsoring institution must also sponsor or be affiliated with ACGME-accredited residencies in at least the specialties of general surgery and internal medicine. (Core)

I.B.2. **There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment.** (Core)

I.B.2.a) **The PLA must:**

I.B.2.a).(1) **be renewed at least every 10 years; and,** (Core)

I.B.2.a).(2) **be approved by the designated institutional official (DIO).** (Core)

I.B.3. **The program must monitor the clinical learning and working environment at all participating sites.** (Core)

I.B.3.a) **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.** (Core)

Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites the program must ensure the quality of the educational experience. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

I.B.4. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience,**

required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)

I.B.5. The majority of rotations for the anesthesiology program must occur at the sponsoring institution. (Core)

I.B.5.a) Participating sites must provide rotations that the sponsoring institution is unable to provide. (Core)

I.B.5.a).(1) Residents should not be required to rotate among multiple participating sites. (Detail)†

I.B.5.a).(2) Assignments to a participating site should not exceed six months. (Detail)

I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

I.D.1.a) There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with visual and other educational aids, study areas for residents, office space for faculty members and residents, diagnostic and therapeutic facilities, laboratory facilities, computer support, and appropriate on-call facilities for male and female residents and faculty members. (Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: (Core)

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

I.D.2.c) **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**

Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in VI.C.1.d).(1).

I.D.2.d) **security and safety measures appropriate to the participating site; and, (Core)**

I.D.2.e) **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)**

I.D.3. **Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**

I.D.4. **The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)**

I.E. **The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)**

I.E.1. **The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)**

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor

the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

II. Personnel

II.A. Program Director

II.A.1. **There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements.** (Core)

II.A.1.a) **The Sponsoring Institution's GMEC must approve a change in program director.** (Core)

II.A.1.b) **Final approval of the program director resides with the Review Committee.** (Core)

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

II.A.1.c) **The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability.** (Core)

Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.

II.A.2. **At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE (at least eight hours per week) of non-clinical time to the administration of the program.** (Core)

II.A.2.a) Programs with more than 20 residents must provide a minimum of 40 percent protected time for the program director. (Core)

II.A.3. **Qualifications of the program director:**

II.A.3.a) **must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee;** (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b) **must include current certification in the specialty for which they are the program director by the American Board of** Anesthesiology **or by the American Osteopathic Board of** Anesthesiology**, or specialty qualifications that are acceptable to the Review Committee;** **(Core)**

II.A.3.c) **must include current medical licensure and appropriate medical staff appointment; and,** **(Core)**

II.A.3.d) **must include ongoing clinical activity.** **(Core)**

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.

II.A.3.e) must demonstrate ongoing academic achievements in anesthesiology, including publications, the development of educational programs, or the conduct of research. (Core)

II.A.4. **Program Director Responsibilities**

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. **(Core)**

II.A.4.a) **The program director must:**

II.A.4.a).(1) **be a role model of professionalism;** **(Core)**

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for

others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

II.A.4.a).(2) **design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)**

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

II.A.4.a).(3) **administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)**

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

II.A.4.a).(4) **develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter, as outlined in V.B.; (Core)**

II.A.4.a).(5) **have the authority to approve program faculty members for participation in the residency program education at all sites; (Core)**

II.A.4.a).(6) **have the authority to remove program faculty members from participation in the residency program education at all sites; (Core)**

II.A.4.a).(7) **have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)**

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role

modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

II.A.4.a).(8) **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**

II.A.4.a).(9) **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)**

II.A.4.a).(10) **provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**

II.A.4.a).(11) **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)**

II.A.4.a).(12) **ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)**

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.

II.A.4.a).(13) **ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)**

II.A.4.a).(13).(a) **Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)**

II.A.4.a).(14) **document verification of program completion for all graduating residents within 30 days; (Core)**

II.A.4.a).(15) **provide verification of an individual resident's completion upon the resident's request, within 30 days; and, (Core)**

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

II.A.4.a).(16) **obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements.** (Core)

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.

II.B.1. **At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location.** (Core)

II.B.1.a) The members of the faculty must have varying interests, capabilities, and backgrounds, and include individuals who have specialized expertise in the subspecialties of anesthesiology, including critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine, and also in research. (Core)

II.B.1.b) Didactic and clinical teaching should be provided by faculty members with documented interests and expertise in the subspecialty involved. (Detail)

II.B.1.c) The number of faculty members must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. (Core)

II.B.1.d) Designated faculty members must be readily and consistently available for consultation and teaching. (Core)

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)

II.B.2.g) pursue faculty development designed to enhance their skills at least annually: (Core)

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

II.B.2.g).(1) as educators; (Core)

II.B.2.g).(2) in quality improvement and patient safety; (Core)

II.B.2.g).(3) **in fostering their own and their residents' well-being; and,** (Core)

II.B.2.g).(4) **in patient care based on their practice-based learning and improvement efforts.** (Core)

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

II.B.3. **Faculty Qualifications**

II.B.3.a) **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.** (Core)

II.B.3.b) **Physician faculty members must:**

II.B.3.b).(1) **have current certification in the specialty by the American Board of** Anesthesiology **or the American Osteopathic Board of** Anesthesiology**, or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.3.c) **Any non-physician faculty members who participate in residency program education must be approved by the program director.** (Core)

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

II.B.4. **Core Faculty**

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

II.B.4.a) **Core faculty members must be designated by the program director.** (Core)

II.B.4.b) **Core faculty members must complete the annual ACGME Faculty Survey.** (Core)

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]

[The Review Committee's specification will be included in the upcoming focused revision to the Anesthesiology Program Requirements]

II.C. Program Coordinator

II.C.1. **There must be a program coordinator.** (Core)

II.C.2. **At a minimum, the program coordinator must be supported at 50 percent FTE (at least 20 hours per week) for administrative time.** (Core)

Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

III.A.1.a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)

III.A.1.b) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)

III.A.1.b).(1) holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)

III.A.1.b).(2) holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)

III.A.2.a) Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)

III.A.2.a).(1) Residents entering a 36-month anesthesiology program that does not include education in fundamental clinical skills of medicine must have successfully completed 12 months of education in fundamental clinical skills of

medicine in a program that satisfies the requirements in III.A.2.

III.A.2.a).(1).(a) If such residents have also been accepted into an anesthesiology program, then in order to be accepted into the CA-1 year, they must demonstrate satisfactory abilities on quarterly written performance evaluations prior to starting their education in fundamental clinical skills of medicine. (Core)

III.A.2.a).(1).(b) When a resident completes education in fundamental clinical skills of medicine in another accredited program, the anesthesiology program director must ensure that he/she receives the resident's quarterly written performance evaluations. (Core)

Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

III.A.3. **A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)**

III.B. **The program director must not appoint more residents than approved by the Review Committee. (Core)**

III.B.1. **All complement increases must be approved by the Review Committee. (Core)**

III.B.2. There must be a minimum of nine residents with, on average, three appointed in each of the CA-1, CA-2, and CA-3 years. (Core)

III.C. **Resident Transfers**

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

IV.A. The curriculum must contain the following educational components: (Core)

IV.A.1. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.1.a) The program's aims must be made available to program applicants, residents, and faculty members. (Core)

IV.A.2. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a resident in attaining skill in each competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

IV.A.3. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility

independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4. **a broad range of structured didactic activities; (Core)**

IV.A.4.a) **Residents must be provided with protected time to participate in core didactic activities. (Core)**

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

IV.A.5. **advancement of residents' knowledge of ethical principles foundational to medical professionalism; and, (Core)**

IV.A.6. **advancement in the residents' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care. (Core)**

IV.B. **ACGME Competencies**

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

IV.B.1. **The program must integrate the following ACGME Competencies into the curriculum: (Core)**

IV.B.1.a) **Professionalism**

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a).(1) **Residents must demonstrate competence in:**

IV.B.1.a).(1).(a) **compassion, integrity, and respect for others; (Core)**

IV.B.1.a).(1).(b) **responsiveness to patient needs that supersedes self-interest; (Core)**

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to

another provider. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

IV.B.1.a).(1).(c) **respect for patient privacy and autonomy; (Core)**

IV.B.1.a).(1).(d) **accountability to patients, society, and the profession; (Core)**

IV.B.1.a).(1).(e) **respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**

IV.B.1.a).(1).(f) **ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**

IV.B.1.a).(1).(g) **appropriately disclosing and addressing conflict or duality of interest. (Core)**

IV.B.1.b) Patient Care and Procedural Skills

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

IV.B.1.b).(1) **Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**

IV.B.1.b).(1).(a) Residents must demonstrate competence in fundamental clinical skills of medicine, including:

IV.B.1.b).(1).(a).(i) obtaining a comprehensive medical history; (Core)

IV.B.1.b).(1).(a).(ii) performing a comprehensive physical examination; (Core)

IV.B.1.b).(1).(a).(iii) assessing a patient's medical conditions; (Core)

IV.B.1.b).(1).(a).(iv) making appropriate use of diagnostic studies and tests; (Core)

IV.B.1.b).(1).(a).(v) integrating information to develop a differential diagnosis; and, (Core)

IV.B.1.b).(1).(a).(vi) implementing a treatment plan. (Core)

IV.B.1.b).(1).(b) Residents must demonstrate competence in anesthetic management, including care for:

IV.B.1.b).(1).(b).(i) patients younger than 12 years of age undergoing surgery or other procedures requiring anesthetics; (Core)

IV.B.1.b).(1).(b).(i).(a) This experience must involve care for 100 patients younger than 12 years of age. (Core)

IV.B.1.b).(1).(b).(i).(b) Within this patient group, 20 children must be younger than three years of age, including five younger than three months of age. (Core)

IV.B.1.b).(1).(b).(ii) patients who are evaluated for management of acute, chronic, or cancer-related pain disorders; (Core)

IV.B.1.b).(1).(b).(ii).(a) This experience must involve care for 20 patients presenting for initial evaluation of pain. (Core)

IV.B.1.b).(1).(b).(ii).(b) Residents must be familiar with the breadth of pain management, including clinical experience with interventional pain procedures. (Core)

IV.B.1.b).(1).(b).(iii) patients scheduled for evaluation prior to elective surgical procedures; (Core)

IV.B.1.b).(1).(b).(iv) patients immediately after anesthesia, including direct care of patients in the post-anesthesia-care unit, and responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia care unit; and, (Core)

IV.B.1.b).(1).(b).(v) critically-ill patients. (Core)

IV.B.1.b).(1).(c) Residents must achieve competence in the delivery of anesthetic care to:

IV.B.1.b).(1).(c).(i) patients undergoing vaginal delivery; (Core)

IV.B.1.b).(1).(c).(i).(a) This experience must involve care for 40 patients. (Core)

IV.B.1.b).(1).(c).(ii) patients undergoing cesarean sections; (Core)

IV.B.1.b).(1).(c).(ii).(a) This experience must involve care for 20 patients. (Core)

IV.B.1.b).(1).(c).(iii) patients undergoing cardiac surgery; (Core)

IV.B.1.b).(1).(c).(iii).(a) This experience must involve care for 20 patients. (Core)

IV.B.1.b).(1).(c).(iii).(b) The care provided to 10 of these patients must involve the use of cardiopulmonary bypass. (Core)

IV.B.1.b).(1).(c).(iv) patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery; (Core)

IV.B.1.b).(1).(c).(iv).(a) This experience must involve care for 20 patients, not including surgery for vascular access or repair of vascular access. (Core)

IV.B.1.b).(1).(c).(v) patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures; (Core)

IV.B.1.b).(1).(c).(v).(a) This experience must involve care for 20 patients. (Core)

IV.B.1.b).(1).(c).(vi) patients undergoing intracerebral procedures, including those undergoing intracerebral endovascular procedures; (Core)

IV.B.1.b).(1).(c).(vi).(a) This experience must involve care for 20 patients, the majority of which must involve an open cranium. (Core)

IV.B.1.b).(1).(c).(vii) patients for whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for peri-operative analgesia; (Core)

IV.B.1.b).(1).(c).(vii).(a) This experience must involve care for 40 patients. (Core)

IV.B.1.b).(1).(c).(viii) patients undergoing procedures for complex, immediate life-threatening pathology; (Core)

IV.B.1.b).(1).(c).(viii).(a) This experience must involve care for 20 patients. (Core)

IV.B.1.b).(1).(c).(ix) patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics; (Core)

IV.B.1.b).(1).(c).(ix).(a) This experience must involve care for 40 patients. (Core)

IV.B.1.b).(1).(c).(x) patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management; (Core)

IV.B.1.b).(1).(c).(x).(a) This experience must involve care for 40 patients. (Core)

IV.B.1.b).(1).(c).(xi) patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities; (Core)

IV.B.1.b).(1).(c).(xii) patients whose peri-operative care requires specialized techniques, including: (Core)

IV.B.1.b).(1).(c).(xii).(a) a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; (Core)

IV.B.1.b).(1).(c).(xii).(b) central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, (Core)

IV.B.1.b).(1).(c).(xii).(c) use of electroencephalography (EEG) or processed EEG monitoring as part of the procedure, or adequate didactic instruction to ensure familiarity with EEG use and interpretation. (Core)

IV.B.1.b).(1).(c).(xiii) patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. (Core)

This must include competency in:

IV.B.1.b).(1).(c).(xiii).(a) using surface ultrasound and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia, critical care, and resuscitation; (Core)

IV.B.1.b).(1).(c).(xiii).(b) understanding the principles of ultrasound, including the physics of ultrasound transmission, ultrasound transducer construction, and transducer selection for specific applications, to include being able to obtain images with an understanding of limitations and artifacts; (Core)

IV.B.1.b).(1).(c).(xiii).(c) obtaining standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)

IV.B.1.b).(1).(c).(xiii).(d) obtaining standard views of the heart with transesophageal echocardiography allowing the evaluation of mycardial function and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)

IV.B.1.b).(1).(c).(xiii).(e) using transthoracic ultrasound for the detection of pneumothorax and pleural effusion; (Core)

IV.B.1.b).(1).(c).(xiii).(f) using surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures; and, (Core)

IV.B.1.b).(1).(c).(xiii).(g) describing techniques, views, and findings in standard language. (Core)

IV.B.1.b).(2) Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)

IV.B.1.c).(1) Residents must demonstrate appropriate medical knowledge in the topics related to the anesthetic care of patients, including:

IV.B.1.c).(1).(a) practice management to address issues such as: (Core)

IV.B.1.c).(1).(a).(i) operating room management; (Core)

IV.B.1.c).(1).(a).(ii) evaluation of types of practice; (Core)

IV.B.1.c).(1).(a).(iii) contract negotiations; (Core)

IV.B.1.c).(1).(a).(iv) billing arrangements; (Core)

IV.B.1.c).(1).(a).(v) professional liability; (Core)

IV.B.1.c).(1).(a).(vi) health care finance, legislative, and regulatory issues; and, (Core)

IV.B.1.c).(1).(a).(vii) fiscal stewardship of health services delivery. (Core)

IV.B.1.c).(1).(b) management skills, to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy; (Core)

IV.B.1.c).(1).(c) care of the patient in the continuum of the peri-operative period, to include collaboration with medical and surgical colleagues to:

IV.B.1.c).(1).(c).(i) optimize preoperative patient condition; and, (Core)

IV.B.1.c).(1).(c).(ii) optimize recovery; (Core)

IV.B.1.c).(1).(d) management of the specific needs of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)

IV.B.1.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a physician develop the habits of mind required to continuously pursue quality improvement, well past the completion of residency.

IV.B.1.d).(1) Residents must demonstrate competence in:

IV.B.1.d).(1).(a) identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)

IV.B.1.d).(1).(b) setting learning and improvement goals; (Core)

IV.B.1.d).(1).(c) identifying and performing appropriate learning activities; (Core)

IV.B.1.d).(1).(d) systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement; (Core)

IV.B.1.d).(1).(e) incorporating feedback and formative evaluation into daily practice; (Core)

IV.B.1.d).(1).(f) locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and, (Core)

IV.B.1.d).(1).(g) using information technology to optimize learning. (Core)

IV.B.1.e) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. **(Core)**

IV.B.1.e).(1) **Residents must demonstrate competence in:**

IV.B.1.e).(1).(a) **communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** **(Core)**

IV.B.1.e).(1).(b) **communicating effectively with physicians, other health professionals, and health-related agencies;** **(Core)**

IV.B.1.e).(1).(c) **working effectively as a member or leader of a health care team or other professional group;** **(Core)**

IV.B.1.e).(1).(d) **educating patients, families, students, residents, and other health professionals;** **(Core)**

IV.B.1.e).(1).(e) **acting in a consultative role to other physicians and health professionals; and,** **(Core)**

IV.B.1.e).(1).(f) **maintaining comprehensive, timely, and legible medical records, if applicable.** **(Core)**

IV.B.1.e).(1).(g) maintaining a comprehensive anesthesia record for each patient, including evidence of pre- and post-operative anesthesia assessment, the drugs administered, the monitoring employed, the techniques used, the physiologic variations observed, the therapy provided, and the fluids administered; and, (Core)

IV.B.1.e).(1).(h) creating and sustaining a therapeutic relationship with patients, engaging in active listening, providing information using appropriate language, asking clear questions, and providing an opportunity for comments and questions. (Core)

IV.B.1.e).(2) **Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.** **(Core)**

Background and Intent: When there are no more medications or interventions that can achieve a patient's goals or provide meaningful improvements in quality or length of life, a discussion about the patient's goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to participate effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

Programs may teach this skill through direct clinical experience, simulation, or other means of active learning.

IV.B.1.f) **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

IV.B.1.f).(1) **Residents must demonstrate competence in:**

IV.B.1.f).(1).(a) **working effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Core)

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

IV.B.1.f).(1).(b) **coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;** (Core)

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

IV.B.1.f).(1).(c) **advocating for quality patient care and optimal patient care systems;** (Core)

IV.B.1.f).(1).(d) **working in interprofessional teams to enhance patient safety and improve patient care quality;** (Core)

IV.B.1.f).(1).(e) **participating in identifying system errors and implementing potential systems solutions;** (Core)

IV.B.1.f).(1).(f) **incorporating considerations of value, cost awareness, delivery and payment, and risk-**

benefit analysis in patient and/or population-based care as appropriate; and, (Core)

IV.B.1.f).(1).(g) **understanding health care finances and its impact on individual patients' health decisions. (Core)**

IV.B.1.f).(2) **Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals. (Core)**

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. **The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)**

[The Review Committee must further specify]

[The Review Committee's specification will be included in the upcoming focused revision to the Anesthesiology Program Requirements]

Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

IV.C.2. **The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction. (Core)**

IV.C.2.a) The program must have a written policy and an educational program regarding substance abuse as it relates to physician well-being that specifically addresses the needs of anesthesiology; (Core)

IV.C.3. 12 months of the resident's educational program must provide broad education in fundamental clinical skills of medicine relevant to the practice of anesthesiology. (Core)

IV.C.3.a) Fundamental clinical skills of medicine education completed as part of an anesthesiology residency need not be contiguous, but must be completed before starting the final year of the program. (Core)

IV.C.3.b) At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family

medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core)

IV.C.3.c) The program director must maintain oversight of resident education in fundamental clinical skills of medicine; (Core)

IV.C.4. During the first 12 months of the program, there must be at least one month, but not more than two month(s) each of critical care and emergency medicine. (Core)

IV.C.5. Thirty-six months of education must be in peri-operative medicine. (Core)

IV.C.5.a) This must include experience with a wide spectrum of disease processes and surgical procedures available within the CA-1 through CA-3 years to provide each resident with broad exposure to different types of anesthetic management. (Core)

IV.C.5.b) The program must ensure that the rotations for residents beginning the peri-operative medicine component of the residency be in surgical anesthesia, critical care medicine, and pain medicine. (Core)

IV.C.5.c) Residents must receive training in the complex technology and equipment associated with the practice of anesthesiology. (Core)

IV.C.5.d) Clinical experience in surgical anesthesia, pain medicine, and critical care medicine must be distributed throughout the curriculum in order to provide progressive responsibility in the later stages of the program. (Core)

IV.C.6. Residents must have a rotation of at least two weeks in pre-operative medicine. (Core)

IV.C.7. Residents must have a rotation of at least two weeks in post-anesthesia care. (Core)

IV.C.7.a) Resident clinical responsibilities in the post-operative care unit must be limited to the care of post-operative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. (Core)

IV.C.8. Resident education must include a minimum of four months of critical care medicine, (Core)

IV.C.8.a) No more than two months of this experience should occur prior to the CA-1 year. (Core)

IV.C.8.b) Each critical care medicine rotation must be at least one month in duration, with progressive patient care responsibility in advanced rotations. (Core)

IV.C.8.c) Training must take place in units, providing care for both men and women, in which the majority of patients have multisystem disease. (Core)

IV.C.8.d) Residents must actively participate in all patient care activities as fully integrated members of the critical care team. (Core)

IV.C.8.e) During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically-ill patients seen by residents, and in the educational activities of the residents. (Core)

IV.C.9. Resident education must include a minimum of two one-month rotations each in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. (Core)

IV.C.9.a) Additional subspecialty and research rotations are encouraged, but resident rotations in a single anesthesia subspecialty must not exceed six months. (Detail)

IV.C.9.b) Advanced subspecialty rotations must not compromise the learning opportunities for residents participating in their initial subspecialty rotations. (Core)

IV.C.10. Resident education must include a minimum of three months in pain medicine, including: (Core)

IV.C.10.a) one month in an acute peri-operative pain management rotation; (Core)

IV.C.10.b) one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain; and, (Core)

IV.C.10.c) one month of a regional analgesia experience rotation. (Core)

IV.C.11. Residents must have at least two weeks of experience managing the anesthetic care of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)

IV.C.12. In the clinical anesthesia setting, faculty members must not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents. (Core)

IV.C.12.a) Clinical instruction of residents by non-physician personnel should be limited to not more than 10 percent of total instruction, and should use such personnel only when access to their specific

expertise will enhance the educational experience of residents. (Detail)

IV.C.13. All residents must obtain advanced cardiac life support (ACLS) certification at least once during the program. (Core)

IV.C.14. Residents must participate in at least one simulated clinical experience each year. (Core)

IV.C.15. The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)

IV.C.15.a) The program director must ensure that experience logs are submitted annually to the Review Committee in accordance with the format and the due date specified by the Committee. (Core)

IV.C.16. The program director must determine sequencing of rotations; (Detail)

IV.C.17. The program director must monitor the appropriate distribution of cases among the residents; and, (Core)

IV.C.18. The program director must ensure that service commitments do not compromise the achievement of educational goals and objectives. (Core)

IV.C.19. The curriculum must contain didactic instruction through a variety of learning opportunities occurring in conference, in the clinical setting or online that encompasses clinical anesthesiology and related areas of basic science. (Core)

IV.C.20. Other topics from internal medicine that are important for the pre-operative preparation of the patient, from surgery as to the nature of the surgical procedure affecting anesthetic care, and from obstetrics that impacts anesthetic management of the patient, should be included. (Core)

IV.C.20.a) The material covered in the didactic program must demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held learning exercises. (Core)

IV.C.20.a).(1) There should be evidence of regular faculty member participation in didactic sessions. (Detail)

IV.C.20.a).(2) The program director and faculty members from other disciplines and other institutions should conduct these sessions. (Detail)

IV.C.21. When 12 months of education in fundamental clinical skills of medicine is approved as part of the accredited program, the program director must maintain oversight for all rotations, and must approve the rotations for individual residents. (Core)

IV.C.22. The program director must review written resident performance evaluations from each clinical service on which each resident rotates on a quarterly basis. (Core)

IV.C.23. The education must culminate in sufficiently independent responsibility for clinical decision-making and patient care, so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a leader of peri-operative care teams. (Core)

IV.C.24. As the resident advances through the program, goals and objectives must reflect the opportunity to learn to plan and administer anesthesia care for patients with more severe and complicated diseases, as well as for patients who undergo more complex surgical procedures. (Core)

IV.C.25. International rotations should be limited to the final year of training and should be limited to three months or less. (Detail)

IV.C.25.a) International rotations must be approved by the Review Committee through a written request submitted by the program director. (Detail)

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) **The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.** (Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- **Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan**
- **Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature**
- **When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)**
- **Improving resident learning by encouraging them to teach using a scholarly approach**

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

IV.D.2. **Faculty Scholarly Activity**

IV.D.2.a) **Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:** (Core)

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

IV.D.2.b) **The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

IV.D.2.b).(1) **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)‡**

IV.D.2.b).(2) **peer-reviewed publication. (Outcome)**

IV.D.3. Resident Scholarly Activity

IV.D.3.a) **Residents must participate in scholarship. (Core)**

IV.D.3.b) Each resident must complete, under faculty member supervision, an academic assignment. (Core)

IV.D.3.b).(1) Academic assignments should include grand rounds presentations; preparation and publication of review articles, book chapters, manuals for teaching or clinical practice; or development, performance, or participation in one or more clinical or laboratory investigations. (Detail)

IV.D.3.b).(1).(a) The outcome of resident investigations should be suitable for presentation at local, regional, or national scientific meetings, and/or result in peer-reviewed abstracts or manuscripts. (Detail)

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **residents identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where residents are struggling and address problems immediately**

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

V.A.1.a) **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.b) **Evaluation must be documented at the completion of the assignment. (Core)**

V.A.1.b).(1) **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**

V.A.1.b).(2) **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)**

V.A.1.c) **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)**

V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d).(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)

V.A.1.d).(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)

V.A.1.d).(3) develop plans for residents failing to progress, following institutional policies and procedures. (Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

V.A.1.e) At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)

V.A.1.f) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

V.A.2. Final Evaluation

V.A.2.a) **The program director must provide a final evaluation for each resident upon completion of the program.** (Core)

V.A.2.a).(1) **The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.** (Core)

V.A.2.a).(2) **The final evaluation must:**

V.A.2.a).(2).(a) **become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;** (Core)

V.A.2.a).(2).(b) **verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;** (Core)

V.A.2.a).(2).(c) **consider recommendations from the Clinical Competency Committee; and,** (Core)

V.A.2.a).(2).(d) **be shared with the resident upon completion of the program.** (Core)

V.A.3. **A Clinical Competency Committee must be appointed by the program director.** (Core)

V.A.3.a) **At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.** (Core)

V.A.3.a).(1) **Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** (Core)

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief

residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

V.A.3.b) **The Clinical Competency Committee must:**

V.A.3.b).(1) **review all resident evaluations at least semi-annually; (Core)**

V.A.3.b).(2) **determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)**

V.A.3.b).(3) **meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)**

V.B. Faculty Evaluation

V.B.1. **The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)**

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

V.B.1.a) **This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)**

V.B.1.b) **This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)**

V.B.2. **Faculty members must receive feedback on their evaluations at least annually.** (Core)

V.B.3. **Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.** (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

V.C. Program Evaluation and Improvement

V.C.1. **The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.** (Core)

V.C.1.a) **The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident.** (Core)

V.C.1.b) **Program Evaluation Committee responsibilities must include:**

V.C.1.b).(1) **acting as an advisor to the program director, through program oversight;** (Core)

V.C.1.b).(2) **review of the program's self-determined goals and progress toward meeting them;** (Core)

V.C.1.b).(3) **guiding ongoing program improvement, including development of new goals, based upon outcomes; and,** (Core)

V.C.1.b).(4) **review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

V.C.1.c) **The Program Evaluation Committee should consider the following elements in its assessment of the program:**

V.C.1.c).(1) **curriculum;** (Core)

V.C.1.c).(2) **outcomes from prior Annual Program Evaluation(s); (Core)**

V.C.1.c).(3) **ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)**

V.C.1.c).(4) **quality and safety of patient care; (Core)**

V.C.1.c).(5) **aggregate resident and faculty:**

V.C.1.c).(5).(a) **well-being; (Core)**

V.C.1.c).(5).(b) **recruitment and retention; (Core)**

V.C.1.c).(5).(c) **workforce diversity; (Core)**

V.C.1.c).(5).(d) **engagement in quality improvement and patient safety; (Core)**

V.C.1.c).(5).(e) **scholarly activity; (Core)**

V.C.1.c).(5).(f) **ACGME Resident and Faculty Surveys; and, (Core)**

V.C.1.c).(5).(g) **written evaluations of the program. (Core)**

V.C.1.c).(6) **aggregate resident:**

V.C.1.c).(6).(a) **achievement of the Milestones; (Core)**

V.C.1.c).(6).(b) **in-training examinations (where applicable); (Core)**

V.C.1.c).(6).(c) **board pass and certification rates; and, (Core)**

V.C.1.c).(6).(d) **graduate performance. (Core)**

V.C.1.c).(7) **aggregate faculty:**

V.C.1.c).(7).(a) **evaluation; and, (Core)**

V.C.1.c).(7).(b) **professional development. (Core)**

V.C.1.d) **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)**

V.C.1.e) **The annual review, including the action plan, must:**

V.C.1.e).(1) **be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)**

V.C.1.e).(2) **be submitted to the DIO. (Core)**

V.C.2. **The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)**

V.C.2.a) **A summary of the Self-Study must be submitted to the DIO. (Core)**

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-Year Accreditation Site Visit, is available on the ACGME website.

V.C.3. ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

V.C.3.a) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)**

V.C.3.b) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)**

V.C.3.c) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than**

the bottom fifth percentile of programs in that specialty. **(Outcome)**

V.C.3.d) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

V.C.3.e) **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** **(Outcome)**

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

V.C.3.f) **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** **(Core)**

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- ***Excellence in the safety and quality of care rendered to patients by residents today***

- ***Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***

- ***Excellence in professionalism through faculty modeling of:***

  - ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***

  - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***

- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by

residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) **Patient Safety**

VI.A.1.a).(1) **Culture of Safety**

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** **(Core)**

VI.A.1.a).(1).(b) **The program must have a structure that promotes safe, interprofessional, team-based care.** **(Core)**

VI.A.1.a).(2) **Education on Patient Safety**

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. **(Core)**

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

VI.A.1.a).(3) **Patient Safety Events**

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are

essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) **Residents, fellows, faculty members, and other clinical staff members must:**

VI.A.1.a).(3).(a).(i) **know their responsibilities in reporting patient safety events at the clinical site; (Core)**

VI.A.1.a).(3).(a).(ii) **know how to report patient safety events, including near misses, at the clinical site; and, (Core)**

VI.A.1.a).(3).(a).(iii) **be provided with summary information of their institution's patient safety reports. (Core)**

VI.A.1.a).(3).(b) **Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**

VI.A.1.a).(4) **Resident Education and Experience in Disclosure of Adverse Events**

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) **All residents must receive training in how to disclose adverse events to patients and families. (Core)**

VI.A.1.a).(4).(b) **Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)**

VI.A.1.b) **Quality Improvement**

VI.A.1.b).(1) **Education in Quality Improvement**

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary

in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) **Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.** (Core)

VI.A.1.b).(2) **Quality Metrics**

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)

VI.A.1.b).(3) **Engagement in Quality Improvement Activities**

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) **Residents must have the opportunity to participate in interprofessional quality improvement activities.** (Core)

VI.A.1.b).(3).(a).(i) **This should include activities aimed at reducing health care disparities.** (Detail)

VI.A.2. **Supervision and Accountability**

VI.A.2.a) ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) **Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is**

responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) **This information must be available to residents, faculty members, other members of the health care team, and patients.** (Core)

VI.A.2.a).(1).(b) **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.** (Core)

VI.A.2.b) ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.***

VI.A.2.b).(1) **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** (Core)

VI.A.2.c) **Levels of Supervision**

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) **Direct Supervision – the supervising physician is physically present with the resident and patient.** (Core)

VI.A.2.c).(2) **Indirect Supervision:**

VI.A.2.c).(2).(a) **with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.** (Core)

VI.A.2.c).(2).(b) **with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care,**

but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)

VI.A.2.c).(3) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** (Core)

VI.A.2.d) **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)

VI.A.2.d).(1) **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.** (Core)

VI.A.2.d).(2) **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.** (Core)

VI.A.2.d).(3) **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

VI.A.2.e) **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** (Core)

VI.A.2.e).(1) **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** (Outcome)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

VI.A.2.e).(1).(a) **Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.]** (Core)

VI.A.2.f) **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident**

and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) **safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)**

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

VI.B.4.c) **assurance of their fitness for work, including: (Outcome)**

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

VI.B.4.c).(1) **management of their time before, during, and after clinical assignments; and, (Outcome)**

VI.B.4.c).(2) **recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)**

VI.B.4.d) **commitment to lifelong learning; (Outcome)**

VI.B.4.e) **monitoring of their patient care performance improvement indicators; and, (Outcome)**

VI.B.4.f) **accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)**

VI.B.5. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)**

VI.B.6. **Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)**

VI.B.7. **Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)**

VI.C. **Well-Being**

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

VI.C.1. **The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:**

VI.C.1.a) **efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)**

VI.C.1.b) **attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)**

VI.C.1.c) **evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)**

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

VI.C.1.d) **policies and programs that encourage optimal resident and faculty member well-being; and, (Core)**

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

VI.C.1.d).(1) **Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.e) **attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)**

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

VI.C.1.e).(1) **encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)**

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e).(2) **provide access to appropriate tools for self-screening; and, (Core)**

VI.C.1.e).(3) **provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)**

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. **There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)**

VI.C.2.a) **The program must have policies and procedures in place to ensure coverage of patient care. (Core)**

VI.C.2.b) **These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)**

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements.

Teammates should assist colleagues in need and equitably reintegrate them upon return.

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: In the new requirements, the terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours"

replace the terms "duty hours," "duty periods," and "duty." These changes have been made in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that residents' duty to "clock out" on time superseded their duty to their patients.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling

While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an

electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Residents
PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident's assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

VI.F.2.c) **Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)**

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

VI.F.2.d) **Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)**

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

VI.F.3. **Maximum Clinical Work and Education Period Length**

VI.F.3.a) **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)**

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from

resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

VI.F.3.a).(1) **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.** **(Core)**

VI.F.3.a).(1).(a) **Additional patient care responsibilities must not be assigned to a resident during this time.** **(Core)**

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. **Clinical and Educational Work Hour Exceptions**

VI.F.4.a) **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:**

VI.F.4.a).(1) **to continue to provide care to a single severely ill or unstable patient; (Detail)**

VI.F.4.a).(2) **humanistic attention to the needs of a patient or family; or, (Detail)**

VI.F.4.a).(3) **to attend unique educational events. (Detail)**

VI.F.4.b) **These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)**

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

VI.F.4.c) **A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**

The Review Committee for Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.F.4.c).(1) **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. (Core)**

VI.F.4.c).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)**

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

Background and Intent: This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time

residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

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***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†**Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡**Outcome Requirements:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition
For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

MOCA 2.0® Part 1: Medical License

For the Medical License (Professionalism and Professional Standing) requirement, ABA diplomates must hold an active, unrestricted license to practice medicine in at least one jurisdiction of the United States (U.S.) or Canada. Furthermore, all U.S. and Canadian medical licenses that a diplomate holds must be unrestricted. Diplomates must advise us of any and all restrictions placed on any of their medical licenses and provide complete information concerning such restrictions within 60 days after their imposition.

To be considered "Participating in MOC" for this requirement, diplomates should annually update their medical license information via their portal account. View all of the requirements that need to be completed by Years 5 and 10 to be considered as "Participating in MOC." (/MOCA/About-MOCA-2-0#MOCparticipation)

Click here for instructions on how to update your medical license in your portal (/PDFs/MOCA/MOCA-Part-1-Update-Medical-License.pdf).

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- About MOCA 2.0 (/MOCA/About-MOCA-2-0)
- MOCA 2.0 New Features (/MOCA/MOCA-2-0-New-Features)
- MOCA 2.0: What You Need to Know (/MOCA/MOCA-2-0-What-You-Need-to-Know)
- MOCA 2.0 Registration (/MOCA/MOCA-2-0-Registration)
- MOCA 2.0 Part 1 (/MOCA/MOCA-2-0-Part-1)
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- MOCA Activity Providers (/MOCA/MOCA-Activity-Providers)
- Status Designations (/MOCA/Status-Designations)

MOCA 2.0® Part 2: CME

The CME (Lifelong Learning and Self-Assessment) requirement is 250 credits of CME activities that meet the following criteria:

- All credits must be Category 1 CME activities:
  - ACCME/AMA PRA-approved
  - American Osteopathic Association Category 1-A
  - Accredited CPD credits issued by the Royal College of Physicians of Canada and the Association of Faculties of Medicine of Canada
- No more than 70 credits per calendar year (completed between 2006 and 2012) will be credited toward the requirement
- No more than 60 credits per calendar year (completed in or after 2013) will be credited toward the requirement
- At least 20 credits of ABA-approved Patient Safety CME

Self-Assessment CMEs are no longer required. If you previously completed Self-Assessment CME, you will receive credit for them in MOCA 2.0®. You will also receive CME credit if you complete Self-Assessment CMEs in the future.

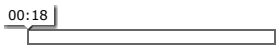
You must submit half of your CMEs (125) by the end of Year 5 of your 10-year MOCA cycle and all 250 CMEs by the end of Year 10.

View all of the requirements that need to be completed by Years 5 and 10 to be considered as "Participating in MOC." (/MOCA/About-MOCA-2-0#MOCparticipation)

Submitting CMEs:

You should submit your CME activities to us in your portal account. Self-reported CME activities are subject to audit and verification within three years of submission. CME activities reported to us by qualified CME providers, such as the ASA, are not subject to audit and are now automatically credited to your account.

How to Report CME in Your Portal



- How to Report CME Activities PDF (/PDFs/MOCA/MOCA-Part-2-Submit-CME)
- List of ABA-Approved Patient Safety CME (/PDFs/MOCA/ABA-Approved-PS-CME)
- CME Activity Classification (/PDFs/MOCA/MOCA-Part2-CME-Classification-AMA)
- Registered CME Providers (/PDFs/MOCA/Registered_CME_Providers)
- How to Become a Registered CME Provider (/PDFs/MOCA/How_to_Become_a_Registered_CME_Provider)

The American Board of Anesthesiology® is a Member Board of the American Board of Medical Specialties.

Sept. 28-Oct. 1

REQUEST DUPLICATE CERTIFICATE (/PDFS/FOOTER/DUPLICATE-CERTIFICATE-REQUEST)

NAME CHANGE (/PDFS/FOOTER/NAME-CHANGE)

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STATUS DESIGNATIONS (/DIPLOMATES/STATUS-DESIGNATIONS)

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Part 3: MOCA Minute®

MOCA Minute® is an interactive learning tool that replaces the MOCA Exam as the MOCA Part 3: Assessment of Knowledge, Judgment, and Skills (formerly the Cognitive Examination). It consists of multiple-choice questions like those typically on MOCA exams.

MOCA Minute allows you to continuously assess your knowledge, fill knowledge gaps and demonstrate your proficiency. You need to answer 30 questions per calendar quarter **(120 per year by 11:59 p.m. EST on Dec. 31)**, no matter how many certifications you are maintaining. View all of the requirements that need to be completed by Years 5 and 10 to be considered as "Participating in MOC." (/MOCA/About-MOCA-2-0#MOCparticipation)

We encourage you to answer your MOCA Minute questions over time, rather than all of them in one day, to promote continuous learning and knowledge retention. You cannot answer more than 30 questions per calendar quarter and cannot answer more than 30 questions per day. You will receive similar questions over time on some of the same topics to gauge whether you have retained your knowledge.

You may access MOCA Minute questions in three ways – weekly email reminders, in your portal account or on the MOCA Minute mobile app. Once you access a question, you will have 60 seconds to answer it. Whether the question is answered correctly or not, the correct answer, rationale and links to additional resource materials are displayed on the screen.

MOCA Minute® Performance Standard

Given the innovative nature of the MOCA Minute longitudinal assessment, we are using a new approach to evaluate diplomates' performance. It is called Measurement Decision Theory (MDT) and is a statistical model that estimates the likelihood or probability that our diplomates are keeping their specialty-specific knowledge up-to-date based on their pattern of responses to MOCA Minute questions.

Diplomates who answer 120 MOCA Minute questions each year by 11:59 p.m. EST on Dec. 31 and maintain an MDT probability or p-value of ≥ 0.10 are meeting the MOCA Minute standard. **Any questions that you do not answer by 11:59 p.m. EST on Dec. 31 will be counted as incorrect.** We chose this p-value based on an initial analysis of diplomates' MOCA Minute responses and the historical pass rates for the MOCA examination. If you are not meeting the MOCA Minute performance standard in the year your certification expires, you have the option to take the Anesthesiology Special Purpose Examination (ASPEX) for the certificate(s) you are maintaining (Anesthesiology, Critical Care Medicine and/or Pain Medicine) as a secondary assessment. If you take and pass the ASPEX, you will complete the MOCA Minute component of the program.

We set a standard using MDT to ensure that diplomates continue to demonstrate they have the knowledge and skills required of a board-certified anesthesiologist. Using MOCA Minute and the MDT model, the vast majority of diplomates will meet the standard, as they have with the MOCA Exam. We will make decisions about diplomates' certification status based on their performance in all four components of the MOCA 2.0® program, not just MOCA Minute. View all of the requirements that need to be completed by Years 5 and 10 to be considered as "Participating in MOC." (/MOCA/About-MOCA-2-0#MOCparticipation)

We created three short videos to provide more information about MOCA Minute and to introduce MDT.

Why MOCA Minute?

What is Measurement Decision Theory?

How to get the most out of the MOCA Minute process

If you are a diplomate and want to review your MOCA Minute performance, log into your portal account (https://portal.theaba.org) and click on "Review Your Progress" under the gray MOCA bar on your home page. Your MOCA Minute performance will be displayed in the Part 3 section of your Certification Summary.

- **MOCA 2.0 Content Outline (/PDFs/MOCA/MOCA-Content-Outline)**
- **MOCA Minute overview presentation (/PDFs/MOCA/MOCA-Minute-Presentation)**
- **MDT Infographic (http://info.theaba.org/acton/attachment/34108/f-4b77253e-b2c9-45a6-8dc7-4614b3054832/0/-/-/-/-/MDT-Infographic.pdf)**
- **Sample MDT Calculation (/PDFs/MOCA/Sample-MDT-Calculation)**

MOCA Minute® Mobile App

(http://www.abms.org/)

The American Board of Anesthesiology® is a Member Board of the American Board of Medical Specialties.

Upcoming Dates

APPLIED Exam Week 7.5
July 18-19

APPLIED Exam Week 8
Sept. 14-17

APPLIED Exam Week 9
Sept. 28-Oct. 1

Quick Links

CREATING A PORTAL ACCOUNT (/PDFS/FOOTER/HOW_TO_CREATE_A_PORTAL_ACCOUNT_AND_APPLY)

RESIDENT PORTAL TIPS (/PDFS/FOOTER/RESIDENT-PORTAL-ACCOUNT-TIPS)

REQUEST DUPLICATE CERTIFICATE (/PDFS/FOOTER/DUPLICATE-CERTIFICATE-REQUEST)

NAME CHANGE (/PDFS/FOOTER/NAME-CHANGE)

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MOCA 2.0® Part 4: Quality Improvement

For the Quality Improvement (Part 4) requirement, diplomates must complete multiple activities during their 10-year MOCA® cycle to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement activities.

Diplomates can choose activities that are most relevant to their practice. Points are awarded for each activity based on the time and effort associated with their completion. Diplomates must earn a minimum of 50 Part 4 points during their 10-year cycle in MOCA 2.0® (25 points during Years 1-5 and 25 points during Years 6-10). Diplomates will complete an attestation of their clinical activity in Year 9 as part of MOCA 2.0 registration; however, they no longer need to submit references. View all of the requirements that need to be completed by Years 5 and 10 to be considered as "Participating in MOC." (/MOCA/About-MOCA-2-0#MOCparticipation)

You no longer need to upload templates or documentation in your account. Just select the activity completed from the dropdown list, enter the time spent completing it, and click submit. All self-reported activities are subject to audit for eight weeks after submission. Documentation may be requested, if audited.

- View Activity Examples (/PDFs/MOCA/MOCA-2-0-Part-4-Completed-Template-Examples)
- How to Report Activities in Your Portal (/PDFs/MOCA/MOCA-2-0-Part-4-Reporting-Instructions)

QI Videos

How to Report QI Activities

Implementing an Improvement Plan

Part 4 Activities

MOCA Simulation Course - ASA-endorsed Center

Description	Simulation that realistically replicates clinical scenarios that participants can work through in a manner similar to what they may experience in clinical practice. • Details on Simulation Education Courses and ASA Endorsed Simulation Centers (https://education.asahq.org/totara/mod/page/view.php?id=20716) At least one instructor must be an ABA diplomate participating in MOCA 2.0.
Point Value	Participants receive 20 points for completing the course and 5 additional points for completing the post-course survey and 30-day follow-up to document practice improvements.
Reporting Mechanism	The education provider will report completion of both components to us.

Other On-site Simulation Course

Description	Simulation that realistically replicates clinical scenarios that participants can work through in a manner similar to what they may experience in clinical practice.

	At least one instructor must be an ABA diplomate participating in MOCA 2.0.
Point Value	1 point per hour spent on the activity, up to 15 points.
Reporting Mechanism	Self-report completion based on how much time was spent on the activity.

Online Simulation

Description	Online simulation that realistically replicates clinical scenarios that participants can work through using computer technology. Thes • ASA Anesthesia SimSTAT (https://www.asahq.org/education-and-career/educational-and-cme-offerings/simulation-educatic **release new versions every three years.** • VHA DAARC (https://www.sharedfedtraining.org/external_content/DAARCweb/DAARC/index.html) (up to 6 points) If you ar url=https%3A%2F%2Fwww.train.org%2Fvha%2Fwelcome&data=02%7C01%7CDee.Chinnis%40theaba.org%7C8b9ae288 You will need to first create an account using Google Chrome and then conduct the search using the following ID number: 1 VHATRAIN@va.gov. (mailto:VHATRAIN@va.gov)
Point Value	1 point per hour spent on the activity, up to 25 points.
Reporting Mechanism	The ASA will report completion to us for Anesthesia SimSTAT. Self-report completion for VHA DAARC based on time spent on the activity.

Other ABMS Member Board Part 4 Activities

Description	Any MOC Part 4: Improvement in Medical Practice activity completed through another ABMS Member Board.
Point Value	1 point per hour spent on the activity, up to 25 points.
Reporting Mechanism	Self-report completion based on how much credit was granted by the other Board.

Institutional/Departmental Quality Improvement Project Leader

Description	The quality improvement (QI) project leader will initiate and/or guide the work of a QI project team and will serve as the "key contact" responsible for communicating with team members, stakeholders, and the ABA.
Point Value	1 point per hour spent on the activity, up to 25 points.
Reporting Mechanism	Self-report completion based on time spent on the activity.

Completing an Improvement Plan Based on:

Description	A process in which a diplomate implements changes designed to improve patient outcomes based on feedback from one of the following: • Quality data registries • Joint Commission's Focused Professional Practice Evaluation (FPPE) process • Joint Commission's Ongoing Professional Practice Evaluation (OPPE) process • 360 professional reviews • Patient experience of care surveys • ASA's Understanding the Relationship between Intraoperative Hypotension and Clinical Outcomes in Surgical Patients (https://www.asahq.org/shop-asa/e018g00w00) • ASA's Cases from the Perioperative Surgical Home: A Journey to Improve Quality and Patient Safety Part 1: New Hanover Regional Medical Center (https://www.asahq.org/shop-asa/e018g01w00) • ASA's Cases from the Perioperative Surgical Home: A Journey to Improve Quality and Patient Safety Part 2 (https://www.asahq.org/shop-asa/e019g01w00) • ASA's (https://www.asahq.org/shop-asa/e018g01w00)Cases from the Perioperative Surgical Home: A Journey to Improve Quality and Patient Safety - Part 3 (https://www.asahq.org/shop-asa/e019g02w00) (https://www.asahq.org/shop-asa/e019g02w00) • ASA's Continued Need for Neuromuscular Block Monitoring: A Journey to Improve Patient Safety and Patient Outcomes (https://www.asahq.org/shop-asa/e018g02w00) • ASA's Real World Experiences in Neuromuscular Blockade and Its Reversal: Case Studies from Various Practice Settings (https://www.asahq.org/shop-asa/e019g03w00)

	• ASA's Cases from the Perioperative Surgical Home: Transitioning the PSH to a Health System (https://www.asahq.org/shop-asa/e019g01w00) • ASA's Cases from the Perioperative Surgical Home: Dealing with Adversity by Focusing on Different Service Lines (https://www.asahq.org/shop-asa/e019g02w00) • ASA's (https://www.asahq.org/shop-asa/e019g01w00)Cases from the Perioperative Surgical Home: Scaling your PSH Clinical Operations Across Multiple Healthcare Facilities (https://www.asahq.org/shop-asa/e019g04w00) • Cases from the Perioperative Surgical Home - Perspectives on PSH: Implementation in an Academic Medical Center Part 5 (https://www.asahq.org/shop-asa/e019g05w00) • Neuromuscular Blockade in the Ambulatory Setting: Safe Practices (https://www.asahq.org/shop-asa/e019g09w00) • ACGME Program Evaluation and Improvement **NEW COVID-19 ACTIVITY** • intubateCOVID (https://intubatecovid.knack.com/registry#add-intubation/) (a global registry to track occupational exposures and health outcomes for anesthesia providers performing airway management procedures for patients with COVID-19 illness)
Point Value	1 point per hour spent on the activity, up to 25 points
Reporting Mechanism	The ASA will report your completion of their activities to us. You'll earn up to 7.5 points per activity (collected from modules 2 and 3 of each activity). For all other options, you will self-report completion based on time spent on the activity.

Clinical Pathway (CP) Development Leader

Description	A clinical pathway (CP) development leader will organize and guide development of structured multidisciplinary care plans to inform clinical practice based upon evidence-based guidelines while optimizing efficiency. The CP development leader will also serve as the "key contact" person responsible for communication with clinicians and administrative staff.
Point Value	1 point per hour spent on the activity, up to 25 points.
Reporting Mechanism	Self-report completion based on time spent on the activity.

Clinical Pathway (CP) Development Participant

Description	The clinical pathway participant will contribute to the development of structured multidisciplinary care plans to inform clinical practice based upon evidence-based guidelines while optimizing efficiency.
Point Value	1 point per hour spent on the activity, up to 15 points.
Reporting Mechanism	Self-report completion based on time spent on the activity.

ABMS Multi-Specialty Portfolio Program

Description	Individual healthcare organizations can apply and gain approval for administering group quality improvement activities.
Point Value	**Leaders:** 1 point per hour spent on the activity, up to 25 points. **Participants:** 1 point per hour spent on the activity, up to 20 points.
Reporting Mechanism	ABMS will report completion to us.

MPOG: ASPIRE Provider Feedback Emails

Description	Diplomates who practice at an active MPOG (Multicenter Perioperative Outcomes Group) site can receive a monthly performance feedback email from ASPIRE. They'll review their personal performance on ASPIRE quality measures to direct practice improvements. Learn how to become an MPOG member. (https://mpog.org/quality/moca/)
Point Value	1 point per hour spent on the activity up to 25 points

Reporting Mechanism	MPOG will report completion to us.

Case Evaluation/Presenting an M&M/Case Discussion/Practice Improvement CME

Description	A case evaluation is a process in which diplomates assess their practice and implement changes designed to improve patient outcomes. A Morbidity & Mortality (M&M) conference is a peer-review of adverse (or potentially adverse) patient outcomes, in order to learn from the experiences of care and to modify behavior and judgment to prevent or reduce the incidence of future errors or complications. A case discussion is a peer review discussion regarding a unique case or patient issue. Practice improvement CME is a process by which evidence-based performance measures and quality improvement interventions are used to help physicians identify patient care areas for improvement and change their performance. The accredited CME provider structures the activity as a 3-stage process.
Point Value	1 point per hour spent on the activity, up to 15 points
Reporting Mechanism	Self-report completion based on time spent on the activity.

Point-of-care Learning

Description	Point-of-care learning consists of self-directed knowledge acquired during the course of patient care.
Point Value	1 point per hour spent on the activity, up to 15 points
Reporting Mechanism	Self-report completion based on time spent on the activity. There is a minimum of one hour per case that must be reported within 31 days of case.

AQI NACOR: Measure Review and Quality Improvement Action Plan

Description	Diplomates who submit data to the Anesthesia Quality Institute's (AQI) National Anesthesia Clinical Outcomes Registry (NACOR) can review their data, track benchmarks and create and implement improvement plans based on their NACOR feedback. **Learn how to submit data to AQI. (https://www.aqihq.org/)**
Point Value	1 point per hour spent on the activity, up to 25 points
Reporting Mechanism	AQI will report completion to us.

Click here to see a **PDF list of MOCA 2.0 Part 4 activity options (/PDFs/MOCA/MOCA-2-0-Part-4-Requirements)**. Click here to see **how to report activities (/PDFs/MOCA/MOCA-2-0-Part-4-Reporting-Instructions)** in your portal.

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Supervision of Nurse Anesthetists

Physician anesthesiologists are highly trained medical specialists. They evaluate, monitor, and supervise patient care before, during, and after surgery. Additionally, they diagnose and treat any complications that may occur – from cardiac arrest to excessive bleeding. In recent years, a growing number of state nurse anesthetist associations have promoted legislation or regulation to diminish or eliminate laws requiring nurse anesthetists to work within the relationship of a physician. To ensure optimal patient safety, it is critical that states maintain requirements for physician involvement when non-physician anesthetists such as nurse anesthetists administer anesthesia.

Physician anesthesiologists have 12,000-16,000 hours of clinical patient care in their curriculum. Nurse anesthetists have 1,650 hours of patient care training in their curriculum. A physician's medical education prepares him or her to manage the comprehensive care of the patient in all situations, especially those complicated situations when an emergency arises,

Equally important as the difference in education and training is the difference in depth of knowledge. Physicians complete all courses relevant to the practice of medicine, including associated laboratory courses. The breadth of courses plus the duration and hours of course work allow for detailed, comprehensive medical knowledge that prepares the physician to provide a patient with an informed, supportable diagnosis. Nurse anesthetists take selected courses related to their areas of nursing focus. The limited number of courses plus the shorter duration and fewer hours do not allow for detailed, comprehensive knowledge.

A common arrangement for providing anesthesia care is through the Anesthesia Care Team. Based on their medical training and education, physician anesthesiologists are uniquely qualified to lead the Anesthesia Care Team. When physician anesthesiologists and nurses work together as a team, patients receive high-quality and safe anesthesia care. Nursing skills are important but cannot replace the training of a physician.

To learn more about the importance of the patient centered, physician-led anesthesia care team, visit www.asahq.org/WhenSecondsCount

anesthesiologist

noun

Save Word

To save this word, you'll need to log in.

Log In

an·es·the·si·ol·o·gist | \ ˌa-nəs-ˌthē-zē-ˈä-lə-jist \
plural anesthesiologists

Definition of *anesthesiologist*

: anesthetist specifically **:** a physician specializing in anesthesiology

Examples of *anesthesiologist* in a Sentence

Recent Examples on the Web The *anesthesiologist* and critical-care doctor went to work in his home garage with wire and plastic bags, and researched the sizes of various patient beds. — Laura Garcia, *ExpressNews.com*, "San Antonio doctor invents device to protect health care workers from COVID-19," 15 June 2020 Ternovan, who also attended Berea-Midpark High School, will be pursuing a nursing degree at the University of Cincinnati, with her sights set on becoming a nurse *anesthesiologist*. — Rich Heileman, *cleveland*, "Three area women win scholarships: Around The Town," 5 June 2020

These example sentences are selected automatically from various online news sources to reflect current usage of the word 'anesthesiologist.' Views expressed in the examples do not represent the opinion of Merriam-Webster or its editors. Send us feedback.

See More

First Known Use of *anesthesiologist*

1922, in the meaning defined above

Keep scrolling for more

Learn More about *anesthesiologist*

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Time Traveler for *anesthesiologist*

The first known use of *anesthesiologist* was in 1922

See more words from the same year

Dictionary Entries near *anesthesiologist*

anesone

anesthesia

TOP DEFINITIONS QUIZZES EXAMPLES EXPLORE DICTIONARY BRITISH

anesthesiologist or an·aes·the·si·ol·o·gist

[an-*uh* s-thee-zee-**ol**-*uh*-jist] SHOW IPA

noun

1 a physician who specializes in anesthesiology.

Definition of 'anesthesiologist'

Word Frequency

anesthesiologist

(ænɪsθiːziɒlədʒɪst)

Word forms: plural **anesthesiologists**

COUNTABLE NOUN

An **anesthesiologist** is a doctor who specializes in giving anaesthetics to patients.

[*US*]

REGIONAL NOTE:
in BRIT, use **anaesthetist**

AMA Advocacy Resource Center

"Truth in Advertising" campaign

Resource materials to support state legislative and regulatory campaigns

ama-assn.org/truth-advertising

Identifying the problem, providing a solution, taking action

The problem

Patients are confused about the differences between various types of health care providers. Often, patients mistakenly believe they are meeting with physicians (medical doctors or doctors of osteopathic medicine) when they are not. The American Medical Association (AMA) believes that patients deserve to have increased clarity and transparency in health care. There is no place for confusing or misleading health care advertising that has the potential to put patient safety at risk.

Patients are confused about health provider qualifications

With the escalating cost of health care and an ever-growing variety of health care choices, America's patients deserve to know who provides their health care, and exactly what their health care providers are qualified and licensed to diagnose, prescribe, and treat. Currently, patients mistake physicians with non-physician providers, and they do not know that certain medical specialists are physicians.

Is this person a medical doctor?[1]	Yes (%)	No (%)	Not sure (%)
Dentist	61	33	6
Podiatrist	67	22	11
Optometrist	47	43	10
Psychologist	43	50	7
Doctor of nursing practice	39	50	11
Chiropractor	27	63	10

Patients are not confident about the truth of health advertisements

Confusing and misleading ads undermine the reliability of our health care system. Unfortunately, only half of patients surveyed believe that it is easy to identify who is a physician—and who is not—by reading what services they offer, their title, and other licensing credentials in advertising and marketing materials.

Do you agree or disagree with the following?	Agree (%)	Disagree (%)	Don't know (%)
It is easy to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials	55	35	10

1. Baselice & Associates conducted an internet survey of 802 adults on behalf of the AMA Scope of Practice Partnership, July 12-19, 2018. The overall margin of error is +/- 3.5 percent at the 95 percent confidence level.

The solution

Confusion about who is and who is not qualified to provide specific patient care undermines the reliability of the health care system and can put patients at risk. People unqualified to perform health services can lead to medical errors and patient harm. The AMA urges lawmakers to take action to rectify this problem.

To help ensure patients can answer the simple question, "Who is a doctor?", the AMA believes that all health care professionals—physicians and non-physicians—should be required to accurately and clearly disclose their training and qualifications to patients.

Full disclosure: Americans want to know if a provider is not a physician

Asking medical professionals to display their credentials and capabilities allows patients to make informed choices about their health care. In fact, 88 percent of patients believe that health care providers should be required to display their level of training and legal licensure. This includes full disclosure in all advertising and marketing materials. In addition, while some non-physicians call themselves "doctor" by virtue of a doctoral degree, nearly nine out of 10 patients believe only a medical doctor or doctor of osteopathic medicine should be able to use the title "physician."

Do you agree or disagree with the following?	Agree (%)	Disagree (%)	Don't know (%)
Only licensed medical doctors or doctors of osteopathic medicine should be able to use the title "physician"	88	6	6

Uninformed choice leads to unintended consequences and potentially dangerous consequences. Patients look to physicians to treat serious conditions and care for their families. Allowing non-physicians to advertise that they treat conditions that they may not have the appropriate education and training to provide care for puts patients' safety at increased and unnecessary risk.

Taking action

Truth in advertising increases clarity and enhances reliability

The need for truth-in-advertising legislation transcends party lines, gender, race and geography. Patients overwhelmingly support stricter standards on medical advertising. Legislation is needed to require health care providers to clearly and honestly state their level of training, licensing and what procedures they may legally perform in all of their advertising and marketing materials.

Patients must be able to rely on what their health care providers tell them. Truth-in-advertising legislation helps patients do just that.

Survey results

Education and training matters when it comes to who provides your health care, but do most patients know the qualifications of their health care provider? A 2008[2] survey found that while patients strongly support a physician-led health care team, many are confused about the level of education and training of their health care provider. Follow-up surveys conducted in 2010[3], 2012[4] and 2014[5] confirmed that patients want a physician to lead the healthcare team. The surveys also underscored that patient confusion remains high. Key findings included:

- Ninety percent of respondents said that a physician's additional years of medical education and training (compared to a nurse practitioner) are vital to optimal patient care, especially in the event of a complication or medical emergency.
- Eighty-six percent of respondents said that patients with one or more chronic diseases benefit when a physician leads the primary health care team.
- Eighty-four percent of respondents said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care.

Truth-in-advertising legislation can help provide the clarity and transparency necessary for patients to have the information they need to make informed decisions about their health care.

Patients are not sure who is—and who is not—a physician[1]

Is this person a medical doctor?[1]	Yes (%)	No (%)	Not sure (%)
Orthopedic surgeon/orthopaedist	90	5	5
Obstetrician/gynecologist	88	6	6
Primary care physician	88	7	5
General or family practitioner	84	11	5
Dermatologist	80	13	8
Ophthalmologist	73	15	12
Psychiatrist	72	21	7
Anesthesiologist	70	22	8
Podiatrist	67	22	11
Dentist	61	33	6
Optometrist	47	43	10
Psychologist	43	50	7
Doctor of medical science	61	27	12

2. Global Strategy Group conducted a telephone survey on behalf of the AMA Scope of Practice Partnership Aug. 13–18, 2008. Global Strategy Group surveyed 850 adults nationwide. The overall margin of error is +/- 3.4 percent at the 95 percent confidence level.
3. Baselice & Associates conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between Nov. 4–8, 2010. Baselice & Associates surveyed 850 adults nationwide. The overall margin of error is +/- 3.4 percent at the 95 percent confidence level.
4. Baselice & Associates conducted a telephone survey on behalf of the AMA Scope of Practice Partnership between March 8–12, 2012. Baselice & Associates surveyed 801 adults nationwide. The overall margin of error is +/- 3.5 percent at the 95 percent level.
5. Baselice & Associates conducted an internet survey of 801 adults on behalf of the AMA Scope of Practice Partnership between May 1–June 6, 2014. The overall margin of error is +/- 3.5 percent at the 95 percent confidence level.

Is this person a medical doctor?[1]	Yes (%)	No (%)	Not sure (%)
Doctor of nursing practice	39	50	11
Chiropractor	27	63	10
Nurse anesthetist	21	71	8
Nurse practitioner	19	74	7
Physical therapist	19	74	7
Physician assistant	17	76	7
Midwife	5	86	9

Additional findings from the truth-in-advertising survey

Patients strongly prefer physicians to lead the health care team

Should only a MD or DO be allowed to perform the following procedures or should other health care professionals be allowed to perform this specific activity?[1]	Only a MD or DO (%)	Both equally/ either one (%)	Don't know (%)
Amputations of the foot	89	4	7
Surgical procedures on the eye that require the use of a scalpel	89	5	7
Facial surgery such as nose shaping and face lifts	85	7	8
Treat chronic pain by prescribing drugs or other substances that have a high potential for addiction or abuse	60	32	8
Write prescriptions for medication to treat mental health conditions such as schizophrenia and bi-polar disorder	63	28	9
Order and interpret diagnostic imaging studies like X-rays and MRIs	41	52	7
Administer and monitor anesthesia levels and patient condition before and during surgery	61	30	9
Commit individuals for psychiatric care against their wil	63	24	13

Patients want their health care professional to clearly designate their education and training

Do you agree or disagree with the following?[1]	Agree (%)	Disagree (%)	Don't know (%)
Only licensed medical doctors or doctors of osteopathic medicine should be able to use the title of "physician."	88	6	6
It is easy to identify who is a licensed MD or DO and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials?	55	35	10
I would support legislation to require all health care advertising materials to clarify designate the level of education, skills and training of all health care professionals promising their services.	79	6	15

Sample press release

FOR IMMEDIATE RELEASE MONTH, DAY, YEAR

STATE PATIENTS DESERVE TO KNOW WHO IS PROVIDING THEIR CARE.
MEDICAL SOCIETY proposes law to help end patient confusion about who is a "doctor."

CITY, STATE—In an effort to help provide clarity and transparency for STATE patients, MEDICAL SOCIETY recently introduced legislation that helps ensure patients know the education, training and licensure of their health care provider.

Under the "Health Care Professional Transparency Act," all health care professionals will have to wear a name tag during all patient encounters clearly identifying the type of license they hold. Health care professionals will also have to display their education, training and licensure in their office.

"We believe patients deserve to know whether the person they see is a physician, registered nurse, chiropractor or other medical professional," said MEDICAL SOCIETY SPOKESPERSON. "It's not enough information for patients to just hear, 'Hi, I'm your doctor.'"

This bill comes on the heels of a new survey that shows there is significant public confusion about the qualifications of different health care providers. These advertisements or websites must be free of deceptive or misleading information, and must identify the professional license.

[INSERT RELEVANT SURVEY RESULTS]

This bill also promotes "Truth in Advertising" among health care professionals by ensuring that any advertisements or professional websites they have do not promote services beyond what they are legally permitted to provide. These advertisements or websites must be free of deceptive or misleading information, and must identify the professional license.

"We want all health care professionals—physicians and non-physicians alike—to clearly display their education and licensure so that patients know who is providing their care," said SPOKESPERSON. "Providing patients upfront with the education, training and qualifications of health care professionals can help them make more informed decisions about their health care."

# # #

Frequently asked questions

Why is the AMA conducting a "Truth in Advertising" campaign?

The American Medical Association (AMA)—along with our state and specialty society partners—created the "Truth in Advertising" campaign to help ensure patients know the education, training and qualifications of their health care professionals. Many different health care professions now offer a "doctor" degree, but just using the title "Dr." does not help a patient know all they need to know. In fact, a recent survey found that patients overwhelmingly want all health care professionals—physicians and non-physicians alike—to clearly state their level of education, training and licensure.

Aren't there already laws that prevent deceptive advertising?

Many if not most states likely have consumer protection statutes to help protect consumers from false advertising, but what we're doing is a bit different. Because there has been an explosion of health care professionals with "doctor" degrees, we believe patients deserve to know what kind of doctor they are seeing. There is a great difference between a doctor of psychology and a medical doctor who practices psychiatry, for example.

What are the key elements of this campaign?

We would like to see all health care professionals—physicians and non-physicians alike—clearly display their education and licensure so that patients have relevant information about the person who is providing their care. The letters after someone's name might mean something to a health care professional, but without something more, patients will not know that a DO is a Doctor of Osteopathic Medicine, or that an AuD means a person has a doctorate of audiology.

Furthermore, we want to help ensure that when health care practitioners advertise their services, they are clear about what license they hold, and are not promising more than what their education, training and licensure permits.

Is this campaign an attempt to restrict the practice of non-physicians?

No. The AMA believes that efficient, high-quality health care requires all members of the health care team to work closely together. Every member of the health care delivery team plays an important role, but to ensure optimal care and patient safety, physicians and non-physicians must provide only the services that their education and training have prepared them to provide—and their licensure legally allows them to provide.

What would you say to critics who call this campaign a "turf battle"?

The "Truth in Advertising" campaign is about transparency for patients, patient education and patient safety. This campaign does not increase or limit anyone's scope of practice. Instead, this campaign increases the transparency of health care professionals' qualifications for patients, so that patients can clearly see and make informed decisions about who provides their care.

Is this legislation really necessary?
Yes. The Internet and other forms of communication provide almost limitless outlets for health care advertisements. We believe that for the health care system to operate most effectively, patients must be able to rely on their health care practitioner. We believe that legislators will be providing a proactive public service by requiring health care practitioners to be truthful in marketing themselves and their services.

Is false advertising of medical services really a problem?
The problem is real. Confusion about who is and who is not qualified to provide specific patient care undermines the reliability of the health care system and can put patients at risk. People unqualified to perform health services can lead to medical errors and cause patient harm. Bottom line: Patients deserve to know who is providing their care.

Even a brief amount of online research will uncover thousands of examples of potentially misleading or deceptive advertising from a variety of non-physician practitioners. And remember that this is not simply about misleading ads—it's about increasing transparency. Anyone can call themselves "doctor." We want patients to know whether that doctor is a physician, nurse, podiatrist, chiropractor, and so on. Titles and definitions matter because they influence patients.

How will this legislation help solve the confusion among patients?
This will alleviate confusion by making sure patients understand precisely what type of health care professional is treating them—a physician, nurse, assistant or technician.

Why is the AMA pushing this legislation now? Aren't there a lot bigger problems in our health care system?
Improving the nation's health care system requires looking at many issues. This legislation will help empower patients to take a more active role in their health care and become more informed about the qualifications and training of health care professionals.

Who did your survey and what methodology was used?
Baselice & Associates conducted an internet survey of 802 adults on behalf of the AMA Scope of Practice Partnership, July 12-19, 2018. The overall margin of error is +/- 3.5 percent at the 95 percent confidence level.

"Health Care Professional Transparency Act": A model bill created by the AMA

Purpose

The purpose of this model bill is to help provide clarity and transparency for patients when they seek out and go to a health care practitioner. Due to the explosion of professional and quasi-professional titles employing the term "doctor," patients are confused about the training and education of health care practitioners. This model bill helps ensure that patients are promptly and clearly informed of the training and qualifications of their health care practitioner.

Definition

This model bill defines "deceptive" or "misleading" advertisements and any advertisement or affirmative communication or representation that mis-states, falsely describes, holds out or falsely details the health care practitioner's profession, skills, training, expertise, education, board certification or licensure.

The model bill also includes definitions for several different types of health care practitioner, including medical doctors, doctors of osteopathic medicine, podiatrists, chiropractors, dentists, optometrists, naturopaths, physician and medical assistants, psychologists, therapists, audiologists and counselors. Medical societies using this model bill will need to determine which definitions to include in their legislation.

Requirements

There are three main requirements under this model bill. First, the health care practitioner must wear a name tag during all patient encounters that clearly identifies the type of license held by the health care practitioner. Second, the health care practitioner must display in his or her office a writing that clearly identifies the type of license held by the health care practitioner. Third, the health care practitioner must identify his or her license in all advertisements for health care services. These ads must be free from deceptive or misleading information.

Violations and enforcement

The model bill provides that it is a violation to knowingly aid, assist, procure, employ or advise any unlicensed person to practice or engage in acts contrary to the health care practitioner's degree of licensure. It also is a violation to delegate or contract for the performance of health care services to a person that does not have the required authority to provide the health care services.

Violators under this model bill are guilty of unprofessional conduct and subject to disciplinary action under the health care practitioner's licensing statute. Of note, this model bill does not provide for criminal penalties, although a state may wish to pursue that course.

Model legislation

IN THE GENERAL ASSEMBLY
STATE OF _____

Health Care Professional Transparency Act

Be it enacted by the People of the State of _____, represented in the

General Assembly:

Section 1. Title

This act shall be known and may be cited as the "Health Care Professional Transparency Act."

Section 2. Purpose

The Legislature hereby finds and declares that:

(a) There are a multitude of professional degrees using the term "doctor," including Medical Doctor (MD); Doctor of Osteopathic Medicine (DO); Doctor of Dental Surgery (DDS) Doctor of Podiatric Medicine (DPM); Doctor of Optometry (OD); Doctor of Chiropractic (DC); and other designations which may be used by health care practitioners.

(b) A July 2018 study by the American Medical Association found that twenty-seven (27) percent of patients believe that a chiropractor is a medical doctor; thirty-nine (39) percent of patients believe that a doctor of nursing practice is a medical doctor; forty-three (43) percent of patients believe that a psychologist is a medical doctor; forty-seven (47) percent of patients believe that an optometrist is a medical doctor; and sixty-seven (67) percent of patients believe a podiatrist is a medical doctor.

(c) There are widespread differences regarding the training and qualifications required to earn the professional degrees described in and subject to this act. These differences often concern the training and skills necessary to correctly detect, diagnose, prevent and treat serious health care conditions.

(d) There is a compelling state interest in patients being promptly and clearly informed of the training and qualifications of the health care practitioners who provide health care services.

(e) There is a compelling state interest in the public being protected from potentially misleading and deceptive health care advertising that might cause patients to have undue expectations regarding their treatment and outcome.

Section 3. Definitions

For the purposes of this act:

(a) "Advertisement" denotes any communication or statement, whether printed, electronic, or oral, that names the health care practitioner in relation to his or her practice, profession, or institution in which the individual is employed, volunteers or otherwise provides health care services. This includes business cards, letterhead, patient brochures, email, Internet, audio and video, and any other communication or statement used in the course of business.

(b) "Deceptive" or "misleading" includes, but is not limited to, any advertisement or affirmative communication or representation that mis-states, falsely describes, holds out or falsely details the health care practitioner's profession, skills, training, expertise, education, board certification or licensure.

(c) "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation.

Drafting note re: Health care practitioner—*to provide further guidance on different types of health care practitioners that a state may wish to include as a subset under this "Definitions" provision, this drafting note provides the following suggestions.*

Categories of health care practitioner include:

(1) Practitioners of allopathic medicine, signified by the letters "MD" or the words surgeon, medical doctor, or doctor of medicine by a person licensed to practice medicine and surgery.

(2) Practitioners of osteopathic medicine, signified by the letters "DO" or the words surgeon, osteopathic surgeon, osteopath, doctor of osteopathy, or doctor of osteopathic medicine.

(3) Practitioners of nursing, signified by the letters "DNP," "NP," "RN," "LPN," "CRNA," "CNA," or any other commonly used signifier to denote a doctorate of nursing practice, nurse practitioner, registered nurse, licensed practical nurse, certified registered nurse anesthetist, or certified nurse assistant, respectively, as appropriate to signify the appropriate degree of licensure and degree earned from a regionally accredited institution of higher education in the appropriate field of learning.

(4) Practitioners of podiatry, signified by the letters "DPM" or the words podiatrist, doctor of podiatry or doctor of podiatric medicine.

(5) Practitioners of chiropractic, signified by the letters "DC" or the words chiropractor or doctor of chiropractic.

(6) Practitioners of dentistry, signified by the letters "DDS" or "DMD", as appropriate, or the words dentist, doctor of dental surgery, or doctor of dental medicine, as appropriate.

(7) Practitioners of optometry, signified by the letters "OD" or the words optometrist or doctor of optometry.

(8) Practitioners of naturopathy, signified by the letters, "ND" or the words naturopathic doctor or doctor of naturopathy.

(9) Physician assistants, signified by the letters "PA" or the words physician assistant.

(10) Medical assistants, signified by the letters "MA" or the words medical assistant.

(11) Practitioners of audiology, signified by the letters "AuD," "ScD," or "PhD," or the words audiologist or doctor of audiology.

(12) Psychologists, pharmacists, physical therapists, speech-language pathologists, counselors, or any other health care practitioner not covered under this section, including but not limited to those signified by the letters "PhD," "EdD," "PharmD," "PT," "MPT," "PsyD," or "ScD," as appropriate to signify the appropriate degree of licensure and degree earned from a regionally accredited institution of higher education in the appropriate field of learning.

(d) "Licensee" means a health care practitioner who holds an active license with the licensing board governing his or her practice in this state.

Section 4. Requirements

(a) An advertisement for health care services that names a health care practitioner must identify the type of license held pursuant to the definitions under this act. The advertisement shall be free from any and all deceptive or misleading information.

Drafting note re: Board certification—*to provide further guidance on an additional type of requirement related to MD or DO board certification, this drafting note provides the following sample.*

A medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or "board certified," unless all of the following criteria are satisfied:

(a) The advertisement states the full name of the certifying board.

(b) The board either:

1. Is a member board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); or

2. Is a non-ABMS or non-AOA board that requires as prerequisites for issuing certification:

(i) successful completion of a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified by the non-ABMS or non-AOA board;

(ii) certification by an ABMS or AOA board covering that training field that provides complete ACGME or AOA-accredited training in the specialty or subspecialty certified by the non-ABMS or non-AOA board; and

(iii) successful passage of examination in the specialty or subspecialty certified by the non-ABMS or non-AOA board.

(b) A health care practitioner providing health care services in this state must conspicuously post and affirmatively communicate the practitioner's specific licensure as defined under this act. This shall consist of the following:

1. The health care practitioner shall wear a photo identification name tag during all patient encounters that shall include (i) a recent photograph of the employee; (ii) the employee's name; (iii) the type of license (e.g., "medical doctor", "psychologist", "nurse practitioner", "podiatrist"); and (iv) the expiration date of the license. The name tag shall be of sufficient size and be worn in a conspicuous manner so as to be visible and apparent.

2. The health care practitioner shall display in his or her office a writing that clearly identifies the type of license held by the health care practitioner. The writing must be of sufficient size so as to be visible and apparent to all current and prospective patients.

(c) A health care practitioner who practices in more than one office shall be required to comply with these requirements in each practice setting.

(d) A medical doctor or doctor of osteopathic medicine who supervises or participates in collaborative practice agreements with non-MD or non-DO health care practitioners shall be required to conspicuously post in each office a schedule of the regular hours when he or she will be present in that office.

(e) Health care practitioners working in non-patient care settings, and who do not have any direct patient care interactions, are not subject to the provisions of this act.

Drafting note re: Exceptions—*To provide further guidance on different types of exceptions provisions, this drafting note provides a representative sample from states with truth in advertising laws.*

California, Nevada, Tennessee and West Virginia waive any name tag requirements for health care practitioners who provide services in certain medical facilities such as medical research laboratories, community mental health facilities, and other medical facilities where the person does not provide services directly to the public.

Texas, Illinois and Utah require that health care providers who are providing direct patient care at the hospital must where a photo identification badge during all patient encounters, unless precluded by sterilization or isolation protocols.

Maine, Mississippi and Illinois provide that health care practitioners working in non-patient care settings, and who do not have any direct patient care interactions, are not subject to provisions regarding the use of a name badge/identification during the course of service.

Pennsylvania and Utah provide an exemption when wearing a badge would not be clinical feasible.

Pennsylvania, Utah, and West Virginia allow the last name of the employee to be concealed or omitted when the employee is concerned about his or her safety, when delivering direct care to a consumer who exhibits signs of irrationality or violence, or when wearing identification would jeopardize the health care provider's safety.

Utah exempts solo health care practitioners or offices where the license type and names of all health care providers in the office are displayed on the office door.

Section 5. Violations and enforcement

(a) Failure to comply with any provision under this Section shall constitute a violation under this act.

(b) Knowingly aiding, assisting, procuring, employing or advising any unlicensed person or entity to practice or engage in acts contrary to the health care practitioner's degree of licensure shall constitute a violation under this act.

(c) Delegating or contracting for the performance of health care services by a health care practitioner when the licensee delegating or contracting for performance knows, or has reason to know, the person does not have the required authority pursuant to the person's licensure, shall constitute a violation under this act.

(d) Each day this act is violated shall constitute a separate offense and shall be punishable as such.

(e) Any health care practitioner who violates any provision under this act is guilty of unprofessional conduct and subject to disciplinary action under the appropriate licensure provisions governing the respective health care practitioner.

(f) Any and all fees and other amounts billed to and paid by the patient shall be effectively rescinded and refunded. This includes third parties contracted to collect fees on behalf of the health care practitioner, the health care practitioner's employer, or other entity contracting with the health care practitioner.

(g) The imposition of professional sanctions, administrative fees or other disciplinary actions shall be publicly reported in a journal of official record.

(h) Notwithstanding the imposition of any penalty, a professional licensing board or other administrative agency with jurisdiction may seek an injunction or other legal means as appropriate against a person or entity violating this act.

Drafting note re: Enforcement—*to provide further guidance on different types of enforcement provisions, this drafting note provides a representative sample from eight states with truth-in-advertising-type laws.*

California. Current law requires a health care practitioner to display the type of license, highest level of academic degree and the name of a certifying board or association (if applicable) in writing at the patient's initial office visit or in a prominent display in an office area visible to patients. Violators are guilty of a misdemeanor, may result in license revocation or suspension, "or other disciplinary action including an administrative fine not to exceed $10,000." (Cal. Bus. & Prof. Code § 651 (2010)).

Florida. Current law requires health care practitioners to inform patients about their credentials. Violations for misleading or deceptive statements, or offering to practice beyond one's scope of practice, include professional licensure sanctions, suspension, restrictions and probation. Violators also may be subject to administrative fines and be forced to undergo "remedial education." (Fla. Stat. § 456.072 (2006)).

Georgia. Current law provides that "Any person willfully violating, with intent to defraud, subsection (a) of this Code section shall be guilty of a misdemeanor." (Ga. Code Ann. §10-1-422 (2006)).

Illinois. Under current law, advertisements for health care services must identify the license of the health care professional and be free of deceptive or misleading information. The law also requires a health care professional to clearly communicate his or her licensure on a visible name tag or office display. Violators are guilty of unprofessional conduct and subject to disciplinary action at the discretion of the state medical board. (225 ILCS § 145 (2010)).

New Hampshire. Current law is limited to health care practitioners being required to wear name tags or some other form of identification that "readily discloses the name, licensure status, if any, and staff position." Violations are limited to fines "of no more than $50 on the facility per infraction." (N.H. Rev. Stat. Ann. § 151:3-b (1999)).

Oklahoma. Current law provides that any advertisement must include a notice stating "If you find anything in this communication to be inaccurate or misleading, you may report the same by writing to [the MD or DO medical board]." The law also deems violations of the appropriate health care practitioner licensing act. An amendment enacted in 2010 provides that nine classes of health professionals may use the title "doctor" or "Dr." in conjunction with appropriate licensing designation. The amendment requires a provider to identify in any advertisement for health care services the type of license, using the applicable words for the profession. Violators are subject to fines; repeated or gross violations will be referred to the Attorney General. (O.S. § 59-725.1-3 (2010)).

Tennessee. Current law provides a requirement that all licensed health care practitioners in the state keep their "certificate of registration" in a conspicuous place, and the certificate contain the "recognized professional abbreviation or designation" after the practitioner's name. An amendment enacted in 2011 expands the categories of health care practitioners who are required to communicate this information, and requires disclosure of licensure on Internet advertisements. Violations, including civil penalties, suspension or license revocation, are at the discretion of the respective health care licensing boards. (Tenn. Code Ann. § 63-1-109 (2011) [Amended effective January 1, 2012]).

Utah. Current law requires all licensed health care providers to include their name and license type in any advertisement for health care services. Violations are considered unprofessional conduct. (Utah Code Section § 58-1-501.6 (2011)). See also, Ariz. Rev. Stat. § 32-3213.

Section 6. Effective date

This act shall become effective immediately upon being enacted into law.

Section 7. Severability

If any provision of this act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this act, and to this end the provisions of this act are hereby declared severable.

State bill summaries

Minnesota SF 482 (2017)

Background

On May 17, 2017, the governor of Minnesota signed Senate File (SF) 482, which amended the medical practice act to prohibit any individuals other than medical doctors or doctors of osteopathic medicine from using terms including "medical doctor," "physician," or "surgeon."

Title Protection

A person not licensed to practice medicine is prohibited from using the title "doctor of medicine," "medical doctor," "doctor of osteopathic medicine," "osteopathic physician," "physician," "surgeon," "M.D.," or "D.O." in the conduct of any occupation or profession pertaining to the diagnosis of human disease or conditions. Health care professionals are allowed, however, to incorporate any of these words into the professional's title, if the title or designation is permitted under the health care professional's practice act.

Georgia HB 416 (2015)

Background

On May 12, 2015, the governor of Georgia signed House Bill (HB) 416, the Consumer Information and Awareness Act, which requires advertisements for health care services to identify the type of license the health care practitioner holds, and required health care practitioners to wear a name badge displaying the practitioner's type of license or educational degree, subject to certain exceptions.

Disclosure Requirements

The law requires an advertisement by a health care practitioner to identify the type of license the health care practitioner holds. The law exempts health care practices or facilities in which multiple health care practitioners are employed, and does not require such practice or facilities to list in an advertisement the name of every employed health care practitioner.

The law requires health care practitioners to wear an identifier during all patient encounters that includes:

- The health care practitioner's name; and
- The type of license or educational degree the health care practitioner holds.

The identifier must be of sufficient size and be worn in a conspicuous manner so as to be visible and apparent. A lab coat or similar distinguishing clothing or uniform indicating the practitioner's specific licensure may be considered an identifier if such clothing or uniform meets the requirements of division (i) of this subparagraph (name and license).

An identifier is not required:

- In an operating room or other setting where surgical or other invasive procedures are performed or in any other setting where maintaining a sterile environment is medically necessary; or
- In any mental health setting where it would impede the psychotherapeutic relationship.

If a safety or health risk to the health care practitioner or a patient would be created as a result of the practitioner wearing such identifier in a specified practice setting, an identifier shall not be required or may be modified by omitting or concealing the last name of the practitioner in accordance with the requirements of the health care practice or facility.

A health care practitioner in a health care practice or facility other than a hospital must display in the reception area of such practice or facility a notice that clearly identifies the type of health care practitioners employed in such practice or facility and the right of a patient to inquire as to the type of license of the health care practitioner treating such patient. The notice must be of sufficient size so as to be visible and apparent to all current and prospective patients.

Health care practitioners who practice in a non-patient care setting and who do not have any direct patient care interactions are not subject to this law.

Texas SB 1753 (2015)

Background

On May 5, 2015, the governor of Texas signed Senate Bill (SB) 1753, which modified a law adopted in 2013 (SB 945) requiring all licensed health care providers to wear a name badge displaying the health care provider's type of license and name, subject to certain exceptions.

Purpose

The Amendment requires that hospitals adopt a policy requiring a health care provider providing direct patient care at the hospital to wear a photo identification badge during all patient encounters unless precluded by adopted isolation or sterilization protocols.

Definitions

"Health care provider" is defined as any person who provides health care services at a hospital as a physician, as an employee of the hospital, under a contract with the hospital, or in the course of a training or educational program at the hospital.

The titles allowed for each category of health care provider are defined in Texas Health and Safety Code Section 241.009(c).

Utah SB 137 (2014)

Background

On March 28, 2014, the governor of Utah signed Senate Bill (S.B.) 137, which requires all licensed health care providers to wear a name badge displaying the health care provider's type of license and name, subject to certain exceptions.

Definitions

"Badge" means a tag or badge in plain view (i) attached to a health care provider's clothing; or (ii) hanging from a lanyard around a health care provider's neck.

"Clothing" means a health care provider's outermost article of clothing that is visible to others.

"Deceptive or misleading conduct" means any affirmative communication or representation that falsely states, describes, holds out, or details an individual's licensure, training, education, or profession.

"Health care provider" means a natural person who is: (i) defined as a health care provider in Section 78B-

3-403; and (ii) licensed under this title.

"License type" means a designation of the license type that satisfies the requirements of Section 58-1-501.6.

"Patient encounter" means an interaction in a health care facility, health care clinic, or office in which a patient can see a health care provider delivering services directly to a patient.

Disclosure requirements

Beginning Jan. 1, 2015, except as provided below, a health care provider shall wear identification during any patient encounter. The identification must be a badge or stitching, or permanent writing in plain view on clothing that:

- includes the health care provider's name;
- includes the license type held by the health care provider;
- is worn in a manner that is visible and apparent to others; and
- contains the information required by (i) and (ii):
    - in a manner and of sufficient size that can be easily read; and
    - on both sides of the badge, unless the badge or tag is attached to clothing in a way that prevents the badge from rotating.

An individual who is a student or is in training to obtain a license as a health care provider shall wear identification during patient encounters that identifies the person as in training, or a student, for the particular license type.

Exceptions

A health care provider's identification may be covered if required under sterilization or isolation protocols.

A health care provider is not required to wear identification:

- if wearing identification would jeopardize the health care provider's safety; or
- in an office in which
    - the license type and names of all health care providers working in the office are displayed on the office door; or
    - (i) each health care provider working in the office has the health care provider's license posted prominently in the office and readily visible to a patient; and

      (ii) if the office is an office of a solo health care provider or of a single type of health care provider.

Violations

It is unprofessional conduct if a health care provider violates this section. It is unlawful conduct if an individual: (a) wears identification in a patient encounter that suggests that the individual is practicing or engaging in an occupation or profession that the individual may not lawfully practice or engage in under this title; or (b) engages in deceptive or misleading conduct.

West Virginia SB 602 (2014)

Background

On March 6, 2014, the Governor of West Virginia signed S.B. 602, an act requiring health care providers to wear identification badges.

Definitions

"Direct patient care" means health care that provides for the physical, diagnostic, emotional or rehabilitation needs of a patient or health care that involves examination, treatment or preparation for diagnostic tests or procedures.

"Employee" means an employee or contractor of a health care providers who employ at least three licensed practitioners or more than ten employees, or a person who is granted privileges by a health care provider who delivers direct patient care.

"Health care provider" means an individual, partnership, corporation, facility, hospital or institution licensed or certified or authorized by law to provide professional health care service in this state to a patient during that patient's medical, remedial or behavioral health care, treatment or confinement.

"Secretary" means the Secretary of the West Virginia Department of Health and Human Resources. The secretary may define in rules any term or phrase used in this article which is not expressly defined.

Identification badge requirements

The act requires employees to wear an identification badge when providing direct patient care. The identification badge must be worn in a conspicuous manner so as to be visible and apparent.

The Secretary of the Department of Health and Human Resources, in consultation with appropriate health care provider professional licensing boards, shall propose rules to implement the provisions of this article. These rules shall include, at a minimum:

- The contents of the identification badge, which shall at least include the name of the employee and title of the employee;
- The title to be used to identify employee licensure information;
- The appearance of the identification badge, which shall have the title of the employee as large as possible in block type: Provided, that health care facilities providing identification badges prior to enactment of this article shall not be required to issue new badges; and
- The process and procedure for seeking an exemption from the requirements of this article.

Exceptions

An employee shall not be required to wear an identification badge while delivering direct patient care if it is not clinically feasible.

The last name of the employee may be omitted or concealed from an identification badge when delivering direct patient care if the employee is concerned for his or her safety.

An employee may petition the secretary for an exemption from the requirements of this article for reasons that are not set forth in this section.

An employee providing direct patient care in a behavioral health care setting may not be required to wear an identification badge.

Violations

A person may file a complaint with the practitioner's licensing board regarding a health care practitioner who fails to provide the consumer with the information required in the Act.

A health care practitioner who violates this section is guilty of unprofessional conduct and will be subject to disciplinary action based on the specific law(s) governing his or her license.

The licensing board may impose requirements for professional conduct and advertising on a health care practitioner in addition to the requirements of the Act.

Maryland SB 512 (2013)

Background

On May 16, 2013, the governor of Maryland approved Senate Bill (S.B.) 512, which creates requirements regarding the use of identification badges during work hours by health care practitioners.

Definitions

"Health care practitioner" means a person who is licensed, certified, or otherwise authorized under the Health Occupations article to provide health care services in the ordinary course of business or practice of a profession.

Disclosure requirements

When providing health care to a patient, a health care practitioner must wear a badge or other form of identification that clearly displays the health care practitioner's name and the type of license the health care practitioner holds.

Senate Bill 512 applies only to a health care practitioner who practices in a freestanding ambulatory care facility, a physician's office, or an urgent care facility. A badge or other form of identification is not required to be worn if:

- The patient is being seen in the office of a health care practitioner who is a solo practitioner and the name and license of the health care practitioner can be readily determined by the patient from a posted license or sign in the office; or
- The patient is being seen in an operating room or other setting where surgical or other setting where surgical or other invasive procedures are performed or any other setting where maintaining a sterile environment is medically necessary.

Each occupations board may adopt regulations to implement S.B. 512. If the board finds it necessary for the patient or health care practitioner's safety, or for therapeutic concerns, the board may provide exemptions from wearing a badge or other form of identification or allow use of the health care practitioner's first name only.

Violations

A violation may be reported to the health occupations board that licensed or certified the health care practitioner. A health occupations board may then send an advisory letter or a letter of education to the health care practitioner. Such a letter sent under S.B. 512 is confidential and may not be publicly reported as a disciplinary action.

Maine LD 727 (2013)

Background

On June 18, 2013, the Governor of Maine approved LD 727, "An Act Establishing Health Care Practitioner Transparency Requirements" (the Act), to provide definitions, regulate and provide standards for health care practitioners' advertisement practices and communications.

Definitions

"Advertisement" means a communication, whether printed, electronic or oral, that names a health care practitioner and the practice, profession or institution, in which the practitioner is employed, volunteers or otherwise provides health care services. "Advertisement" includes business cards, letterhead, patient brochures, e-mail, Internet, audio and video communications and any other communication used in the course of business.

"Deceptive or misleading advertising" includes, but is not limited to, use of an advertisement that misstates, falsely describes, falsely holds out or falsely details the health care practitioner's professional skills, training, expertise, education, board certification, or licensure.

Advertising requirements

The Act requires that advertisements for health care services that name a health care practitioner must identify the type of license held by the practitioner, must include the practitioner's name and the common term for the practitioner's profession, and must be free from deceptive or misleading information.

A health care practitioner providing health care services must post in their office a copy of their licensure. If a health care practitioner sees patients in a setting outside of a licensed health care facility, the copy must be visible and apparent to patients and no smaller than the original license.

Disclosure requirements

A health care practitioner seeing patients on a face-to-face basis must wear a name badge or some other form of identification that clearly discloses:

- The name of the health care practitioner;
- The type of license, registration or certification the held by the practitioner, including the common term for the practitioner's profession; and
- The health care practitioner's medical staff position, if applicable.

A health care practitioner who does not have direct patient care interactions is not subject to the identification provisions of this Act.

Violations

A person may file a complaint with the practitioner's licensing board regarding a health care practitioner who fails to provide the consumer with the information required in the Act.

A health care practitioner who violates this section is guilty of unprofessional conduct and will be subject to disciplinary action based on the specific law(s) governing his or her license.

The licensing board may impose requirements for professional conduct and advertising on a health care practitioner in addition to the requirements of the Act.

Nevada AB 456 (2013)

Background

On June 1, 2013, the Governor of Nevada approved Assembly Bill 456 (AB 456) to provide definitions, regulate and provide standards for health care practitioners' advertisement practices and communications.

Definitions

"Advertisement" means any printed, electronic or oral communication or statement that names a health care professional in relation to the practice, profession or institution in which the health care professional is employed, volunteers or otherwise provides health care services. The term includes, without limitation, any business card, letterhead, patient brochure, pamphlet, newsletter, telephone directory, electronic mail, Internet website, physician database, audio or video transmission, direct patient solicitation, billboard, and any other communication or statement used in the course of business.

"Deceptive or misleading information" means any information that falsely describes or misrepresents the profession, skills, training, expertise, education, board certification or licensure of a health care professional.

"Health care facility" means a hospital, an independent center for emergency medical care, a psychiatric hospital, and a surgical center for ambulatory patients.

"Health care professional" means any person who engages in acts related to the treatment of human ailments or conditions and who is subject to licensure, certification or regulation by the provisions of this title.

"Physician" means a person who has compiled all the requirements of this chapter for the practice of medicine.

"Osteopathic Physician" means a person who is a graduate of an academic program approved by the Board or is qualified to perform medical services by reason of general education, practical training and experience determined by the Board to be satisfactory, and has a license from the Board to practice Osteopathic medicine.

Advertising requirements

AB 456 requires that an advertisement for health care services that names a health care professional must identify the type of license or certificate held by the health care professional and must not contain any deceptive or misleading information.

If an advertisement for health care services is in writing, the information concerning licensure and board certification must be prominently displayed in the advertisement.

A physician or osteopathic physician shall not hold himself or herself out the public as board certified in a specialty or subspecialty. Advertisements for health care services cannot include a statement regarding

the board certification of a physician or osteopathic physician unless:

- the physician discloses the full and correct name of the board by which he or she is certified; and
- the board is a member of the American Board of Medical Specialties or the American Osteopathic Association; or
- Requires certification in a specialty or subspecialty:
- Successful completion of a postgraduate training program which is approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and which provides complete training in the specialty or subspecialty;
- Prerequisite certification by the American Board of Medical Specialties or the American Osteopathic Association in the specialty or subspecialty; and
- Successful completion of an examination in the specialty or subspecialty.

Health care professionals who practice in more than one office shall comply with these requirements in each office where he or she practices.

Disclosure requirements

A health care professional who provides health care services must affirmatively communicate their licensure or certification to all current and prospective patients. This communication must include, without limitation, a written patient disclosure statement that is conspicuously displayed in the office of the health care professional and which clearly identifies the type of license or certificate held.

When providing health care services to a patient, other than sterile procedures, in a health care facility the health care professional must wear a name tag which indicates his or her specific licensure or certification.

Violations

A health care professional who violates any provision of this section is guilty of unprofessional conduct and is subject to disciplinary action by the board, agency, or other entity in this State by which he is she is licensed.

Mississippi SB 2670 (2012)

Background

On April 18, 2012, the governor of Mississippi approved Senate Bill 2670 (SB 2670), "The Patient's Right to Informed Health Care Choices Act," to provide definitions, regulate and provide standards for health care practitioners' advertisement practices and communications.

Purpose

The act requires that health care practitioners display their licensure such that patients and prospective patients are made aware of their specific qualifications.

The act reflects the state's recognition that choosing a health care provider is one of the most important decisions a patient makes, which should be supported by full disclosure from their health care provider. The differences regarding training and qualifications of different health care providers often speak to the skills necessary to correctly detect, diagnose, prevent and treat serious health care conditions. Thus, the act states, there is a compelling state interest in patients being promptly and clearly informed of the actual training and qualifications of their health care practitioners who provide health care services.

Definitions

"Advertisement" means any communication or statement, whether printed, electronic or oral, that names the health care practitioner in relation to his or her practice, profession, or institution in which the individual is employed, volunteers or otherwise provides health care services.

"Deceptive" or "misleading" includes, but is not limited to, any advertisement or affirmative communication or representation that misstates, falsely describes, holds out or falsely details the health care practitioner's profession, skills, training, expertise, education, board certification or licensure.

"Health care practitioners" are those who engage in acts that are the subject of licensure or regulation, including practitioners of allopathic medicine, osteopathic medicine, nursing, podiatry, chiropractic, dentistry, optometry and audiology, as well as physician assistants, psychologists, therapists, speech-language pathologists, counselors, and any other denotations of licensure.

Advertising requirements

The act requires that advertisements for health care services that name a health care practitioner must identify the type of license held by the practitioner, and must be free from deceptive or misleading information.

A health care practitioner providing health care services must post in their office, and affirmatively communicate, their licensure. The practitioner must display visibly to all current and prospective patients the type of license held by the practitioner.

Practitioners who practice in multiple settings must comply with these requirements at each location.

Practitioners working in nonpatient care settings are not subject to the provisions of the act.

Violations

Failure to comply with any provision under this section constitutes a violation of the act. Professional licensing boards or other administrative agencies with jurisdiction may seek an injunction or other legal means as penalty for violation of this act.

Connecticut HB 5045 (2011)

Background

On Oct. 1, 2011 the governor of Connecticut signed Substitute House Bill 5045 (HB 5045), which creates requirements regarding the use of identification badges during work hours by health care providers.

Definitions

Under HB 5045, a "health care provider" is defined as any person employed or acting on behalf of a health care institution or facility. Institutions and facilities include "a hospital, rest home, nursing home, home health care agency, homemaker-home health aide agency emergency medical services organization, assisted living services agency, outpatient surgical facility and an infirmary" operated by educational institutions for the care of students, faculty and employees.

Health care provider identification badge requirements

The bill requires that any "heath care provider who provides direct patient care must wear identification badges in plain view" during the provider's work hours. The identification badge must include the:

- Name of the health care facility/institution
- Name of the health care provider
- Type of license
- Certificate/employment title held by the provider within the facility/institution

The size content, and format of the identification badges may be determined by the health care institution/facility in consultation with the Department of Public Health.

Tennessee SB 505 (2011)

On April 14, 2011, the governor of Tennessee signed Senate Bill 505 (SB 505), which amends the Tennessee Codes Annotated § 63-1-109 governing the disclosure requirements of health care practitioners. This amended section took effect on Jan. 1, 2012.

Purpose

The purpose of the law is to require health care practitioners to clearly disclose proof of the type of their professional licensure to patients. The law expands the categories of health care practitioners who are required to communicate this information to patients. The law also requires disclosure of licensure on all Internet advertisements by the health care professional.

Disclosure requirements

All licensed health care practitioners are required to display a copy of their license or registration in their office. The disclosure must clearly indicate the practitioner's name and degree abbreviation above the title of their profession (or specialty, where applicable). Those who are required to display this information include: chiropractors, dentists, physicians, surgeons, optometrists, osteopathic physicians, podiatrists, nurses, physician assistants, psychologists, acupuncturists and midwives.

Each health care practitioner must, at all times during patient encounters, wear a visible photo identification name tag that includes a recent photograph of the licensee, the licensee's full name, and the type of license. A health care practitioner must communicate in writing his or her full name and type of license at each patient's initial office visit.

Any practitioner who advertises health care services on an Internet website must prominently display the practitioner's full name and type of license.

A health care practitioner who works in a non-patient care setting and who has no direct interaction with patients is exempt from these requirements.

Violations

A health care practitioner who violates this section is guilty of unprofessional conduct and will be subject to disciplinary action based on the specific law(s) governing his or her profession or license. This includes injunctions or other appropriate legal means.

Utah SB 134 (2011)

Background

On July 1, 2011, the 2011 General Session enacted Senate Bill 134 (SB 134), Transparency in Health Care Provider Advertising, which amended Utah Code § 58-1-501.6. This law requires all licensed health care providers to include their name and license type in any advertisement for health care services. The amended provisions of SB 134 apply to any advertisement for the health care provider's services if the health care provider's licensing authority and professional ethics permits advertisements.

Advertisements for health care services

Any advertisement that includes the health care provider's name must identify the type of license as used by the division the health care provider is practicing.

Under SB 134, the definition of advertisement includes "any means of promotion intended to directly or indirectly induce a person to enter into an agreement for services with a health care provider." Specifically, the bill applies to "billboards, brochures, pamphlets, direct mail solicitations, radio, television, telephone solicitation scripts, telephone directories, televisions, radio, Internet websites, and any other means of promotion" for health care services. The bill does not apply to materials that provide information about health care provider networks established by health insurance carriers.

Violations

Violations are considered acts of unprofessional conduct.

Arizona SB 1255 (2010)

Background

On April 20, 2010, the governor of Arizona signed Senate Bill 1255 (SB 1255), which amends Arizona Revised Statutes § 32-3200 to include provisions relating to truth in advertising.

Advertisements for health care services

SB 1255 requires that any advertisement for health care services must include the health professionals' title, type of license held and type of license under which the health professional practices. Any health professional who violates the requirements commits an act of unprofessional conduct.

For the purposes of the act, advertising includes billboards, brochures, pamphlets, radio and TV scripts, electronic media, telephone directories, telephone/mail solicitations and other means of promoting the

health professional—directly or indirectly—in order to obtain business from consumers.

Insurers and other entities regulated under Arizona Title 20 are not covered by SB 1255.

California AB 583 (2010)

Background

On Sept. 29, 2010, the governor of California signed Assembly Bill 583 (AB 583), which amends Division 2, Chapter 1, Article 5 of the California Business and Professions Code to include provisions related to truth in advertising.

Advertisements for health care services

With limited exceptions, all health care practitioners will be required to communicate to a patient his or her name, state-granted practitioner license type, and highest level of academic degree. The disclosure requirement may be satisfied by providing the patient a writing at the patient's initial office visit or by prominently displaying a writing in an area visible to patients in the practitioner's office.

Health care practitioners who provide information regarding health care services on the Internet will be required to prominently display the practitioner's name, state-granted practitioner license type and highest level of academic degree. Physicians who are certified by an American Board of Medical Specialties member board or equivalent board approved by the practitioner's medical licensing authority shall disclose the name of the board or association.

Illinois SB 3509 (2010)

On July 27, 2010, the Governor of Illinois signed into law Senate Bill 3509 (SB 3509), which creates the Truth in Health Care Professional Services Act. In creating the Truth in Health Care Professional Services Act, legislators expressed the need for Illinois patients to be promptly and clearly informed about health care professionals' education and training.

Definitions

Under the Truth in Health Care Professional Services Act, "advertisements" are defined broadly and include printed, electronic and oral media that identify the health care professional, as well as business cards, letterhead, brochures, email, Internet, audio and video, and other communication used in the course of business. Advertisements and communications that mis-state, falsely describe, or falsely represent a health care professional's skills, training, expertise, education, board certification or licensure are deemed "deceptive" or "misleading."

Advertisements for health care services

Under the Truth in Health Care Professional Services Act, advertisements for health care services must identify the type of license the health care professional possesses. Ads also must be free of deceptive or misleading information.

Disclosure requirements

A health care professional also must conspicuously post and affirmatively communicate his or her

licensure in the following manner:

- Wear a visible name tag during all patient encounters that identifies his or her license
- If seeing patients in an office, there must be a visible writing displayed that clearly identifies the type of license the health care professional possesses
- Use titles or initials authorized by the applicable licensing act
- If working in more than one office, the health care professional must comply with these requirements in each setting

Health care professionals working in non-patient care settings and who do not have direct patient care interactions are not required to comply with these requirements.

Violations and enforcement

Health care professionals found to be in violation of the act are guilty of unprofessional conduct and are subject to disciplinary action based on the specific law(s) governing their profession.

Oklahoma HB 1569 (2010)

Background

On May 11, 2010, the governor of Oklahoma signed House Bill 1569 (HB 1569), which amends several sections of the state professions and occupations statutes to include provisions related to disclosure requirements and truth in advertising.

Use of the term "doctor" and "physician"

HB 1569 provides that nine classes of health professionals may use the title, "doctor" or "Dr."—but such use also requires the person to clarify that title with the applicable licensing designation as follows:

1. The letters "DPM" or the words podiatrist, doctor of podiatry, podiatric surgeon, or doctor of podiatric medicine.
2. The letters "DC" or the words chiropractor or doctor of chiropractic.
3. The letters "DDS" or "DMD," as appropriate, or the words dentist, doctor of dental surgery, or doctor of dental medicine, as appropriate.
4. The letters "MD" or the words surgeon, medical doctor, or doctor of medicine by a person licensed to practice medicine and surgery.
5. The letters "OD" or the words optometrist or doctor of optometry by a person licensed to practice optometry.
6. The letters "DO" or the words surgeon, osteopathic surgeon, osteopath, doctor of osteopathy, or doctor of osteopathic medicine.
7. The letters "PhD," "EdD," or "PsyD" or the words psychologist, therapist, or counselor by a person licensed as a health service psychologist.
8. The letters "PhD," "EdD," or other letters representing a doctoral degree or the words language

pathologist, speech pathologist, or speech and language pathologist by a person licensed as a speech and language pathologist.

9. The letters "PhD," "EdD," or other letters representing a doctoral degree or the word audiologist by a person licensed as an audiologist.

Under the statute, "physician" includes medical doctors, doctors of osteopathic medicine, podiatrists, chiropractors, dentists and optometrists.

Each of the nine classes are required to provide written notice, which may include wearing a name tag, that identifies the type of license. Each applicable licensing board is authorized to create, by rule, how its license holders will comply with this disclosure requirement.

Advertisements for health care services

Under HB 1569, any advertisement for health care services that names a provider must identify the type of license of the provider, using the applicable letters or words for the profession. The term "advertisement" includes any printed document including letterhead, video clip, or audio clip created by, for, or at the direction of the provider or providers and advertised for the purpose of promoting the services of the doctor or provider.

The term "deceptive or misleading statement or act" includes, but is not limited to:

a. Such statement or act in any advertising medium;

b. Making a false statement regarding the education, skills, training, or licensure of a person; or

c. In any other way describing the profession, skills, training, expertise, education, or licensure of a person in a fashion that causes the public, a potential patient, or current patient to believe that the person is a medical doctor, doctor of osteopathic medicine, doctor of dental surgery, doctor of dental medicine, doctor of optometry, doctor of podiatry, or doctor of chiropractic when that person does not hold such credentials.

Violations

Any licensed health care provider found by the appropriate licensing board or state agency to have violated the act shall be punished by a fine not less than $25 and not more than $1,000. Each day the act is violated shall constitute a separate offense. Repeated or gross violations of the act shall be referred to the Attorney General.

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Anesthesiologist: The silent force behind the scene

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Abstract

The Anesthesiologist provides continuous medical care before, during, and after operation to permit the surgeons to perform surgeries; sometimes quite challenging that could otherwise cause substantial threats to the patient's survival. Anesthesiologists, because of their combination of skills are uniquely qualified to care for dying patients suffering from end diseases like cancer. These skills include knowledge of analgesic and sedative pharmacology for the management of pain, awareness of perceptual alterations along with well-known skills in drug titration and experience with critically ill and highly anxious, often agitated patients under stressful circumstances. Anesthesiologists are physicians who provide medical care to patients in a wide variety of situations. This includes preoperative evaluation, consultation with the surgical team, creation of a plan for the anesthesia (which is different in each patient), airway management, intraoperative life support, pain control, intraoperative stabilization of all the vitals, postoperative pain management. Outside the operating room, Anesthesiologist's spectrum of action includes with general emergencies, trauma, intensive care units, acute and chronic pain management. In spite of providing these highly skilled services, Anesthesiologists are facing a lot of stress these days which predisposes them to burnout, fatigue, substance abuse, and suicide. The practice of anesthesia in Indian scenario is different as compared to the western countries. In India, the Anesthesiologists are dependent on surgeons for their work. The degree of stress faced is due to a number of factors like the type and quality of work, his/her relationship with surgeons and the support he/she receives from colleagues and family.

Keywords: Anesthesiologist, critical care unit, pain clinic, stress

INTRODUCTION

Anesthesiology is a specialized field of medicine practiced by highly trained doctors. It is defined by American Society of Anesthesiologists as "the practice of medicine dedicated to the relief of pain and total care of surgical patients before, during, and after surgery."[1] Anesthesiologist is a highly skilled specialist doctor who provides continuous medical care before, during, and after surgery to enable the patient to live a normal anatomical, physiological, pharmacological, and psychological life. Anesthesiologists are the Physicians specializing in perioperative care, development of anesthetic plan, and administration of anesthetics. Constant research in the field of anesthesia has led to marked reduction in anesthesia-related mortality and morbidity in spite the increase in challenging operations in pediatrics, adults, older, and sick population. To practice anesthesia, it needs dedication and hard work of approximately 12 years as compared to other nonmedical fields, and all this hard work is done for the benefit of society.[2]

DUTIES OF ANESTHESIOLOGIST

The Anesthesiologist is not only responsible for the anesthesia and overall medical management during surgery but also helps in optimizing the comorbid conditions of the patient for the safe outcome of the patient in the perioperative period.

With respect to such large responsibilities on the shoulder of Anesthesiologist, he/she not only functions as a person who administer anesthesia but also acts like a physician. That is why the name given to Anesthesiologist as a Physician Anesthesiologist or perioperative Physician is appropriate. It is said that “anesthesiologist is a physician to a surgeon and a surgeon to a physician.”

These days, role of Anesthesiologist extends beyond the operating room where he/she not only deals with complications of anesthesia postoperatively but also manages postoperative pain, chronic pain of cancer, labor analgesia, in cardiac and respiratory resuscitation, in blood transfusion therapies, respiratory therapies, etc. Hence, the Anesthesiologist has spread its wings beyond the four walls of operation theater. Following are the few duties carried out by the Anesthesiologist.

Preoperative evaluation

The aim of preoperative evaluation is to discover risk factors that may have an adverse impact on the safe conduct of anesthesia. Therefore, it is important that the Anesthesiologist must be provided with the true history of the patient and diagnostic tests. Preoperative evaluation also provides opportunity for the Anesthesiologist to interact with the patient and tell him/her about the outcome of the surgery and also reviews the risk and benefits of available treatment options without terrorizing the patient and makes him/her understand the importance of proper optimization and management of the risk factors. All this is called “informed consent” which should not be just a formality to take sign of the patient on a form or a file.

In India and other developing countries, sometimes Anesthesiologist is not made aware about the concurrent illnesses and medication status of the patient. Hence, the risk factors remain hidden. Many a times, diagnostic values are not true, ultimately leading to disaster on the table. Sometimes in order to get the case done, the patient is asked to hide the fasting status by the surgeons, which may ultimately lead to aspiration and then all the faults are made to fall over the Anesthesiologist. It is a common

saying “never to tell lie to an advocate and doctor.” As per surgeon's point of view, they have their own problems with ever increasing lists of patients on every sitting, and they try to finish the list and do not want to postpone the patient.

Intraoperative management of patient

Physician Anesthesiologist uses advanced technology as required by minimum monitoring standards (MMS) to monitor the body's functions and determine how best to regulate body's vital organ system and treat any eventuality that occurs intraoperatively. These vital functions are heart rate and rhythm, breathing, blood pressure, body temperature, fluid, and electrolyte balance, and he/she also maintains a record of all the vital functions of the patient's body.

In India and in other developing countries, where anesthesia assistants are in shortage or not well-trained and in many hospitals which are not fully equipped with automatic monitoring devices, all the perioperative functions are manually monitored by the Anesthesiologist. It includes maintenance of intravenous lines at the appropriate site according to the type of surgery, preparing preanesthetic medication, and labeling them. He/she prepares emergency drugs and labels them, keeps ready intubation cart, does intubation, and then breathes the patient. Regional anesthesia whether spinal or epidural is administered by an Anesthesiologist because it is a highly technical job and requires skills and expertise which cannot be given by nonprofessionals. Most of the times, patients would not even realize that the Anesthesiologist is providing these critical services during surgery. All the stress is born by the Anesthesiologist to keep the patient safe and to keep the surgeon calm. This is the idea of our discussing this issue or, in other words, “silent force behind the scene.”

Anesthesiologists form an important member of the team performing fast track surgeries. Fast track surgery represents a multidisciplinary approach to improving perioperative efficiency by facilitating recovery after both minor that is, outpatient and major inpatient surgery procedures. It requires patient education and motivation, early feeding and mobilization, and a multimodal analgesic regime. The decision of the Anesthesiologist as a key perioperative physician is of critical care team in developing a successful fast track surgery program. By adopting fast track surgery technique, there is a significant reduction in the length of hospital stay without any increase in perioperative morbidity.[3]

Postanesthesia care unit

Role of Anesthesiologist in postanesthesia care unit or “recovery room” is even more important because after completion of surgery patient is still under the influence of some residual effects of the anesthetic agents and the Anesthesiologist has to watch the patient's activity level, adequacy of breath, circulation, level of consciousness, and oxygen saturation. Pain is optimized before sending the patient to ward or home or sometime to intensive care unit (ICU) if patient's outcome is not proper. Recovery room is the place where most of the casualties occur because in most of the hospitals/institutions, the recovery room is monitored by staff nurses or paramedical staff and is liable to be neglected. In the pre- and peri-operative period, patient is under the control of Anesthesiologist and the chances of error are negligible. Hence, recovery room is the place where Anesthesiologist should remain utmost vigilant.[1]

Pain clinic

This is an important field where Anesthesiologist has made its presence felt. More and more Anesthesiologists are focusing their attention in the specialty of pain management. Pain is to be managed not only in the postoperative period but other conditions such as intractable pain of cancer, pain of burns, herpetic neuralgias, low back pain, and diabetics neuropathies are also managed by Anesthesiologists directly. Almost all the units in government and private sectors have pain clinics where Anesthesiologist can do pain relieving procedures, counsel patients and their families, and can also give rehabilitative services to the patients having pain. Anesthesiologists also coordinate with other healthcare professionals who are working in pain clinics by forming multidisciplinary teams.[4,5]

Critical care unit

Anesthesiologists are uniquely qualified to give critical care services because of their extensive training in clinical physiology, pathology, pharmacology, and resuscitation. Some Anesthesiologists pursue advanced training in critical care medicine as ICU intensivists in both adult and pediatric hospitals. Being the incharge of ICUs, they direct the complete medical care for the sick patients. In ICU, Anesthesiologists as intensivists provide medical and diagnostic services, care of intubated or nonintubated patients, and also control the various types of infections besides coordinating with various other medical and paramedical personnel as the leader of the team.[6]

Role in trauma and disaster management

The disaster management is a new concept which is also being looked after by none other than an Anesthesiologist. Teams of doctors, which are meant for looking after disaster management, are usually headed by Anesthesiologists; because they are basically intensivists and are fully trained and expert in resuscitative measures. Though the concept is new, still many more things are to be done by the government agencies to handle the situations such as earthquakes, tsunamis, and terrorist attacks where mass casualties are there. In developed countries, disaster management is a separate and specialized branch.

Obstetric analgesia and anesthesia

In obstetric analgesia and anesthesia, Anesthesiologists work in the maternity unit to administer anesthesia to mothers for cesarean sections and prepare for painless normal deliveries (labor analgesia). Most of the labors and deliveries go smoothly but on some occasions when things go wrong, life of the mother and baby is at risk. In such patients, the presence of Anesthesiologist deals with two lives; one that of mother and another that of baby. Many a times, in the absence of pediatrician, an Anesthesiologist has to resuscitate the baby in addition to the patient undergoing lower segment cesarean section.

Burn unit

This is another aspect of working area of an Anesthesiologist where total care of patient; right from maintaining airway, circulation, and a fluid and electrolyte balance to managing pain of the patient is managed by the Anesthesiologist. In burn patients, very difficult situation arises when even intravenous

access to the patient becomes difficult and here again Anesthesiologist is the person who accesses the intravenous lines by putting central venous lines. In some setups, there are hyperbaric oxygen units which are also monitored by the Anesthesiologists.

Anesthesia outside the operating room

As the medical technology advances, it becomes the need of the hour to involve the Anesthesiologist in caring for the patient during uncomfortable and prolonged procedures outside the traditional operational suites. The procedure includes radiological images such as computed tomography and magnetic resonance imaging in children, gastrointestinal endoscopy, placement and testing of cardiac pacemaker, defibrillation, lithotripsy, and electroconvulsive therapy. It would be impossible to perform many of these tests on infants and young children without the use of anesthesia and various sedation techniques provided by an Anesthesiologist.

Basic sciences and clinical research

Anesthesia research at the clinical and basic sciences level has been completed almost exclusively by Anesthesiologists with the goal of continuously improving patient care and safety. Research is conducted in each of specialties of pediatric, geriatrics, obstetrics, critical care, cardiovascular, neurosurgical, and ambulatory anesthesia.

Other areas of active study by the Anesthesiologist include transfusion therapies (blood transfusion and fluid therapy), infection control, and organ transplantation. The Anesthesiologists also do undergraduate and postgraduate teaching. They also supervise the trainees who are providing anesthetic services.

JOB AND LIFE SATISFACTION

Anesthesiologists are also reported to have high levels of job satisfaction, job challenge, work commitment and empowerment. Anesthesiologist has a long and successful career ahead, who is working with commitment is earning better than their counterpart in other specialties.[7] Junior Anesthesiologists being more active and young are easily employed and absorbed by the corporate sector. Even an independent Anesthesiologist who opts for freelancing is also earning fairly good monthly emoluments. In other specialties such as surgery, gynecology and obstetrics, orthopedics, eye, and ENT where a new postgraduate takes much longer time to settle after attaining various skills in the art of surgery, an Anesthesiologist settles very early in the job.[8]

Life satisfaction is arbitrary and average on account of good numerations they are getting but, on the whole, excessive workload contributes to a negative self-evaluation on quality of life besides hindering access to leisure activities whether in government job or in private set up.

STRESS IN ANESTHESIOLOGIST

The main cause seen for stress is lack of control of work environment, the unpredictability of work leading to high level of anxiety and overextension of work. Stress levels in Indian Anesthesiologists are more or less similar and universal as compared to their counterparts in the developed world. Due to ever increasing population ICUs are overloaded, nonavailability of trained staff, equipment and

monitoring gadgets at district hospitals and peripheries, stress is increasing day by day on the Anesthesiologists to give up to mark care to the patients. Stress reaction is a basic physiological response to real or perceived danger which enables an individual to stand and fight or flee.[9] Anesthesiology is an area identified as being extremely stressful. Mean workload, an Anesthesiologist bears is elevated as compared to other professionals. The night shift in Anesthesiology changes sleep patterns. The atmosphere in the ICU is very gloomy where everybody is in stress, whether it is patient's attendants or staff. All this is reflected on us particularly when we see a patient dying before our eyes, whom we make every effort to save.[10]

When operation becomes successful, and patient goes to his/her home in a fine condition, all the credit is born by the surgeon. Anesthesiologist is seen nowhere in the picture. Even patient forgets the Anesthesiologist, who is the main person who gives a second life to the patient. The saddest issue is that if something unfortunate happens during the surgery which may be inevitable, all the discredit goes to the Anesthesiologist. In India, it is a common saying by a layman or even an operating surgeon that an overdose of anesthetic has probably been given, even if the faults might have been with the surgeon and the surgery itself.

Remarkably international studies of occupational stress and burnout in Anesthesiologist all have a similar outcome.[11,12] Imbalance between the demand at home and work, insufficient personal time, inadequate recognition, lesser reimbursement, fear of competition, job insecurity, social and professional isolation, litigation, and peer review were identified as stress factors. To cope up these stress factors, many Anesthesiologists adopt chemical abuse, alcoholism, and even may commit suicide.[13,14] Stress manifests itself as physical and emotional illness, absenteeism, poor performance, social withdrawal, substance abuse, and negative attitude.[15,16] There is high divorce rate and increasing number of single-parent families and other problems related to workload and stress in the Anesthesiologist. However, job satisfaction and good emoluments have temporarily reduced the stress-related problems in Anesthesiologists.[17] Parameters are there to obtain levels of his/her catecholamines released during the surgery and insult given by the increase in blood pressure to his/her vital organs. A study has been conducted on obtaining salivary cortisol levels during stressful conditions of Anesthesiologists.[18] They observed 12.5% endocrine reactions from 3781 samples. The mean cortisol increase amounted to 10.6 nmol/L (219%). A high proportion (71.3%) of endocrine reactions occurred without conscious perception of stress. Unawareness of stress was higher in intensive care nurses (75.1%) than in intermediate care nurses (51.8%, $P < 0.01$). Sources of stress can be environmental, interpersonal, and personal factors.

Physical assaults on doctors/anesthesiologists

Many times, Anesthesiologist has to face the wrath of the public, he or she is manhandled. People bring their patient in ICUs or in emergency in serious conditions and want that their patients should be hale and hearty after the treatment. In spite of the fact that attendants are very well-conveyed about the seriousness of the patient verbally as well as in writing, authorities and police remain mute spectator in such situations. The one major factor which comes into play is the nonpayment of hospital/ICU dues if mishaps have occurred.

Stress management

First of all, we have to recognize various causes of stress and sources from where stress is causing trouble to the Anesthesiologist. Then we look for various methods to resolve stress and these are:

- Discussing our problems with our colleagues on some platform like different societies, conferences, social network media like WhatsApps, etc
- Don't react immediately to any untoward situation unthoughtfully. Take time and then assert yourself
- Anesthesiologist should take proper rest, otherwise mishaps are liable to occur
- One can go on for yoga or meditation to relieve stress
- Getting personal indemnity done is also one of the methods to relieve stress in the form of legal and financial securities
- Avoid aggression[19]
- Nonchemical stress busters, avoid anesthetizing patients in stressful conditions, workplace which is understaffed or under equipped when under effects of alcohol or drugs and allurement of money
- Personal indemnity and insurance: To save oneself from litigation, Anesthesiologist has to get his/her personal indemnity and the premium for the personal indemnity for the Anesthesiologist is maximum out of all the specialties.

Future of Anesthesiology

In 1985, “the anesthesia patient safety foundation” was created, after that Anesthesiologist in India also started taking a keen interest in patient's safety. Many older techniques of anesthesia were rejected and new techniques were introduced, MMS were accepted as guidelines and new machines were introduced for the safety of the patient, with the result that mortality due to anesthesia has significantly reduced in India also. The contribution of Anesthesiologist resulting in improved medical care provided to the surgical patient is being widely recognized, and our role as intensivist is now being widely accepted. The Anesthesiologist will continue to enthusiastically share their unique perspective and expertise while serving as members of their medical staff. But at the grass root level, movements to impact legislative reforms and secure the advancement of anesthesia quality and patient safety, Anesthesiologists are yet not being involved, which is very important which if, as is heard that government is going to introduce nursing home act.

CONCLUSION

We, therefore, conclude by saying that an Anesthesiologist is a highly skilled professional and the most important member of the medical team for patient's safety and care. Although he/she is well-commuted to his/her job, job satisfaction is very high and they are highly paid, but excessive workload, odd working hours, nonappreciation by the surgeons and lack of awareness of their role by the society, inadequate sleep affect the quality of life of Anesthesiologist. With the result, he/she can have a

negative lifestyle of living, but means of improving it, are always there. There is a great scope that services of an Anesthesiologist can be utilized to the greatest for the benefits of society which depends upon the attitude of the later as well as of surgeon.

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Conflicts of interest

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Medical Xpress

JANUARY 23, 2015

Study finds many patients unaware of what the anesthesiologist actually does

by Rob Forman, Rutgers University

It is estimated that more than 104 million surgeries involving anesthesia are done in the U.S. each year.

When patients undergo surgery, there is a doctor in the operating room – the anesthesiologist – whose job is a mystery to many of them, according to new research by a Rutgers physician. That is unfortunate, the researcher says, because if patients had a better sense of what this doctor does, it would improve the chances that their surgery will be both successful and more comfortable.

"I feel that anesthesia is the topic than many patients know least about," says Ferdinand Iannaccone, an anesthesia resident at Rutgers New Jersey Medical School – who presented his findings at the annual meeting of the American Society of Anesthesiologists

(ASA) – "and the best way to calm anxiety is to address the unknown."

More than 104 million surgeries involving anesthesia are performed every year, according to the ASA. Nearly half are inpatient procedures in hospitals; the rest are done in ambulatory care settings.

Iannaccone found that more than 90 percent of the patients he studied were aware that anesthesiologists "put patients to sleep," but fewer than half knew that the anesthesiologist also makes sure that patients are fit for surgery; monitors blood loss and provides transfusions, if needed; controls nausea and vomiting; and controls pain following surgery.

In each of those areas, Iannaccone says, "if they know more prior to their surgeries, they can be helpful to us as anesthesiologists by preparing themselves for what they're about to undergo."

That includes thinking ahead about a conversation they will have with the anesthesiologist during pre-operative screening – a chat that Iannaccone says many patients don't realize is part of the routine. An anesthesiologist who has reviewed the patient's lab work and medical history meets the patient and explains what is planned, including precautions based on the patient's profile – and then asks important questions looking for information that may not appear on a chart.

"A concern I would have is whether you had any interactions with anesthesia in the past," says Iannaccone. "Did you have nausea? Did you have vomiting after the surgery or severe pain? If the answer to any of those is yes, we might be able to either avoid or increase certain medications – or, if you had avoidable pain in the past, use other techniques like nerve blocks and regional anesthesia."

Iannaccone says an anesthesiologist wants the patient to feel as little pain as possible, and also for the patient not to remember much. "The patient won't want to remember the stress of the day – the built up anxiety prior to the surgery. We also don't want the patient to move during surgery, or to have any postoperative complications."

How that is accomplished can vary widely from patient to patient, and procedure to procedure. Iannaccone says his main concern during a surgery is the condition of the patient's heart and lungs, "because being under anesthesia those are the two organ

systems that probably are the most stressed." One condition that can affect both is obesity, he says, because people who are overweight are more likely to have sleep apnea, which can disrupt the patient's breathing during surgery.

To guard against complications in patients at risk, Iannaccone says the anesthesiologist may decide to use monitors that instantly detect blood pressure changes, and have high capacity intravenous needles set up in case large amounts of blood need to be replaced quickly.

Offering choices to the patient

Beyond explaining and obtaining consent for all necessary procedures, Iannaccone also likes to give the patient a choice wherever he can, such as a local instead of general anesthesia if the surgery won't be especially invasive. "Whatever the patient would like," Iannaccone says, "we can at least approach it with a conversation."

Iannaccone is now applying his research results by testing a new high-tech way to make the conversation even richer. During pre-admission testing, his patients are getting digital tablets that offer quick tutorials designed to fill in gaps in their anesthesia knowledge. "It should take less than five minutes," Iannaccone says, "and while we don't expect that to leave them fully educated, we do expect it will make them more engaging in some of the questions they may have that we can answer for them."

First results on how well those tablets work may be available this spring.

Provided by Rutgers University

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UFC
USA Basketball
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US Rowing
US Lacrosse
USA Swimming
USA Volleyball
FIFA
St. Lucie Mets

CUNY Athletic Conference
Iona College Athletes
Saint Peter's College
Public Schools Athletic League

NY Open

Endeavor

Invesco Series QQQ Tennis

Los Leones del Escogido

La Liga Nacional de Baloncesto

Facts at a Glance

494,076
outpatient visits*

33,718
surgeries**

215
licensed beds

45
operating rooms***

386
active medical staff

33
scientists

71
fellows

45
residents

296
advanced practice providers

4,700+
full-time equivalent employees †

$1.15B

hospital operating expense budget, excluding research**

$43.5M

research operations budget**

$204M

HSS endowment**

$46M

National Institutes of Health (NIH) funding for research studies

** for the 2018-2019 academic year*

*** fiscal year 2018*

****includes ambulatory surgery centers*

† Includes physicians and their staff

What is an Anesthesiologist?

What is an anesthesiologist? What training is involved?
An anesthesiologist is a doctor (MD or DO) who practices anesthesia. Anesthesiologists are physicians specializing in perioperative care, developing anesthetic plans, and the administration of anesthetics. He or she has finished college, then medical school (four years), then an internship (one year) followed by a residency in anesthesia (three years). Some anesthesiologists pursue additional years of training (a fellowship).

Who are the HSS anesthesiologists?
Our attending physicians have completed fellowship in fields such as regional anesthesia, pediatric anesthesia, critical care medicine, cardiothoracic anesthesia, chronic pain, and anesthesia research. Your anesthesiologist will be assigned the day before surgery and will be chosen based off of your patient history and individualized needs and the physician's specializations within anesthesiology.

What do anesthesiologists do?
Anesthesiologists help ensure the safety of patients undergoing surgery. The anesthesiologist provides care for the patient to prevent the pain and distress they would otherwise experience. This may involve general anesthesia ("putting the patient to sleep"), sedation (intravenous medications to make the patient calm and/or unaware) or regional anesthesia (injections of local anesthetic near nerves to "numb up" the part of the body being operated on (i.e. nerve blocks or spinal/epidural injections)).

Many types of orthopedic operations are well suited to regional anesthesia, most often with sedation as well. Each HSS anesthesiologist specializes in regional anesthesia.

Before the procedure, your anesthesiologist will talk with you and establish an anesthetic plan in coordination with your surgeon. At this time, your anesthesiologist will also ensure you are ready for the operation. The first priority is getting the patient safely through the procedure. If the patient is sick and could be made healthier, then the operation may be postponed or cancelled (to allow "optimization" of the patient's medical condition). This reduces the potential risk to which a patient may be exposed.

In addition to getting through the operation safely, your anesthesiologist tries to reduce post-operative pain after the operation. This may involve intravenous pain medications, but in many cases at HSS pain relief will involve placing local anesthetic near nerves.

At HSS, the Department of Anesthesiology, Critical Care & Pain Management also runs the recovery room for specialized care immediately after surgery. We also manage an Acute Pain Service to help you manage post-operative pain and oversee the Critical Care Team to provide specialized care for critically ill patients.

Some anesthesiologists at HSS practice pain management. Some HSS anesthesiologists also act as administrators for the hospital and the Department.

Why should patients care about anesthesia?
Your anesthesiologist allows you to undergo surgery safely and comfortably. Anesthesiologists use specialized techniques during surgery to accomplish this. For example, the method of controlled lowering of the blood pressure during hip surgery reduces bleeding and the need for transfusions.

Good pain management is obviously desirable from the patients' perspective. Good pain management also helps patients perform physical therapy and leads to better surgical outcomes after many orthopedic procedures. Good pain management may reduce the rate of heart attacks and other postoperative complications.

Can't the anesthesiologist just do the injection (or put the patient to sleep) and then leave?
No. That would be unsafe. The anesthesiologist, or someone working with him or her (a resident, a fellow, or a nurse anesthetist) must remain with the patient. This is needed so that the patient status can be monitored (heart rate, blood pressure, breathing, level of awareness during sedation), and changes made as needed (so as to prevent or manage major problems that could arise during the surgery).

Back to Department of Anesthesiology, Critical Care & Pain Management

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Types of Anesthesia

During surgery, you will be given some form of anesthesia, which are medicines given to relieve pain and sensation during surgery. Before surgery, you will meet with the physician anesthesiologist or nurse anesthetist. The anesthesiologist will review your medical condition and history to plan the appropriate anesthetic for surgery.

There are various forms of anesthesia. The type of anesthesia you get will depend on the type of surgery and your medical condition. Sedatives (to make you sleepy) and analgesics (to ease the pain) may also be used as part of the anesthesia process. The different types of anesthesia include the following:

Local Anesthesia

Local anesthesia is an anesthetic agent given to temporarily stop the sense of pain in a particular area of the body. You remain conscious during a local anesthetic. For minor surgery, a local anesthetic can be given via injection to the site, or allowed to absorb into the skin. However, when a large area needs to be numbed, or if a local anesthetic injection will not penetrate deep enough, doctors may use other types of anesthesia.

Regional Anesthesia

Regional anesthesia is used to numb only the portion of the body that will undergo the surgery. Usually an injection of local anesthetic is given in the area of nerves that provide feeling to that part of the body. There are several forms of regional anesthetics:

- **Spinal anesthetic.** A spinal anesthetic is used for lower abdominal, pelvic, rectal, or lower extremity surgery. This type of anesthetic involves injecting a single dose of the anesthetic medicine into the area that surrounds the spinal cord. The injection is made into the lower back, below the end of the spinal cord, and causes numbness in the lower body. This type of anesthesia is most often used in orthopedic procedures of the lower extremities.

- **Epidural anesthetic.** The epidural anesthetic is similar to a spinal anesthetic and is commonly used for surgery of the lower limbs and during labor and childbirth. This type of anesthesia involves continually infusing an anesthetic medicine through a thin catheter (hollow tube). The catheter is placed into the space that surrounds the spinal cord in the lower back, causing numbness in the lower body. Epidural anesthesia may also be used for chest or abdominal surgery. In this case, the anesthetic medicine is injected at a higher location in the back to numb the chest and abdominal areas.

General Anesthesia

General anesthesia is an anesthetic used to induce unconsciousness during surgery. The medicine is either inhaled through a breathing mask or tube, or given through an intravenous (IV) line. A breathing tube may be inserted into the windpipe to maintain proper breathing during surgery. Once the surgery is complete, the anesthesiologist ceases the anesthetic and you are taken to the recovery room for further monitoring.

About Your Anesthesiologist

Anesthesiologists are the doctors trained to administer and manage anesthesia given during a surgical procedure. They are also responsible for managing and treating changes in your critical life functions--breathing, heart rate, and blood pressure--as they are affected by the surgery being performed. Further, they diagnose and treat any medical problems that might arise during and immediately after surgery.

Before surgery, the anesthesiologist will evaluate your medical condition and formulate an anesthetic plan that takes your physical condition into account. It is vital that the anesthesiologist knows as much about your medical history, lifestyle, and medicines, including over-the-counter and herbal supplements, as possible. Some particularly important information he or she needs to know includes the following:

- **Reactions to previous anesthetics.** If you have ever had a bad reaction to an anesthetic agent, you need to be able to describe exactly what the reaction was and what your specific symptoms were. Give the anesthesiologist as much detail as possible, such as you felt nauseated when you woke up or the amount of time it took you to wake up.

- **Current herbal supplements.** Certain herbal products, commonly taken by millions of Americans, may cause changes in heart rate and blood pressure, and may increase bleeding in some patients. The popular herbs gingko biloba, garlic, ginger, and ginseng may lead to excess blood loss by preventing blood clots from forming. In addition, St. John's wort, and kava kava, may prolong the sedative effect of the anesthetic. The American Society of Anesthesiologists advises anyone planning to have surgery to stop taking all herbal supplements at least 2 to 3 weeks before surgery to rid the body of these substances.

- **Any known allergies.** Discussing any known allergies with the anesthesiologist is very important, as some anesthetic drugs trigger cross-allergies, particularly in people who have allergies to eggs and soy products. Allergies to both foods and drugs should be identified.

- **All recent and current prescription and over-the-counter medicines.** It is also important to let your surgeon and anesthesiologist know about both prescription medicines and over-the-counter medicines you are taking, or have recently taken. Certain prescription medicines, such as coumadin, a blood thinner, must be discontinued for some time before surgery. In addition, as many people take a daily aspirin to prevent heart attack, and certain dietary supplements, doctors need to be aware of these habits, as they can prolong bleeding and interfere with medicines used by anesthesiologists.

- **Cigarette smoking and drinking alcohol.** Cigarette smoking and alcohol can affect your body just as strongly (and sometimes more strongly) than many prescription medicines you may be taking. Because of the way cigarettes and alcohol affect the lungs, heart, liver, and blood, these substances can change the way an anesthetic drug works during surgery. It is important to let your surgeon and anesthesiologist know about your past, recent, and current consumption of these substances before surgery.

  Undergoing surgery can be a good motivator to quit smoking. Most hospitals are smoke-free and doctors, nurses, and other health professionals will be there to give you support. In addition, you will heal and recover faster, especially in the incision area, or if your operation involves any bones. Smoking cessation before surgery also decreases pulmonary complications after surgery, such as pneumonia. Quitting smoking also reduces your risk of heart disease, lung disease, and cancer.

- **Use of street drugs (such as marijuana, cocaine, or amphetamines).** People are often reluctant to disclose the use of illegal drug, but you should remember that all conversations between you and your surgeon and anesthesiologist are confidential. It is crucial that he or she know about your past, recent, and current use of these substances, as these drugs can effect healing, and responses to anesthesia. It is important to keep in mind that the only interest your doctor has in this information is learning enough about your physical condition to provide you with the safest anesthesia possible.

Meeting the Anesthesiologist Before Your Surgery

Because anesthesia and surgery affect every system in the body, the anesthesiologist will conduct a preoperative interview. Sometimes this is done in person; in other cases, the anesthesiologist will interview you over the phone. During this interview, the anesthesiologist will review your medical history, as well as discuss the information mentioned above. He or she will also inform you about what to expect during your surgery and discuss anesthetic choices with you. This is also the time to discuss which medicines should be stopped, and which can continue before surgery, as well as when to stop eating before the surgery.

If you have not personally met during the preoperative interview, the anesthesiologist will meet with you immediately before your surgery to review your entire medical history as well as results of any medical tests previously conducted. By this time, he or she will have a clear understanding of your anesthetic needs.

How are pre-existing medical conditions handled during surgery?

If you have a pre-existing medical condition, such as diabetes, asthma, heart problems, or arthritis, your anesthesiologist will have been alerted to this and will be well-prepared to treat these conditions during your surgery, as well as immediately afterward. Anesthesiologists are trained to handle sudden medical problems related to the surgery, as well as any chronic conditions that may need attention during the procedure.

How is my condition monitored during surgery?

Monitoring is one of the most important roles the anesthesiologist handles during surgery. Second-by-second observation of even the slightest changes in a wide range of body functions gives the anesthesiologist a tremendous amount of information about your well-being. In addition to directing your anesthesia, the anesthesiologist will manage vital functions, such as heart rate, blood pressure, heart rhythm, body temperature, and breathing. He or she will also be responsible for fluid and blood replacement, when needed. Sophisticated technology is used to monitor every organ system and its function during surgery.

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Role of the Anesthesiologist

A common misconception is that an anesthesiologist is the doctor who “puts patients to sleep” before surgery. It’s true that this is part of their job, but it’s only a small part! An anesthesiologist is actually a *perioperative* physician, where “peri” means all-around. So, an anesthesiologist is responsible for patient care throughout the surgical experience: before, during, and after the surgery itself. An anesthesiologist also has many responsibilities outside of the surgical suite (operating room).

Click on each section below for more information on the role an anesthesiologist plays throughout surgery:

References

American Society of Anesthesiologists

×

Anesthesia Services

If you need surgery, you will receive anesthesia to prevent the sensation of pain during the procedure. Anesthesia can include the use of topical agents, anesthetic gases, intravenous medications or regional blocks that numb a section of the body.

Featured Services

General Anesthesia

Local Anesthesia

Regional Anesthesia

Anesthesia Services

Anesthesia means lack of sensation. It prevents you from feeling any pain during your surgery or medical procedure. Normally, nerves from every part of the body send signals to the spinal cord. The spinal cord relays these messages to the brain, which then interprets the signals as pain or other sensations. Anesthesia temporarily interrupts this relay system.

A doctor who specializes in anesthesia, called an anesthesiologist, will design your anesthetic based on your body composition and your personal health history. Your anesthesiologist will closely monitor you before, during and after your surgery.

There are three main types of anesthesia: general, regional and local. Your surgeon and anesthesiologist will determine the appropriate type of anesthesia needed for your procedure.

- **General Anesthesia** — Induces a total loss of consciousness and lack of ability to feel pain. General anesthesia uses a combination of medications administered intravenously and gases administered through a face mask or breathing tube. The anesthesiologist uses anesthesia equipment and instruments to monitor and manage your vital signs continuously throughout the time you are under general anesthesia until you safely recover.
- **Regional Anesthesia** — Blocks pain to a large part or region of your body. Regional anesthesia can include spinal, epidural and peripheral nerve blocks. Your anesthesiologist injects medication near a cluster of nerves to numb only the area of your body that requires surgery. You may also receive medication to help you relax or sleep during the procedure.
- **Local Anesthesia** — Provides numbness to a very limited part of the body for minor procedures. In most circumstances, your surgeon will administer the local anesthetic, and an anesthesiologist will not be present unless your physical condition warrants close monitoring.
- **Frequently Asked Questions** — For more information about anesthesia services, pain management and how to prepare for your procedure, you can read these commonly asked questions about anesthesia. If you have any additional questions about the anesthesia that will be used for your specific surgery or

procedure, please contact your doctor or anesthesiologist.

Patient Information

Interested in becoming a Sutter patient? Here's what you need to know about health plans, choosing a doctor and how to get started today.

Accepted Health Plans

Tips for Choosing a Doctor

Health Insurance Guide

Services Near You

Alta Bates Summit Medical Center

Sutter Santa Rosa Regional Hospital

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Memorial Medical Center Modesto

Sutter Lakeside Hospital

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Sutter Amador Hospital

Sutter Delta Medical Center

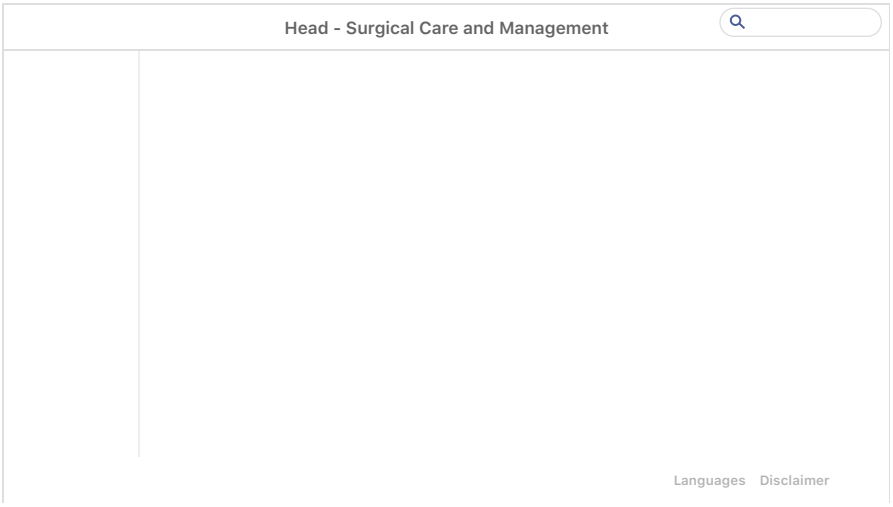
VIEW ALL RELATED LOCATIONS

Understanding Anesthesia

Anesthesia and You

USAP's anesthesiology professionals work closely together and with your physician and surgeon to make your surgical experience as positive as possible. **Our commitment to providing high-quality anesthesia care and creating a positive experience for you is always our top priority.**

We want you to go into your surgery feeling comfortable and relaxed. Below, you'll find a wealth of information, including dos and don'ts, FAQs and more to help you understand anesthesia, prepare for your procedure and know what to expect afterward. If you don't find answers to your questions here, please contact us (/patients/provide-feedback).



I have had surgery many times, so I know what it is like to be a patient. My goal is to have a relaxed, informed patient going into the OR.

Mark Anderson, MD

USAP-Florida

Types of Anesthesia

The goal of anesthesia is to administer medications through various techniques to assure your comfort and safety during a surgical procedure. He or she will maintain constant monitoring and vigilance to assess your response to both the surgery and anesthetic.

General anesthesia

General anesthesia is achieved through a combination of intravenous medications injected through an IV in your vein and/or inhalational agents (gases) you will breathe through a mask or breathing tube. General anesthesia provides a total loss of consciousness and pain control so you will not be aware of sensation or pain during your procedure. It is the most common type of anesthesia technique.

Regional anesthesia

Regional anesthesia blocks pain to a specific area of your body. Your anesthesia clinician injects medication near a targeted nerve, cluster of nerves or the spinal cord. You may also receive medication to help you relax during your procedure. Two main types of regional anesthesia are:

- **Peripheral nerve blocks:** This type of block targets a specific nerve or group of nerves most commonly for procedures on hands, arms, feet, legs or face.
- **Epidural or spinal anesthesia:** This is an injection for nerves in the spinal canal that blocks pain for a large area of the body such as the abdomen, hips or legs.

MAC (Monitored Anesthesia Care or Procedural/Conscious Sedation)

MAC involves IV medication to help you relax and reduce pain. You will not be completely "out" but can be very sleepy. For more detailed information on several anesthesia topics, visit the When Seconds Count website created by the American Society of Anesthesiologists: www.asahq.org/whensecondscount (https://www.asahq.org/whensecondscount)

Common Words and Definitions

We've put together a list of common words with their definitions you may hear before and after your procedure:

- **Analgesia:** Absence of normal sense of pain without loss of consciousness
- **Analgesic:** A drug that relieves pain without causing loss of consciousness, such as an aspirin
- **Anesthesia:** Partial or complete loss of feeling or sensation, with or without loss of consciousness, primarily for the purpose of surgery or other medical procedure. There are three main categories of anesthesia: general, regional, and local.
- **Anesthetic:** a drug that produces anesthesia administered by inhalation (breathing) or intravenously (injection or through an IV)
- **Anesthesia Care Team:** Anesthesiologists, CRNAs and CAAs working together to administer anesthesia and monitor patient condition during surgery, other medical procedures, or delivery of a baby
- **Anesthesiologist:** Physician specializing in administering analgesia and anesthesia
- **Anesthesiology:** The branch of medicine concerned with reducing or eliminating pain or feeling in patients undergoing surgery, the delivery of a baby, or other medical procedures
- **Anesthetist:** One who administers an anesthetic. In many parts of the world, and particularly in Britain, this term applies to both nurses and doctors. However, in the USA and Canada, physicians who administer anesthetics are referred to as anesthesiologists
- **Certified Registered Nurse Anesthetist (CRNA):** A highly-trained nurse specializing in the administration of anesthetics
- **Endotracheal Tube (Breathing Tube):** A tube placed in a patient's windpipe to help the patient breathe; commonly used during general anesthesia
- **Epidural Anesthesia:** Anesthesia produced by injection of a local anesthetic into the peridural space of the spinal cord, frequently used during delivery, for surgeries below the waist, and for post-operative pain management
- **General Anesthesia:** Anesthesia where the patient is rendered unconscious by administration of intravenous and/or inhalation anesthetics for the period of surgery. The patient's major bodily functions are closely monitored by a member of the Anesthesia Care Team. A breathing tube is usually required during general anesthesia
- **Local Anesthesia:** Anesthesia where a small area is deadened by injection of a local anesthetic.
- **Narcotic:** A drug that produces insensibility or stupor. The term is now generally used to describe a class of drugs, such as morphine, which are addictive analgesics
- **Regional Anesthesia:** Anesthesia where an anesthetic is administered by injection to deaden a part of the body such as an arm or leg. The patient remains conscious, though often sedated, throughout the procedure
- **Sedation:** Anesthesia where a drug is given to calm a patient during an otherwise excited, uncomfortable, or anxious period of time. Often administered to patients immediately prior to surgery or during uncomfortable medical procedures
- **Sedative:** A substance that tends to calm, moderate, or tranquilize nervousness or excitement

The History of Anesthesia

The conquest of pain

Try to imagine today's health care without surgery. It's almost impossible. Now try to imagine surgery without anesthesia. Equally impossible. Without anesthesia, many of modern medicine's greatest benefits simply would not exist.

More than 35 million surgical procedures are performed each year in the United States alone. Clearly, the health and well being of almost everyone you know has been touched by the science of anesthesiology. Surgical procedures are carried out in hospitals and outpatient settings by the thousands every day. You usually take them for granted, and you should; current safety figures are impressive. So much so, you may lose sight of how long a way physicians have come in only the last 100 years, and even in the last five years when more lengthy and complex operations than ever before have been made possible by recent advances in anesthesiology.

Today's anesthesiologists now practice one of the most complex disciplines of medical specialization. These doctors, along with their Care Team colleagues, command a vast amount of medical knowledge about the human body, about drugs and how they act upon the body, and about the sophisticated technology used to track every major organ system during surgery and to administer drugs in a variety of ways.

During a major operation, anesthesiologists choose from a variety of medications to fulfill many different functions such as stopping pain, making the patient unconscious, and relaxing the body's muscles. To do this, they may work with Care Team members to administer inhalational anesthetic agents, sedatives, muscle relaxants and many other medications that act to help maintain normal body functions. The anesthesiologist must skillfully orchestrate all of these medications in accordance with the individual medical and surgical needs of each patient.

At the same time, anesthesiologists have improved techniques for turning off a patient's response to pain in specific regions of the body; this means that patients may remain conscious and recover more quickly after certain surgical procedures.

Only 60 years ago, administering ether through a mask and monitoring the patient with a simple stethoscope was considered to be the state of the art. Today, ether is not used for anesthesia and very sophisticated monitors are standard procedure. Currently, medications designed molecule by molecule on computer screens for more effective applications within the human brain are in use in today's operating rooms. Dramatic advances in technology continue to create monitoring devices with even more subtle and accurate measuring capabilities. National and international anesthesiology conferences are regularly convened to transmit the explosion of research, new information and new applications for patient care.

The future of medicine-surgery in particular-will continue to benefit from new advances in anesthesiology. All of this progress will allow anesthesia clinicians to better perform their most crucial and basic task: safely caring for the health, comfort and quality of life of all their patients.

Role in modern medicine

Most people believe that anesthesiologists are the doctors who administer medications, which keep them from feeling pain and sensations. However, few people realize that beyond ensuring the patient's comfort, today's anesthesiologists' primary role in the operating room is to make informed medical judgments to protect and regulate the patient's critical life functions that are affected by the surgery being performed. Also, these medical specialists are the doctors who will immediately diagnose and treat any medical problems that might arise during surgery or the recovery period.

Anesthesiologists need a wide range of knowledge about medications, internal medicine, how the human body works, and its responses to the stress of surgery. As physicians, anesthesiologists are responsible for administering anesthesia to relieve pain and for managing vital life functions, including breathing, heart rhythm, blood pressure, and brain and kidney functions during surgery.

As doctors, they manage, and treat any medical problems which may be present before surgery or that may develop during or immediately after surgery. Those patients who have received medical evaluations or treatment from their physicians before surgery must have that same medical care continued during surgery by their anesthesiologist.

Prior to surgery, anesthesiologists evaluate the patient's medical condition and formulate an anesthetic plan for each individual patient taking into consideration that patient's physical status. During surgery, advanced technology is used to monitor the body's functions. Anesthesiologists must interpret these sophisticated monitors in order to appropriately diagnose, regulate and treat the body's organ systems while a personalized, very delicate balance of anesthetic medications is administered. In some hospitals, nurse anesthetists may assist the anesthesiologists with the monitoring responsibilities. However, it is the anesthesiologists who are responsible for the interpretation of that monitoring and who make educated medical judgments concerning the patient's responses, and when it is and when it is not appropriate to treat the patient.

At the conclusion of surgery, anesthesiologists reverse the effects of the anesthetic medications, and return the patient to consciousness once again.

They maintain the patient in a comfortable state during recovery, and are involved in the provision of critical care medicine in the intensive care unit.

Medical training

Anesthesiologists are physicians who, after graduating from college with a strong background in physics, chemistry, biology and mathematics obtain a medical doctorate degree after completing four years of medical school.

After medical school, today's anesthesiologists learn the medical specialty of anesthesiology during an additional four years of post medical school training (one year of internship and three years in an anesthesiology residency program).

During the first year, anesthesiologists must complete training in diagnosis and treatment in other areas of medicine-such as internal medicine, neurology, obstetrics, pediatrics or surgery-or complete a rotating internship where they spend an equal

amount of time training in each of the other areas of medicine. Today's anesthesiologists then spend three intensive years of training in anesthesiology learning the medical and technical aspects of the specialty. In addition, they may further specialize in a subspecialty, such as neurosurgical anesthesiology, by completing one to two more years in a subspecialty training program.

But, even when residency training is completed, anesthesiologists continue to spend a great deal of time in special courses and seminars studying new medical advances and anesthetic techniques throughout their careers. Today's anesthesiologists are educated in cardiology, critical care medicine, internal medicine, pharmacology and surgery to be able to fulfill their role in modern medicine.

Please Note: The information provided on this website does not take the place of consultation with one's physician. The advice given does not establish a physician-patient relationship.

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Ft. Lauderdale, FL 33301

What do anesthesiologists do?

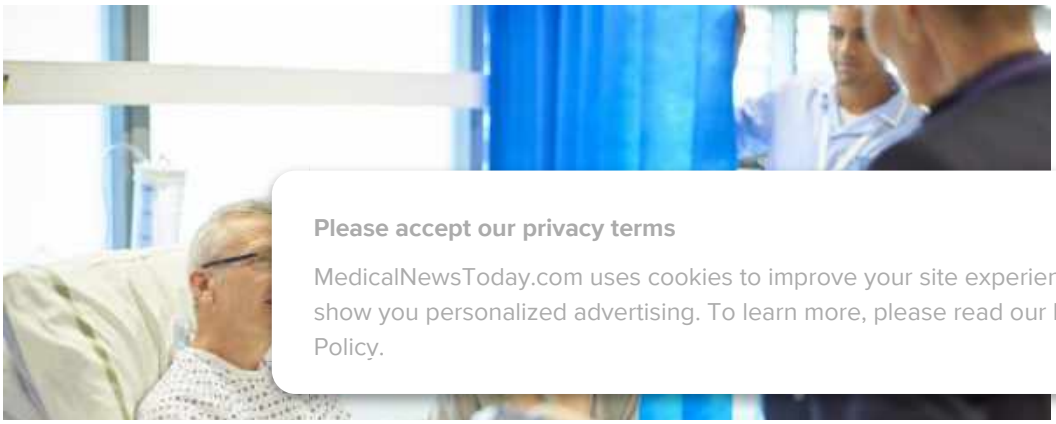
Medically reviewed by Deborah Weatherspoon, Ph.D., R.N., CRNA — Written by Markus MacGill on December 11, 2017

An anesthesiologist is a doctor who gives a patient medication so they do not feel pain when they are undergoing surgery.

However, these specialist physicians play a much wider role than just putting people to sleep for surgery.

They are also involved in a range of other medical procedures, including carrying out assessments in critical care units, dealing with emergency situations, and giving advice about pain management.

What is anesthesiology?



Anesthesiologists manage pain relief and more.

Anesthesiology is defined by the American Society of Anesthesiologists as: “The practice of medicine dedicated to the relief of pain and total care of the surgical patient before, during and after surgery.”

Anesthesiologists are involved in around 90 percent of the more than 40 million surgical procedures that are carried out under anesthetic each year in the United States.

This involvement may include direct care of the patient or supervision of Certified Registered Nurse Anesthetists (CRNAs) or Anesthesia Assistants, who also play a key role in the field.

In 2016, there were over 30,000 anesthesiologists employed in the US and many more who were self-employed.

What do anesthesiologists do?

The anesthesiologist provides pain relief before, during and after surgery, but they also fulfill a number of other important roles.

Pain relief in surgery

Before an operation, a patient will meet with the anesthesiologist for an evaluation. The anesthesiologist will make a plan for the operation that takes into account the individual needs of the patient.

On the day of the operation, the anesthesiologist supervises the administration of medication so that the patient will not experience pain.

However, the anesthesiologist does not physically provide most anesthetics. They supervise either a CRNA or Anesthesia Assistant while they provide the anesthetic. CRNAs often work independently without supervision as well.

The type of pain relief offered during surgery may be:

Sedentary lifestyle linked to cancer mortality

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General anesthesia: The patient “goes to sleep” while the operation lasts.

Sedation: Intravenous drugs calm the patient or make them unaware of the procedure.

Regional anesthesia: Local anesthetic is injected near the nerves to numb the area that will be operated. These may be nerve blocks or spinal or epidural injections.

During the procedure, the surgeon carries out the surgical work, but the anesthesiologist will continue to be responsible for the medical management of the patient.

They monitor the patient’s bodily functions, assess the best way to treat the vital organs, and provide a balance of medications suited to the individual’s needs.

The functions they need to monitor include:

- heart rate and rhythm
- breathing
- blood pressure
- body temperature
- fluid balance

The anesthesiologist controls these vital measures and the patient’s level of pain and unconsciousness throughout the operation.

After surgery

After the procedure, the anesthesiologist continues to be responsible for the patient’s overall care. They will reverse the effects of the anesthesia and continue to evaluate the patient and keep them comfortable as they recover.

During this process, the anesthesiologist will direct other health workers, including specialist nurses.

Critical and emergency care and other roles

The anesthesiologist also plays a key role in critical care and treatment and trauma. They assess patients, make diagnoses, provide support for breathing and circulation, and help to ensure that infection is prevented.

Anesthesiologists are also qualified to contribute to emergency medicine, providing airway and cardiac resuscitation and support and advanced life support, as well as pain control. They help stabilize patients and prepare them for surgery.

Some anesthesiologists will seek additional training and qualifications to specialize in pain medicine and critical care.

Specializations

Every anesthesiologist is trained to support surgical intervention, but many also specialize in particular areas.

These include:

- cardiac anesthesia, for heart surgery
- pediatric anesthesia, for pain management and anesthetics in children
- neuroanesthesia, related to surgery for the nervous system, brain, and spinal cord
- obstetrics, offering pain relief during labor and delivery

Other areas of medical care include pediatric anesthesia (pain management and anesthetics in children), care of the dying in hospice, and palliative care.

Pain control and advice

An anesthesiologist who specializes in pain medicine may assist patients who have pain due to a range of causes, including headaches, burns, diabetes and herpes, or where they are experiencing chest pain, abdominal, pain pelvic pain, and so on.

Their role in this field includes:

- treating the patient
- prescribing medication and rehabilitative services
- performing pain-relieving procedures
- counseling patients and families

They may also direct a multidisciplinary team, coordinate other health care professionals, and act as a consultant about the best way to deliver care to patients who have pain.

Critical care

Anesthesiologists who work in critical care are sometimes known as intensivists.

The anesthesiologist-intensivist helps with diagnosing and managing disorders that affect all body systems, whether to do with circulation, digestion, the kidneys, the nervous system, or any other system.

Anesthesiologists working in critical care are also qualified to help when a patient is unconscious, whatever the reason.

This involves coordinating the overall medical management of a patient and coordinating with a range of medical professionals and possibly also the patient's family and friends.

Obstetrics

Anesthesiologists are involved in maternity units, where they administer pain relief and assist if complications arise.

A midwife can give some kinds of pain relief medication, but if this is insufficient, the anesthesiologists can administer stronger medicines intravenously (IV).

An epidural supplies anesthetic medicines to the lower back to reduce the pain felt from contractions.

If a cesarean section is needed, stronger anesthetics can be given in the same location, to numb the lower body completely for surgery.

If severe complications arise, the anesthesiologist may need to provide a general anesthesia.

The anesthesiologist can provide or supervise the administration of medications such as morphine, fentanyl, and others.

The patient may be given control of their pain management, under the anesthesiologist's supervision. They may be given an infusion pump that delivers additional analgesic medication whenever the patient presses the button.

Qualifications

Anesthesiologists are doctors. Like other doctors, they start by taking a 4-year undergraduate degree, followed by 4 years of medical school.

After this, they must complete a further 4 years in an anesthesiology residency program.

Finally, they can go on to sit a further examination for certification from the American Board of Anesthesiology (ABA).

If they wish to specialize further, they will enter a fellowship program of one year or more, to train in:

- pain management
- cardiac anesthesia
- pediatric anesthesia
- neuroanesthesia
- obstetric anesthesia
- critical care medicine
- hospice and palliative medicine

Finding an anesthesiologist

Before a procedure, the ABA suggests that patients ask questions such as the following, to find out more about their anesthesiologist, and what to expect:

- Are you qualified by the ABA?
- What type of anesthesiology do you recommend for my case?
- What are the risks and benefits of this option, and what other options are there?
- Will I need a breathing tube, and will it be there when I wake up?
- What options will there be for managing my pain after the procedure?

To check whether an anesthesiologist is fully qualified and board certified, contact the ABA website.

Last medically reviewed on December 11, 2017

Surgery Emergency Medicine Medical Students / Training

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What Does an Anesthesiologist Do?

Surgery would be a far more unpleasant experience if it weren't for anesthesiologists. These specialists give you medicine to prevent pain and, if necessary, make sure you sleep through your procedure.

IN THIS ARTICLE

Anesthesiologists don't just work in the operating room. They also give pain relief if you have an ongoing condition like back pain or cancer. And after surgery, they sometimes help you control pain after you get home, too.

What Kind of Training Do Anesthesiologists Have?

A medical doctor (MD) or a doctor of osteopathy (DO) can become an anesthesiologist. After medical school, the next step is a 1-year internship. That's followed by a 3-year hospital residency in anesthesia. Altogether, anesthesiologists can have 12,000 to 16,000 hours of training.

Doctors who complete their residency program can take the American Board of Anesthesiology (ABA) exam. This board certification means a doctor has gone above and beyond the basic standards in anesthesiology. Nearly 75% of anesthesiologists in the U.S. have this distinction.

Some anesthesiologists will do an extra year of training called a fellowship in one of these specialties:

- Heart (cardiac anesthesia)
- Brain and spinal cord (neuroanesthesia)
- Childbirth (obstetric anesthesia)
- Children (pediatric anesthesia)
- Pain management
- Emergency surgery (critical care medicine)

CONTINUE READING BELOW

RECOMMENDED FOR YOU

SLIDESHOW

Why Are My Feet Swollen?

SLIDESHOW

Warning Signs of Kidney Problems

SLIDESHOW

Create a Healthy Bedroom

QUIZ

Summer Health Myths Should You Pee on a Jellyfish Sting?

SLIDESHOW

Things That Hurt Your Feet

Anesthesiologists on the Job

Anesthesiologists can give you several different types of pain relief:

General anesthesia. It puts you "asleep" during surgery. You'll get this for a variety of procedures, including major operations like knee replacement surgery or heart surgery. You get medicine in a needle in a vein (IV) to put you to sleep and then breathe the medicine in through a tube in your airway to keep you asleep. .

Sedation. It helps you relax before and during your procedure. The effects can range from mild drowsiness to full sleep. You may not remember exactly what happened, but you won't be totally unconscious.

Regional anesthesia. This type of anesthesia numbs just the area of your body where you will have surgery. For example, doctors use this type of pain reliever for surgeries on one

arm or leg.

Local anesthesia. It numbs a smaller area where you will have surgery. You could get this type of anesthesia for a procedure to remove skin cancer. The doctor may rub a cream or gel on your skin or give you a shot. You'll be awake, but you won't feel any pain.

Nerve block. It's a shot that relieves pain from injuries and medical conditions. Doctors often use it to treat pain in a certain area, such as the back.

1 2

View All < NEXT PAGE

Propofol: Expert Q&A

The Risks of Anesthesia and How to Prevent Them

What Is an Obstetrician?

What Is General Anesthesia?

What to Expect When You're Sent Home After Surgery

What Is a Pediatrician?

Anesthesiologist Overview

Overall Score 7.2 / 10

#1 in **Best Paying Jobs** | **#12** in **Best Healthcare Jobs** | **#17** in **100 Best Jobs**

What is an Anesthesiologist?

Anesthesiologists are the physicians responsible for administering general or regional anesthesia, which allows surgeons and other physicians to complete invasive procedures with little to no discomfort to the patient. Anesthesiologists also closely monitor a patient's vital signs and critical life functions before, during and after a surgery – making rapid decisions on limited data when required. To say that the profession is stressful is an understatement.

More than 150 years ago, ether – the first anesthetic – was hailed the "greatest gift ever made to suffering humanity." Today the drugs are different, but any woman who has experienced the excruciating pain of contractions followed by the amazing relief of an epidural will tell you that anesthesia remains one of the greatest gifts to humanity.

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MEDIAN SALARY
$208,000

UNEMPLOYMENT RATE
0.4%

NUMBER OF JOBS
1,500

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Rankings

Anesthesiologists rank #1 in Best Paying Jobs. Jobs are ranked according to their ability to offer an elusive mix of factors. Read more about how we rank the best jobs.

#1 in **Best Paying Jobs**

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SCORECARD	7.2
Salary	10
Job Market	10
Future Growth	8
Stress	2
Work Life Balance	2

HOW WE RANK JOBS »

BEST PAYING JOBS

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#2 Surgeon

#3 Oral and Maxillofacial Surgeon

#4 Obstetrician and Gynecologist

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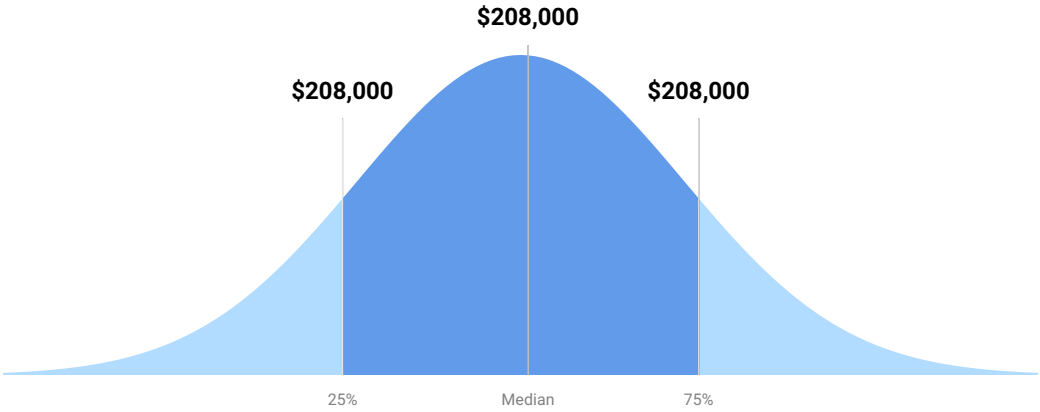
Physician
Median Salary: $194,500

Surgical Technologist
Median Salary: $47,300

SEARCH ALL JOBS »

How Much Does an Anesthesiologist Make?

Anesthesiologists made a median salary of $208,000 in 2018. The best-paid 25 percent made $208,000 that year, while the lowest-paid 25 percent made $208,000.



See Full Salary Details »

How to Become an Anesthesiologist?

The journey to becoming an anesthesiologist is a long one. Here are the steps to take:

1. Get a bachelor's degree. You'll need a college degree to apply to medical school. Several prerequisites are required, such as biochemistry and physics.
2. Take the Medical College Admission Test. Taking the MCAT – and earning a high score – is required for entrance to medical school. Topics covered on the exam include biology, chemistry and critical analysis.
3. Attend medical school. Medical school is typically completed in four years. The curriculum includes clinical rotations in addition to traditional coursework.
4. Pass a licensure exam. Graduates who want to practice medicine in the U.S. need to pass a licensing exam first. Graduates with an MD take the United States Medical Licensing Examination and those with a DO take the Comprehensive Osteopathic Medical Licensing Examination.
5. Undergo residency. After completing medical school, you'll undergo a one-year internship followed by a three-year residency in anesthesiology.
6. Obtain state licensure. All anesthesiologists have to obtain state licensure, though the requirements vary by state.

After going through medical school, residency and a fellowship, an anesthesiologist will have completed anywhere from 12,000 to 16,000 hours of clinical training, according to the American Society of Anesthesiologists.

Most anesthesiology residents go on to do a one- to two-year fellowship program to learn a subspecialty, such as critical care or obstetric anesthesia. Anesthesiologists may also receive their board certification through the American Board of Anesthesiology. Though not required, it

demonstrates advanced skill and knowledge. Becoming certified also helps many with getting more professional opportunities or a higher salary.

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Job Satisfaction

Average Americans work well into their 60s, so workers might as well have a job that's enjoyable and a career that's fulfilling. A job with a low stress level, good work-life balance and solid prospects to improve, get promoted and earn a higher salary would make many employees happy. Here's how Anesthesiologists job satisfaction is rated in terms of upward mobility, stress level and flexibility.

Upward Mobility Opportunities for advancements and salary	**Above Average**
Stress Level Work environment and complexities of the job's responsibilities	**High**
Flexibility Alternative working schedule and work life balance	**Low**

Advice From Real Anesthesiologists »

Emily H. Bratcher

Emily Halonen Bratcher's writing and editing has appeared in many national outlets and ... **READ MORE »**

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Next: Salary →

HOW TO BECOME A ANESTHESIOLOGIST

Alternate Career Title: Anesthesia Specialist

Anesthesiologist Job Description: Anesthesiologists p as needed.

Anesthesiologist Salary (Annual): $261,730

Anesthesiologist Salary Range: $124,080 to $400,000

How Long To Become a Anesthesiologist: 8 years

Anesthesiologist Requirements: Doctor of Medicine D

Related Careers

89
SHARES

Become an Anesthesiologist

Career Description

An **Anesthesiologist** is a medical

doctor who is responsible for prescribing and administering anesthesia to patients as needed. Typically, anesthesia is administered before, during or after a surgery or other medical procedure. In addition to administering anesthesia, these specialized Medical Career professionals evaluate patients prior to surgeries and formulate an anesthetic plan to keep them both safe and comfortable during the procedure.

Throughout a surgery Anesthesiology Specialists will continuously monitor the patient's vital signs and the level and depth of anesthesia, making adjustments as needed. They are also responsible for recognizing any potentially life-threatening emergencies and timely intervention to

Careers

Healthcare Careers » Surgery

- Surgical Assistant
- Surgical Technologist
- Surgeon
- Anesthesiologist

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- Allergist
- Anesthesiologist
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- Obstetrician
- Optometrist
- Pediatrician
- Pharmacist

ensure the safety of all patients.

"A career as an Anesthesiologist is both highly demanding and very fulfilling," Peter Wu, M.D., FASA, CHSE, CPPS, an Anesthesiologist practicing in the Washington D.C.-area, said. "Career satisfaction comes from working in a role that has patient safety and comfort as the primary objectives. The rewards are many including intellectual stimulation, high earning potential and, perhaps most important, spiritual satisfaction that you are helping others."

Anesthesiologists routinely work alongside Perfusionists, LPNs, and Anesthesiologist Assistants.

Education & Training

To become a Anesthesiologist, preparation often begins in high school when a learner is encouraged to take advanced science courses. During this time, learners are also encouraged to begin volunteering or working at a hospital or other healthcare setting to gain first-hand experience within the

Podiatrist

Physician Assistant

Psychiatrist

Psychologist

Surgeon

Toxicologist

Urologist

20 Most Popular

1. Sonographer / Ultrasound Tech
2. Radiation Therapist
3. Dental Hygienist
4. Pharmacy Technician
5. Radiologic Technologist / X Ray Tech
6. Physical Therapy

healthcare industry.

Next, a learner must enroll in a undergraduate degree program. During an undergraduate program, which normally takes four years to complete, learners who intend on becoming Anesthesiologists should take classes including calculus, chemistry, biology, organic chemistry, physics and more.

“The path to becoming an Anesthesiologist is long and challenging, and requires a 4 year Bachelor’s Degree, followed by four years in medical school, followed by at least 4 years of additional training as a resident Physician,” Wu confirmed. “The undergraduate degree can be in any subject, but there are certain courses required to apply to medical school, including two years of chemistry, and one year each of biology, physics and calculus.”

Upon graduating from a undergraduate program, learners should next take their Medical College Admission Test, and upon receiving their score, apply to medical schools. Typically, medical school programs take an additional four years to complete, including two years of in-class instruction and two years of clinical rotations (anesthesia being one of the rotations, although it is not typically a required rotation in most medical schools and should be taken as an elective).

After graduating from medical school, Anesthesiologists must become licensed and certified in anesthesiology and complete a 4-year or longer

Assistant

7 Veterinary Technician

8 Medical Assistant

9 Surgical Technologist

10 Occupational Therapy Assistant

11 Registered Nurse

12 Certified Nursing Assistant

13 Emergency Medical Technician

14 Dental Assistant

15 Respiratory Therapist

16 Physician Assistant

17 Dietitian

18 Cardiovascular Technologist

19 Phlebotomist

20 Surgical Assistant

and complete a 4 year or longer residency program in each of the many settings where anesthesia is administered. These facilities may focus on specific areas within anesthesiology, including pain medicine, research, critical care and education.

"Medical school itself is generally much more challenging than undergraduate school because of the volume and complexity of the material that must be mastered," Wu explained. "Residency also presents challenges, as a resident typically works at least 80 hours per week, and additional must read and study after a clinical shift has ended."

Wu added that a Physician of any specialty faces a large number of examinations throughout their entire career. In Anesthesiology, he noted that

requirements today!

Advancement

"Career advancement in anesthesiology can come in many forms," Wu said. "The most common is to do a fellowship, which is 1 or more additional years of training to practice in a sub-specialty area of anesthesiology, such as cardiac anesthesiology or pain management."

Specialty areas of practice within anesthesiology may include critical care medicine, pain management, pediatric anesthesiology, cardiac anesthesiology, obstetric anesthesiology or neuro-anesthesiology. Additionally, when

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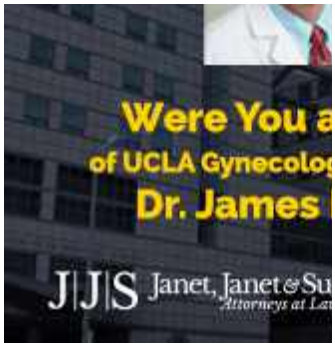
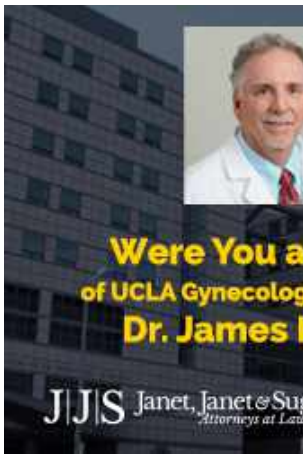
trying to advance in this career in healthcare, networking with other industry professionals, as well as potentially reaching out to career recruiters, can also prove beneficial.



"Anesthesiologists looking to move into hospital administration benefit from Master's Degrees in fields such as business administration or healthcare



administration, and additional certifications are available in the areas of patient safety, medical simulation and coding for billing," Wu explained. "Preparation for leadership roles include assuming collateral duties within a department, for example as a Division Chief or Safety Officer."

Experience & Skills

"To do this work requires being good at math and science, but a successful Anesthesiologist must also have excellent people and procedural skills," Wu explained.

Additionally, to be an effective Anesthesiology Specialist, these Physicians should have exceptional judgment, problem-solving and complex critical thinking skills, allowing them to make immediate decisions when necessary. Furthermore, these professionals should possess communication skills, organizational skills, time management skills, instructional skills and be dexterous. Along with being dexterous, these professionals must be skillful in the operation and manipulation of the

instruments and tools needed to administer anesthesia.

“There is a common misconception that Anesthesiologists don’t need people skills because their patients are always asleep, but nothing could be further from the truth,” Wu expressed. “Anesthesiologists first meet their patients when fully awake, and they must quickly gain the patient’s trust as the Anesthesiologist is about to lead that patient through what is potentially one of the most stressful periods in their entire life.”

Wu added that communication skills are also vital as the Anesthesiologist always works in a team, which may include Surgeons, Nurses and Surgical Technologists, that work in the operating room and other settings. He noted that being able to talk to people and form relationships is critical to being a successful Anesthesiologist. Some Anesthesiologists further noted that sometimes this career can feel like a somewhat thankless position.

Personality

Qualities which make a strong Anesthesiologist include being detail oriented, organized and methodological. These characteristics help to ensure that there is no room for error when administering anesthesia to patients. Also, being able to work as a team with other healthcare professionals is needed, as administering anesthesia is often done

in conjunction with another practitioner is performing. Anesthesiology Specialists should also remain open minded to continuously furthering their education as new technologies and advancements improve how anesthesia can be administered.

“An anesthesiologist should be good with people, good at math and science and able to make rational decisions quickly in stressful situations,” Wu added.

Lifestyle

Most Anesthesiologists are employed full-time, and tend to work long hours. Their days usually start around 6:30 am and typically last 10 to 24 hours. They may also be required to work evenings, nights, weekends and holidays, as well as being on-call as needed. However, the scope of work in this career in healthcare can be high-stress and require a great deal of concentration and alertness.

“Hours in this career range from full-time to part-time, including overnights and weekends in large tertiary care hospital settings, to part-time, lower stress positions in ambulatory surgery centers,” Wu explained. “There is no typical day for me. My day could start at 6 am or 10 pm depending on my shift.”

Furthermore, Anesthesiology Specialists must always be prepared for a potential crisis to arise in emergency care where their services are needed. In

these circumstances, Anesthesiologists must be able to remain calm and focused on their necessary responsibilities.

Employment

Anesthesiologists are greatly needed throughout the field of healthcare, and because of this, the occupation is

projected to grow 7 percent over the next decade. Industries with the highest level of employment in this occupation are the offices of Physicians, hospitals, outpatient care centers, post-secondary education settings and the offices of other health practitioners. The state with the highest employment level in this occupation is Texas, followed by California, Florida, New York and Pennsylvania.

“Because of the demand for anesthesia services in the US, there are many different kinds of anesthesiology positions,” Wu explained. “After completing the required training to become an Anesthesiologist, there are several websites and recruiters that can help you find the best position for you. One popular one is at gaswork.com.”

Earnings

A career as an Anesthesiologist can be extremely lucrative. The average wage for Anesthesiologists was $261,730. While the lowest 10 percent of employees within this occupation were recorded to have earned less than $124,080, the highest 10 percent of

professionals earned more than $400,000.

Additionally, the highest paying employers of Anesthesiologists are the offices of Dentists, outpatient care centers, the offices of Physicians, specialty hospitals and the offices of other health practitioners. Top paying states within this occupation include West Virginia, Oregon, Oklahoma, North Carolina and New Hampshire.

"Earning potential in this career is excellent, for now," Wu said. "There is a growing demand for anesthesia services, and the average age of an anesthesiologist in the United States is in the late 40's to early 50's. I say 'for now,' because there is a lot pressure to reduce healthcare costs, and decision makers will be looking at ways to reduce the total cost of anesthesia care."

He added that reducing the total cost of anesthesia care includes shifting services to Certified Registered Nurse Anesthetists ("CRNAs") and Anesthesiology Assistants ("AAs"), as well as lowering Physician compensation. Wu explained that no one can predict the future of Anesthesiologists' salaries in future with certainty, because there are so many contributing factors.

Unions, Groups, Social Media, and Associations

The **American Society of**

The **American Society of Anesthesiologists** (ASA) is an organization designed to raise the standards of practice of anesthesiology and to improve patient care through education, the scientific association of physicians and research.

The **American Society of Regional Anesthesia and Pain Medicine** (ASRA) is an organization focused of the subspecialty medical societies in anesthesiology. The goal of the ASRA is to be the leader in regional anesthesia and acute and chronic pain medicine through innovations in education and research. ASRA plans to accomplish this mission by addressing the clinical and professional educational needs of physicians and scientists, ensuring excellence in patient care, investigating the scientific basis of the specialty and utilizing regional anesthesia and pain medicine.

Getting Started

- Determine if you are willing to commit to the many years of schooling to become a Physician
- Shadow a working Physician
- Complete an undergraduate degree program striving to obtain the best, most competitive grades possible
- Research and apply to top medical school programs

All statistics are provided by the Bureau of Labor Statistics.

March 23, 2020

NURSING & HEALTHCARE (/BLOG/CATEGORIES.HTML?CATEGORIES=NURSING-HEALTHCARE)

Nurse anesthetist vs. anesthesiologist.

For those interested in pursuing healthcare careers, there are a wide variety of options that you can choose from. And some of the options seem really similar. For example, a nurse anesthetist and anesthesiologist. What are the differences between these two similar positions? While it may seem that they're pretty similar, the

reality is that these two career paths are very unique.

Certified registered nurse anesthetists (CRNAs) are the nurses that work independntly to administer anethesia, or may collaborate with and assist doctors, dentists, surgeons, and other medical professionals in anesthesia administration.

Anesthesiologists are physicians that specialize in the administration of anesthesia.

The major difference between these two professions is that anesthesiologist are medical doctors that administer anesthesia, while nurse anesthetists are registered nurses who may assist or collaborate with doctors in administering anesthesia, or may work entirely independtly as they administer anesthesia.

This guide will dive deeper into the differences between these two healthcare professions, their salaries and job requirements, and their career paths.

What is a nurse anesthetist?

What do certified registered nurse anesthetists do?

Nurse anesthetists are critical members of medical care teams. Their actual role and responsibilities may vary based on the state where they are certified, but some of their job responsibilities may include:

- Providing pain management
- Assisting physicians with anesthesia administration
- Overseeing patient recovery
- Performing epidurals or spinal blocks
- Providing care before, during, and after anesthesia
- Being up-to-date on patient medical history to ensure anesthesia is safely administered
- Discussing anesthesiology side-effects with patients
- Monitoring vital signs during procedure

In many areas, nurse anesthetists are the main providers of anesthesia. Certified registered nurse anesthetists can work in a wide variety of settings including hospitals, surgical centers, outpatient care centers, offices of dentists or plastic surgeons, U.S. military medical facilities, and more.

Earnings and career outlook for CRNAs.

Nurse anesthetists are highly trained and skilled, which means they are well-compensated. CRNAs can expect an average annual salary (https://www.bls.gov/oes/2018/may/oes291151.htm) of about $174,000 or $84 per hour. This is much, much higher than the national average salary, and is one of the highest paying jobs for nurses. (https://www.wgu.edu/blog/top-5-careers-nursing1803.html) This is largely due to the high skill-set certified registered nurse anesthetists need in order to do this specific nursing job well. They are responsible for patient

safety during important surgical procedures, and their work in surgery or pain management is vital to patient success. The location where you work, the nursing education you have, and your nursing experience will greatly influence your average salary as a CRNA.

The demand for nurse anesthetists is expected to grow 26% by 2028, much faster than average job growth. The field is seeing high demand as medical practices advance and more surgical and pain management options become available. There is also a nursing shortage around the country, meaning highly trained nurses like nurse anesthetists are difficult to come by.

Requirements to become a CRNA.

The first step to becoming a CRNA is to get a bachelor's degree in nursing (BSN) (https://www.wgu.edu/online-nursing-health-degrees/bachelors-programs.html) and be a registered nurse (RN). WGU has options for current registered nurses to obtain their BSN, as well as options for nursing hopefuls to earn their BSN and be prepared to become an RN. Once you've become a nurse and obtained your degree and registration, you'll need at least one year of experience as an RN before you can continue with your education. You'll likely need experience in an acute care setting, like the ER or ICU, in order to have the experience you need to progress toward becoming a CRNA.

The next step to becoming a CRNA is to get a master's degree or higher from an accredited nurse anesthesia program. This usually takes 2-3 years. After you've obtained that degree, you'll need to take and pass the National Certification Examination through the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) in order to be licensed and eligible to work as a CRNA. Every two years you'll have to prove that you've had 40 hours of continuing education in order to keep your CRNA license.

While there is a lot of work and education that goes into becoming a certified registered nurse anesthetist, for most it is well worth the time and effort. It is a great, high-paying profession that allows you to help patients heal and feel better every day.

What is an anesthesiologist?

What do anesthesiologists do?

Anesthesiologists are physicians who administer drugs that reduce or completely eliminate pain before, during, or after a medical procedure or surgery. Their job description includes:

- Administering epidurals, anesthesia, spinal blocks, and more
- Monitoring patient vital signs during surgery or procedures
- Supervising anesthesia assistants and CRNAs
- Approving general, sedative, regional, or local anesthetics
- Reviewing medical files and lab results

- Informing patients the side effects of anesthesia
- Complying with medical and hospital regulations

Anesthesiologists are in charge of helping reduce and remove pain and complications that are associated with surgery or medical procedures.

Earnings and career outlook for anesthesiologists.

As medical doctors, anesthesiologists have an incredibly high pay. They earn an average annual salary (https://www.bls.gov/oes/2018/may/oes291061.htm) of $267,000 per year, or $128 per hour. Doctors in general have a much higher pay than the national average because of all the extensive schooling and training that they require. The location where you work and your experience will directly impact how much you can make as an anesthesiologist.

The job outlook for anesthesiologists is 15% growth by 2026. That's double the pace of the national average for job outlook. As healthcare needs continue to grow, as medical procedures and surgeries continue to become more safe and a good option for healing, anesthesiologists will continue to be in high demand.

Requirements to become an anesthesiologist.

Anesthesiologists have an extensive amount of educational requirements. They must begin with a bachelor's degree in a science field. (https://www.wgu.edu/online-nursing-health-degrees.html) After getting an undergraduate degree, students must attend medical school. They can either become a Medical Doctor (MD) or a Doctor of Osteopathy (DO). After graduating from medical school, anesthesiologist hopefuls complete a one-year internship learning about anesthesiology. They then have a three year residency in anesthesiology. After this residency program, students often spend a year or more in a fellowship program to learn an anesthesiology subspecialty. Subspecialties include cardiac, pediatric, neurologic, obstetric, pain management, or critical care. The final step to become an anesthesiologist is to pass the American Board of Anesthesiology Exam. Becoming an anesthesiologist will require extensive schooling, training, and study.

Choosing the right career path for you.

After learning about both of these career paths, you may wonder which one is the best fit for you. There are key differences between these two career paths, including the major job responsibilities, salary, (https://www.wgu.edu/blog/how-the-role-of-a-nurse-affects-earning-power1911.html) and education requirements. If you're interested in anesthesia and pain management and are torn between these two career paths, it may be valuable to consider how much time you have to give to schooling, your current healthcare experience, and what your future career goals are.

Making a career game plan.

It's important to create a clear, but flexible, plan for your career in the future. It's important to understand the career options you're interested in and how they can fit into a career game plan. (https://www.forbes.com/sites/ashleystahl/2018/08/29/3-steps-to-develop-your-career-plan/#2cc15074910f)

If you know what you want and the options you have for getting there, you're much more likely to meet your goals. Spend time setting goals, reflecting on your past and future, and utilize those things to help you create an actionable game

Plan.

Whatever path your career takes, a bachelor's degree (https://www.wgu.edu/online-nursing-health-degrees.html) is a key place to start. A bachelor's degree will help you learn about the things you're good at and the things you enjoy, which can aid you in deciding what your future career goals will be.

CRNAs Will Need A Doctorate Degree By 2025

By Mariam Yazdi

Over the past few decades, the Certified Registered Nurse Anesthetist role has evolved into a popular career choice for nurses who are interested in critical care patient management and are wanting to grow their scope of practice.

Historically, CRNA certification required the successful completion of a master's degree. However, the landscape for CRNA entry requirements is changing, just as it has for RNs. If your goal is to become a nurse anesthetist, this changing landscape is something you must consider.

Why Are The Requirements Changing?

In the world of healthcare, more and more complex needs arise, which calls for more refined education. Many different healthcare practices — including Pharmacy and Physical Therapy — have recognized this, and have permanently moved toward a doctorate-level degree as the entry requirements to the profession.

The COA (Council on Accreditation) — the credentialing body for nurse anesthetists — is in support of raising the degree standard for CRNAs. Because of this, all schools are required to graduate only PhD-level CRNAs starting in the year 2025.

Who Will This Affect?

IN THIS ARTICLE

This will affect all nurses applying to CRNA schools through the year 2022. Because Ph.D. nurse anesthetist programs are typically 3 years, this timeline will allow for the first graduating class to meet the new requirement of having a Ph.D. by 2025.

What If I'm Already Enrolled In A Master's CRNA Program? Will I Need To Get A Doctorate Degree?

If you are already enrolled in a master's CRNA program, it will NOT be required of you to return to school and obtain a doctorate degree. It is important, however, to measure the benefits of continuing your education to obtain a Ph.D.

Questions to ask yourself include:

- Where do I want to work when I graduate?
- What are the typical credentials of the other applicants I will be competing with for the positions I want?
- Will a Ph.D. make me a more competitive candidate for these positions?
- How do I see my career evolving? Will a Ph.D. help me achieve the career advances I hope to accomplish one day?

Many schools offer a post-masters DNP, which works as a bridge program for those nurses who already have their masters and wish to obtain a terminal degree in nurse anesthesia. See below for a breakdown of the schools and what they offer.

Show Me CRNA Programs

I'm Already A CRNA, Will I Have To Obtain A Doctorate Next?

For licensure, current practicing CRNAs who obtained their license through a masters program will NOT have to complete a doctorate degree in order to have an active license. However, facility requirements may differ from institution to institution. It is possible that some facilities may require all their nurse anesthetists to have a Ph.D. in order to be considered for the position.

To keep up with degree requirements changes for CRNAs, follow the American Association of Nurse Anesthetists (AANA) or the Council on Accreditation (COA).

Here is a comparative list of CRNA schools in the United States and what type of degree they offer.

Information obtained from All-CRNA Schools State-by-State Listing

School	Docto
	A

Arizona State	x
	A
Stamford - Alabama	x
The University of Alabama at Birmingham	x
	Ca
Cal State Fullerton	x (and post
LLU School of Nursing	x
USC Medical Center	x
	Cor
Fairfield University Ct. and Bridgeport Hospital	x
Quinnipiac University	x (and post
Yale-New Haven Hospital	x (and post
Integrated Anesthesia Associates CRNA Program	x
	F
Barry University Florida	x (and post
Florida International University Miami	x (and post
University of Miami Florida	x (and post
University of North Florida	x (and post
University of South Florida	x
	G
Augusta University	x
Emory University	x
	I
North Shore University School of Nurse Anesthesia & DePaul University	x
Decatur Memorial Hospital with Milikin University	x (and post
Rush University	x (and post
Southern Illinois University Edwardsville	x (and post
	I
Marian University	x
University of Saint Francis	x

University of Iowa	x (and post·
Newman University Wichita	
University of Kansas Medical Center	x
	K
Baptist Health & Murray State University	x (and post·
Northern Kentucky University	x (and post·
	L
Louisiana State University	x (and post·
Our Lady of the Lake College	x
	I
University of New England	
	M
Uniformed Services University of the Health Sciences	x
University of Maryland	x
	Mas
Boston College	Post ma
Northeastern University	
	M
Michigan State University	
Oakland University	x (and post·
University of Detroit Mercy (UDM)	
University of Michigan Flint	x (and post·
Wayne State University	x
	Mi
Mayo Clinic Minnesota CRNA School	x
Minneapolis School of Anesthesia	
Saint Mary's University of Minnesota	
University of Minnesota Twin Cities	x (and post·
	Mi
University of Southern Mississippi	x
	M
Goldfarb School of Nursing at Barnes-Jewish College	

Goldfarb School of Nursing at Barnes-Jewish College	
Missouri State University School of Anesthesia	x (and post
Webster University St. Louis MO	x
Truman Medical Center School of Nurse Anesthesia University of Missouri Kansas City	x
	N
School of Nurse Anesthesia Bryan College of Health Sciences	x

Find Nursing Programs

1. Current Degree | 2. Desired Degree | Show Me Programs

CRNA vs DNP & DNAP: What's the Difference?

By: Kathleen Gaines BSN, RN, BA, CBC

Certified Registered Nurse Anesthetist (CRNA) is one of the fastest-growing fields for nurses and one of the most in-demand careers. According to the Bureau of Labor Statistics (BLS), there are currently 42,620 registered CRNAs in the United States with a projected rise of 31% from 2016-2026. By 2026, the BLS predicates there will be 48,600 CRNAs practicing in the United States.

Find Nursing Programs

1. Current Degree | 2. Desired Degree | Show Me Programs

A CRNA certification is not considered a terminal degree for nurses whereas a DNP or DNAP is. Currently, individuals can earn either an MSN, DNP, or DNAP depending on the anesthesia program they attend. While there might not seem to be a big difference between the different degrees, the Council on Accreditation of Nurse Anesthesia Education (COA) is transitioning to new requirements for entry into practice for all CRNAs.

By January 1, 2022, all Nurse Anesthesia programs must be doctoral degrees in order to maintain accreditation. Despite this deadline, the Council has extended the deadline to 2025 in order for CRNA programs to develop the proper curriculum that adheres to all national standards. Since MSN programs take over 2 years to complete, 2019 cohorts will likely be the last MSN-educated CRNAs in the field.

FAQ:

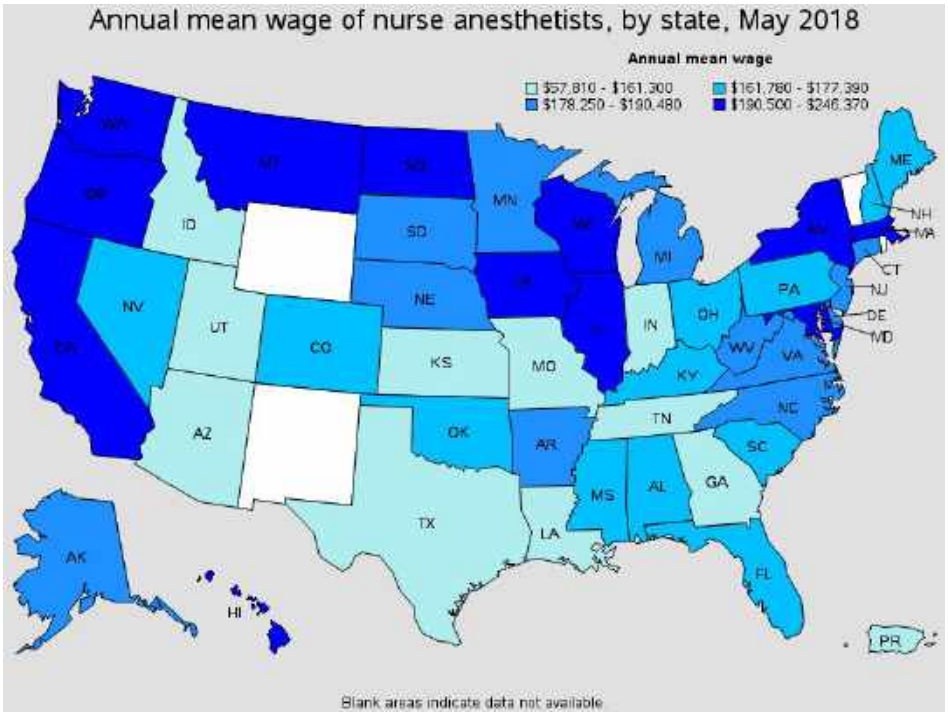
- **What is a CRNA?**
  - A certified registered nurse anesthetist is an advanced practice nurse who administers anesthesia for surgery and/or other medical procedures.
- **What is a DNP?**
  - The DNP is a doctor of nursing practice that is rooted in clinical practice and can be earned by any individual that holds an MSN degree.

IN THIS ARTICLE

- **What is a DNAP?**
  - The DNAP degree is a professional practice degree in nurse anesthesia, which focuses on the utilization of research findings for evidence-based clinical practice, education, and/or administration/business management related to nursing anesthesia.
- **What is the average salary for CRNAs?**
  - The Bureau of Labor Statistics (BLS) reports the average income of a nurse anesthetist to be $169,450 per year, with some CRNAs earning over $252,000. Top earning states include Montana, Wyoming, and California.
- **What is the career outlook for CRNAs?**
  - There are currently 42,620 registered CRNAs in the United States with a projected rise of 31% from 2016-2026. By 2026, the BLS predicates there will be 48,600 CRNAs.
- **Where can a DNP/DNAP work?**
  - Colleges and Universities
  - Research
  - Textbook author
  - Public Health/Government Health Policy
  - Legislation
  - Hospital administration
  - Medical and surgical hospitals
  - Critical access hospitals
  - Mobile surgery centers
  - Outpatient care centers
  - Offices of plastic surgeons, dentists, ophthalmologists, pain management specialists, and other medical professionals
  - U.S. military medical facilities

CRNA Salary

The median pay for a certified registered nurse anesthetist as of May 2018 was $167,950.



The BLS reports that in May 2018 the highest paying states for CRNAs were:

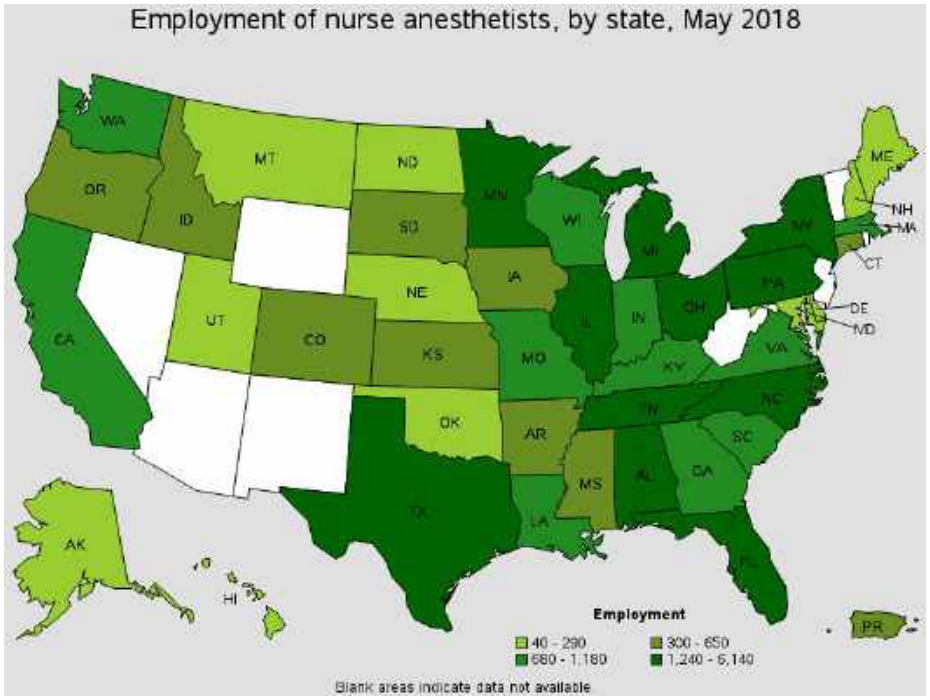
- Montana - $246,370
- California - $212,210
- Iowa - $209,130
- Oregon - $205,730
- Wisconsin - $204,820

The top five states with the highest concentration of jobs and locations for CRNAs were:

- Texas
- North Carolina
- Ohio
- Michigan
- Tennessee

States with the highest number of working CRNAs were:

- Texas
- Ohio
- Pennsylvania
- North Carolina
- Tennessee



The BLS also reported that the top five metropolitan cities for CRNA pay were:

- Akron, Ohio - $285,460
- Columbus, Georgia - $244,330
- Tampa/St.Petersburg/Clearwater, Florida - $243,660
- San Francisco/Oakland/Hayward, California - $242,890
- Vallejo-Fairfield, California - $237,260

The top five non-metropolitan cities for CRNA pay, according to the BLS, were:

- Northeast Iowa nonmetropolitan area - $287,210
- Western Washington nonmetropolitan area - $252,060
- Southern Indiana nonmetropolitan area - $233,730
- Northwest Minnesota nonmetropolitan area - $222,070
- West Kentucky nonmetropolitan area - $218,120

Show Me CRNA Programs

CRNA Scope of Practice

The American Association of Nurse Anesthetists (AANA) identifies the following as responsibilities of nurse anesthetists:

- Administering anesthesia during surgical, therapeutic, diagnostic, and obstetric procedures
- Performing epidural, spinal, or nerve blocks
- Providing care before, during, and after anesthesia
- Examining patients' medical histories for allergies or illnesses to ensure the safe provision of pain management
- Managing a patient's airway and pulmonary status
- Implementing acute and chronic pain management modalities.
- Facilitating emergence and recovery from anesthesia by selecting, obtaining,

ordering and administering medications, fluids, and ventilatory support.
- Discharging the patient from a postanesthesia care area and providing postanesthesia follow-up evaluation and care.
- Discussing any contraindications or side effects of anesthesia with patients
- Monitoring vital signs during medical procedures

CRNA Work Environments

CRNAs typically work in healthcare settings that have operating rooms, emergency rooms, and intensive care units. These may include,

- Medical and surgical hospitals
- Critical access hospitals
- Mobile surgery centers
- Outpatient care centers
- Offices of plastic surgeons, dentists, ophthalmologists, pain management specialists, and other medical professionals
- U.S. military medical facilities

Show Me CRNA Programs

CRNA Program Accreditation

The Council on Accreditation of Nurse Anesthesia Education (COA) is the main accrediting body for nurse anesthesia programs in the United States. The COA runs a comprehensive database of all accredited programs. These programs often change and some programs do lose accreditation.

Similar to BSN programs, accreditation is essential because an individual will not be able to sit for their national CCRN examination if they have not graduated from an accredited program. While the COA is the main accrediting body, the Commission on Collegiate Nursing Education (CCNE) and the Accreditation Commission for Education in Nursing (ACEN) are also often involved.

There are two main reasons for accreditation:

- Ensure quality assessment
- Assist in quality improvement

Requirements For CRNA Application

Regardless of which path you decide to take, there are several requirements that CRNA programs require from their applicants. It is important to have the needed requirements as schools will reject the application. These include:

- Bachelor of Science in Nursing (BSN)
- Registered Nurse License (RN)
- Critical Care/ICU Experience

    - Cardiac Catheterization Lab, Long Term Acute Care Hospital, Neonatal Intensive Care Unit, Post Anesthesia Care Unit do NOT count towards ICU experience
- GPA of 3.0 or higher (Each school has a different minimum requirement but 3.0 is the lowest accepted GPA)
- Life Support Certifications (BLS, ACLS, PALS)
- Resume
- Combined minimum GRE of 300 or better
- Test of English as a Foreign Language (TOEFL), if applicable
- Shadow experience of a CRNA and an accompanying essay
- Nursing Certifications (CCRN, RNC)
- Personal Essay and Interview
- Application Fee

Show Me CRNA Programs

CRNA Program Length

CRNA programs, regardless of whether an individual will earn their MSN, DNP, or DNAP, are all extremely time-consuming. Students are highly discouraged to work as they expected to spend about 60 hours a week studying and preparing for classes on top of the time spent in class. During the practicum, students have call time and work full-time hours while still taking classes. Some programs will offer a stipend to students.

CRNA programs are between 27-36 months of full-time classes. Some programs will split it into 9 distinct semesters with holiday and summer breaks while others will have their students continue right through the program.

Students can expect to take courses such as:

- Applied Statistics for Evidence-Based Practice
- The Science of Health Care Delivery
- Introduction to Genetics and Molecular Therapeutics
- Advanced Pathophysiology
- Survey of Pharmacotherapeutics
- Pathophysiology of Abdominal Systems for Nurse Anesthesia
- Leadership and the CRNA Role
- Ethics/Billing & Coding/Policy
- Respiratory and Cellular Pathophysiology for Nurse Anesthesia
- Applied Theory for Nurse Anesthesia Practice
- Applied Clinical Learning in Nurse Anesthesia
- Clinical Integration Concepts
- Professional Communication and Informatics
- Advanced Pharmacology
- Research for Evidence-Based Practice

Most CRNA programs offer only on-campus programs. There are only a handful of programs that allow online education. Programs such as Virginia Commonwealth University and the University of Cincinnati offer a handful of classes online but the remainder is completed in the classroom.

The entire CRNA program can never be completed solely online as extensive clinical practicums are required for graduation.

CRNA Certification

After graduating from an accredited nurse anesthetist program either with an MSN, DNP, or DNAP, individuals will be able to take their National Certification Exam (NCE) administered by the National Board Certification and Recertification for Nurse Anesthetists (NBCRNA).

The NCE is,

- 100-170 test questions including 30 random, non-graded test questions
- Computerized examination
- Preliminary exam results are delivered immediately following completion of the exam
- Official results are mailed 2-4 weeks after the exam
- The cost of the exam is $995

According to the NBCRNA, in 2018, 3,053 individuals took the exam with a first-time pass rate of 84.3%.

Test takers have three hours to complete the exam, which includes questions related to:

- Basic sciences (25 percent)
- Equipment, instrumentation, technology (15 percent)
- Basic principles of anesthesia (30 percent)
- Advanced principles of anesthesia (30 percent)

After successfully passing the NCE, individuals must apply for an Advanced Practice Registered Nurse (APRN) license in the state they wish to practice. There is no additional examination for this but there are fees and paperwork. CRNAs can hold multiple state licenses similar to an RN license.

The NBCRNA offers subspecialty certification in nonsurgical pain management. CRNAs who obtain certification are competent in neural or neuraxial blocks and alternative techniques for the management of acute and chronic pain (pharmacologic and nonpharmacologic). Criteria for examination include:

- Unrestricted RN/APRN license
- Current CRNA certification
- At least two years of nurse anesthetist clinical experience
- Attestation of being actively engaged in nurse anesthesia practice
- Evidence of completion of education in specific pain management areas
- Provide three letters of support from colleagues who have observed the practitioner's techniques
- Successful completion of a simulation course
- Successful completion of the certification exam

CRNA Recertification

The recertification process for CRNAs can be confusing. It is a combination of continuing education hours, practice hours, and examinations. CRNAs will have to recertify both their state-level APRNs as well as their CRNA certification.

The NCE recertification is broken down into two-year blocks. CRNAs will have to complete a two-year check-in and by year four are expected to complete the following,

- 60 Class A CE Credits
- 40 Class B Credits
- 4 CPC Core Modules (**optional**)
- **NO** CPC Examination

During the second four year cycle the requirements are,

- 60 Class A CE Credits
- 40 Class B Credits
- 4 CPC Core Modules
- First CPC Examination (**does not** affect certification)

The CPC examination is a new requirement that is starting to be implemented. According to the NBCRNA, the first CPC exam (mandatory by 2024 or 2025) will be used to familiarize CRNAs with the exam content/format and will not impact certification. The second CPC exam (mandatory by 2032 or 2033) must be passed in order to recertify.

APRN recertification will vary by state but is typically every 2-4 years and includes,

- Practice hours
- Continuing education hours
- Monetary fee

Show Me CRNA Programs

Doctoral Degrees In Nurse Anesthesia

There are two common types of doctoral degrees for aspiring CRNAs: the Doctorate of Nurse Practice (DNP) and the Doctorate of Nursing Anesthesia Practice (DNAP).

The DNAP degree is a professional practice degree in nurse anesthesia, approved through the Nurse Anesthetists Council of Accreditation, which focuses on the utilization of research findings for evidence-based clinical practice, education, and/or administration/business management related to nurse anesthesia.

The DNP is obtained through a school of nursing, and has its curriculum is set by the American Association of Colleges of Nursing. Individuals who do not have a degree as a nurse anesthetist but a Master's degree in another nursing-related field can obtain a DNP.

The American Nurses Credentialing Center (ANCC) accredited DNP programs while the Nurse Anesthetists Council for Accreditation (NACA) approves DNAP programs, which are specially designed for nurse anesthetist students. Nurses with other Master's degrees

can earn a DNP while ONLY CRNAs can earn a DNAP.

Most doctoral-level degrees require around 100 credits and take about 36 months to complete. This is slightly different for CRNA programs that award DNP or DNAP degrees upon completion. The programs typically are the same length with only a few changes to the practicum aspect.

The main difference between these two degrees is that some institutions do not recognize the DNAP as a terminal degree — meaning they don't consider it the highest degree in the field. A DNP is considered a terminal degree for any advanced practice nursing field.

This primarily affects those who wish to obtain a university faculty position, as this may have a bearing on tenure eligibility. If you're seeking to use your doctorate for practice, however, this shouldn't hinder your career prospects.

Programs are continuing to transition to awarding doctoral degrees. As of July 15, 2019, there are 92 nurse anesthesia programs approved by the COA to offer entry-level doctoral degrees and 25 programs approved to offer post-master's doctoral degree completion programs. Currently, there are 29 programs that remain to be approved to award doctoral degrees.

Show Me DNP Programs

Nurse Anesthesia Programs Awarding Master's and Doctoral Degrees for Entry into Practice

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total	83	85	85	88	93	97	105	106	110	110	110	111	113	114	114	115	116	120	121	121
Masters	83	85	85	88	93	97	105	106	109	107	103	102	97	90	82	76	66	50	41	29
Doctoral	0	0	0	0	0	0	0	0	1	3	7	9	16	24	32	39	50	70	80	92

Council on Accreditation of Nurse Anesthesia Education

DNP and DNAP Programs

DNP and DNAP programs can be completed both online and in class. To pursue a DNP or DNAP, individuals already would have completed a traditional or accelerated BSN program and have an MSN. In order to apply for a DNAP program, individuals must have an active CRNA license.

A DNP or DNAP program completion can take roughly one to four years. This will depend on the program and whether it is being completed on a full time or part-time basis. Programs are typically between 30-40 credit hours and 1,000 clinical hours. A percentage

of clinical hours earned during an MSN program can transfer in some programs.

Nurses who have earned their CRNA with an MSN can go back to earn their DNP or DNAP.

Show Me DNP Programs

Individuals should expect to take the following classes:

- Advance Leadership
- Advance Healthcare Policy
- Clinical Information Systems
- Research
- Evidence Appraisal
- Project Development
- Clinical Information Systems
- Statistics
- Clinical Reasoning
- Clinical Pharmacology
- Advanced Health Assessment and Measurement
- Health Promotion and Risk Reduction Across the Lifespan
- Epidemiology
- Ethics for advanced nursing practice

The American Association of Colleges of Nursing released a position statement for the basis of a curriculum for a DNP program:

- Scientific Underpinnings for Practice
- Organizational and Systems Leadership for Quality Improvement and Systems Thinking
- Clinical Scholarship and Analytical Methods for Evidence-Based Practice
- Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
- Health Care Policy for Advocacy in Health Care
- Interprofessional Collaboration for Improving Patient and Population Health Outcomes
- Clinical Prevention and Population Health for Improving the Nation's Health
- Advanced Nursing Practice

The objectives of a typical DNAP program, according to the Virginia Commonwealth University DNAP program, are as follows:

- Apply physiological, safety, and organizational theories to promote patient safety, enhance quality care, and improve nurse anesthesia practice.
- Analyze relevant scientific literature and apply results to improve nurse anesthesia practice and patient care outcomes in a culturally sensitive manner.
- Communicate effectively with patients, families, the public, and other health professionals.
- Demonstrate leadership skills to meet the challenges of increasingly complex health care and educational environments impacting nurse anesthetists.
- Develop effective strategies for managing ethical dilemmas inherent in anesthesia patient care and the workplace.

- Employ teaching and learning principles for the nurse anesthetist in educating and counseling individuals, families, students in training, and groups.
- Demonstrate nurse anesthesia scholarship through presentations, publications, leadership activities, and collaboration with other disciplines.
- Utilize technology and information systems to analyze, manage, and present data.

DNP/DNAP Admission Requirements

Requirements for DNP and DNAP programs will vary but most will require the following:

- MSN degree from a regionally accredited higher education institution and a nationally accredited school of nursing
- Valid CRNA certification
- GPA of at least 3.0 or higher in the Master's program
- Current, unencumbered nursing license
- RN experience
- Letters of Recommendation (both academic and professional references)
- Official Transcripts (from all previous colleges/universities)
- Current Resume/CV
- Goal statement
- Personal essay
- Advanced Practice Registered Nursing license at the state level
- Interview with faculty
- Test of English as a Foreign Language (TOEFL) or the International English Language Testing System (IELTS) if applicable
- Application fee

Show Me DNP Programs

DNP/DNAP Work Environments

Individuals that have earned this advanced degree can work in the same setting as CRNA but also have additional options in academia.

- Colleges and Universities
- Research
- Textbook author
- Public Health/Government Health Policy
- Legislation
- Hospital administration
- Medical and surgical hospitals
- Critical access hospitals
- Mobile surgery centers
- Outpatient care centers
- Offices of plastic surgeons, dentists, ophthalmologists, pain management specialists, and other medical professionals
- U.S. military medical facilities

Find Nursing Programs

1. Current Degree | 2. Desired Degree | Show Me Programs

Additional Resources

RN to CRNA Guide

RN to DNP Guide

DNP Career Guide

American Association of Nurse Anesthetists

National Board of Certification & Recertification for Nurse Anesthetists

American Society of Regional Anesthesia and Pain Medicine

American Society of PeriAnesthesia Nurses

International Student Journal of Nurse Anesthesia

American Association of Colleges of Nursing

Can You Be Referred to as a Doctor If You Earn a DNP?

Last Updated/Verified: Mar 21, 202(

Search Nursing Programs

Search Through Thousands of Nursing Programs in Just a Few Steps!

1 - Select Nursing Background

2 - Select Program of Interest

SHOW PROGRAMS

Nurses who earn a DNP (https://www.registerednursing.org/degree/dnp/) have met a significant milestone in their careers. A doctorate is one of the highest degrees a nurse can earn and entitles them to be referred to as "doctor." The title of "doctor" (also earned through a Ph.D. (https://www.registerednursing.org/degree/phd/)), is an acknowledgment of the tremendous hard work and perseverance he or she experienced through the rigorous education requirements of a DNP or Ph.D. program.

Several roles allow for the title of "doctor," including those who have earned a Ph.D., lawyers, veterinarians, pharmacists, and DNP-prepared nurses. The answer to the question of if a DNP-prepared nurse can be referred to as doctor is yes - however, there are different schools of thoug on the matter, and restrictions of *when* and *where* the nurse may be referred to as a doctor.

Those who support using the title of "doctor" for DNP or Ph.D. nurses have a few reasons why it should be allowed. First, it's a recognition of the level of expertise and clinical skills of a nurse. It represents that the nurse has achieved the highest degrees possible in nursing and should be considered an expert in his or her field. Second, it also can help build trust between the nurse an patient as the patient can be reassured of the nurse's competency. This is especially true for nurs practitioners who practice similarly to physicians. Additionally, if other professionals can refer to themselves as "doctor," why shouldn't someone who earned a Doctor of Nursing Practice?

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Search through nursing programs by selecting the options below.

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INDUSTRY March 4, 2020

Some Doctoral-Prepared Nurses Use The Title, “Doctor” and It’s Causing a Heated Debate

By: Chaunie Brusie

As doctoral-prepared nurses become more mainstream, a debate between medical doctors and doctoral-prepared nurses, is growing more prevalent. The number of nurses with doctoral degrees has increased significantly in the past decade. For instance, in just four years, from 2014 to 2018, the number of nurses with doctoral degrees, either DNPs or PhDs, nearly doubled, from 3,065 to 6,090.

For example, let’s take a look at a recent informational video on our Instagram page featuring Dr. Charnelle, “Nurse Nelle,” a doctorate-prepared CRNA, that brought up an interesting question in the healthcare community: should doctorate-prepared nurses be called doctors? Or is the distinction too confusing for patients and even fellow staff?

Here’s a closer look at doctoral-prepared nurses, why there’s controversy over the use of “Dr.” in their title, and how nurses feel about the topic.

The Nurse vs. Doctor Debate

Our Nurse.org video features Charnelle, who goes by "Dr. Nurse Nelle, CRNA" on her Instagram account @iamnursenelle, explaining how she made the decision to pursue an advanced practice nursing degree as a CRNA. By the way, we love her reasons! But despite the fact that the video is geared towards nurses looking to advance their education, the comment section quickly fired up with a heated argument over Hayes identifying herself with her "Dr." degree.

An Instagram user who described herself as a board-certified ER and family physician, DO--commented,

"So she is a Doctor Nurse? Please correct this she is a Nurse who has a Doctorate in Nursing...DOCTORATE DEGREE IN NURSING NOT MEDICINE. PLEASE RESPECT OUR PROFESSION AND REPRESENT YOURS...Again, this is a misrepresentation of the Medical profession period."

Others, however, supported Hayes' decision to use "Dr." in her title, pointing out, "If she has a doctorate degree, her title is Dr. So yes she is a dr." "If she was a professor that had a doctorate would you feel the same way?" wrote another. "As a physician I'm sure you have had plenty. I'm sure and everyone else in the room knows she isn't an MD nor is she trying to be."

After some back-and-forth, with many other people backing Charnelle, the original commenter reaffirmed her position, writing, "...A Medical Doctor will never be a Nurse and a Nurse will never be a Medical Doctor. It is confusing for patients."

Charnelle provided the following response and goes into further detail here about the DNP degree,

"As a doctorate prepared CRNA, it is important that the patients that I care for know who I am and my role in their care. Physicians do not have exclusivity of the term "Doctor," as there are many fields that grant a doctorate degree from Public Health to Music. It is in our best interest to not misrepresent ourselves. While it is a major accomplishment to have earned a doctorate degree, using "Dr." as a non-physician in the hospital setting should always precede one's job position. This allows the patient to understand the level of care they're receiving as well as ensure that the correct profession is properly recognized and not mistaken for another." - Charnelle Lewis DNP, CRNA

What's in a Name?

In a large way, the growth of doctoral degrees in other healthcare specialties--including pharmacists, nurses, and physical therapists--represents the shift in healthcare in general. Gone are the days of a strictly linear hierarchical structure, with the doc at the top, serving as the end-all, know-all in all matters of a patient's health. Today's healthcare is teamwork-based, with many different care team members, including the physician, working together.

However, that being said, even if the team-based model is the modern face of healthcare, the insurance world hasn't exactly caught up. One of the major considerations into who gets to call themselves "doctor" is also tied to healthcare insurance reimbursement practices.

When a physician sees and treats a patient, Medicare reimburses the physician at a higher rate than when an NP--doctorate or not--sees that same patient. Both the physician and the NP could spend the exact same amount of time with the patient, offer the same diagnosis, and provide identical treatment, but Medicare will only reimburse NP visits at 85% of the full rate. With the difference not distinguishable in care delivered, some see the move towards more doctoral-prepared nurses as a push for a more equitable reimbursement service as well--so what's in a name might be more than meets the eye.

Who can use the title "Dr."?

In sheer technical terms, anyone who has a doctorate degree can rightfully call themselves a doctor. But in the medical world, understandably, things can get a little trickier. To some degree, to a patient or caregiver, it could be argued that in a world where everyone wears scrubs, titles don't matter so much as the job the person wearing the scrubs is doing. But for other roles, the degree on the badge is everything.

Some physicians even argue that advanced practice nurses who obtain their doctorates should not be considered on an equal playing field as physicians in terms of clinical care--so they certainly should not share the same title. "The average training for a nurse practitioner is 6 years compared to an average physician training of 11 years," argues Starla Fitch, MD for Medpage Today.

"With all due respect to our healthcare team, I beg to differ that going through four years of college and completing an additional two years – sometimes online, no less – can truly be 'just as effective…as I see it, though, putting physicians and our skill side-by-side, on equal footing, with those who are not physicians only serves to drive a deeper wedge between the healthcare folks who need, at this crucial time, to come together," she added.

Other doctors issue warnings of nurses allegedly purposefully trying to mislead patients into thinking they are physicians. However, studies have consistently found that clinical care with an NP is as effective, and in some cases, even more effective, for patients as physicians.

In 2011, when *The New York Times* broached the topic of if nurses should be called doctors, the piece broached the topic that some physicians worried that nurses were trying to "take over" the jobs of physicians. However, Dr. Kathleen Potempa, the then-dean of the University of Michigan

School of Nursing and president of the American Association of Colleges of Nursing (AACN), made her feelings on the matter very clear--she asserted that in no way, shape or form are nurses going for doctoral degrees as a way to "compete" with physicians or "take over" their jobs. In her eyes, nurses are not out to steal anything from docs and are just fine with their own roles, thank you very much.

"Nurses are very proud of the fact that they're nurses," she told the *Times*. "And if nurses had wanted to be doctors, they would have gone to medical school."

What is the The American Association of Nurse Practitioners stance?

So, what's the final decision on if nurses with doctorate degrees can use their Dr. title? Well, currently, there is no one decision. The American Association of Nurse Practitioners does not have an official position on if doctoral-prepared nurses should use "Dr." in their titles. In their position statement on DNPs, they simply state:

"The transition to the new title must be handled smoothly and seamlessly to avoid negative impact on NP practice and sound patient care and to maintain parity."

For now, it's up to an individual nurse's discretion if they would like to refer to themselves by the "Dr." title and/or make any distinction regarding their scope of practice for their patients' sake. And as the number of doctoral-prepared nurses will only grow in the future, the chances are, it is a decision that many will be forced to face sooner rather than later.

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Departments: Letter to the Editor

When Nurses Use the Title "Doctor"

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- Free

I enjoyed reading Dr Jean Barry's guest editorial, *To Use or Not to Use: The Clinical Use of the Title "Doctor" by DNP Graduates*, in the March 2009 issue [39(3):99-102]. It does, however, perpetuate a myth about Ohio that has been circulating for several years. In her article, Dr Barry cited the 2007 Pearson report when including Ohio among those states in which the title "doctor" is reserved by law for physicians; she states, "Currently, there are 7 states that have laws prohibiting nonphysicians from using this title."[(p101)]

I am not an attorney, but I offer the following information. The oft-quoted statute in the Ohio Revised Code 4731.34(A)(1) states, "A person shall be regarded as practicing medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, within the meaning of this chapter, who does any of the following: Uses the words or letters, 'Dr.,' 'Doctor,' 'M.D.,' 'physician,' 'D.O.,' 'D.P.M.,' or any other title in connection with the person's name in any way that represents the person as engaged in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, in any of its branches." Other nonphysicians in Ohio do indeed use the title "doctor" including veterinarians, dentists, optometrists, psychologists, and professors like Dr Barry. The Ohio Revised Code simply states that nonphysicians cannot use the title "doctor" "in any way that represents the person as engaged in the practice of... medicine..." When I introduce myself to my patients, I use my earned title, and I state clearly that I am their nurse practitioner. I believe that my actions are clearly within the law because I represent myself as practicing advanced nursing, and I do not represent myself as practicing medicine, akin to how veterinarians, dentists, optometrists, psychologists, and professors in Ohio represent themselves. I might add that neither my dentist nor my optometrist goes to the same extent introducing themselves to their patients that I do with mine. Both the 2007 and 2008 Pearson reports inaccurately report a statutory restriction in Ohio against advanced practices nurses with a doctorate being addressed as "doctor." The 2009 report (http://www.webnp.net/), however, reflects the more accurate state of the issue when it states, "Nothing in the Ohio NPA prohibits a nurse from using the term 'Dr.'" The online edition of the 2009 edition expands on this concept.

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