

Introduction

The Accreditation Council for Graduate Medical Education (ACGME) conducts ongoing site visits to the clinical sites that comprise the learning environments responsible for providing postgraduate education (resident/fellow training) for over 150,000 US physicians.

From March 2018-October 2019 the ACGME conducted a special subset of visits specifically designed to provide access to and observation time in the operative and procedural areas. These visits provided a unique perspective on opportunities to improve learning, patient safety, and health care quality.¹

Methods

The ACGME’s Clinical Learning Environment Review (CLER) Program designed and administered an operative and procedural area site visit protocol to a sample of 25 clinical sites that collectively oversee 1,719 ACGME-accredited post graduate residency and fellowship programs with 375 to 2,095 residents and fellows.

The visits included meetings with executive leaders, graduate medical education leaders, patient safety and quality leaders, and operating room physician and nursing leaders and staff. Additionally, a significant portion of each visit was devoted to interviews in the pre and post operative areas and observing in the operating rooms.

Results

The key findings from these visits highlight many opportunities for improvement, some that are like other places in the clinical learning environment, and some that are unique to the perioperative environment such as:

- When time outs were observed, residents and fellows did not appear to have a defined role in the process.
- Residents and fellows occasionally indicated they were not informed about their participation in elective cases with enough time to meet the patient and educate themselves on the patient’s condition, the proposed procedure, and their role.
- Across and within sites, the use of standardized elements for hand-off communication during transitions within the peri-operative suite between residents/fellows and nurses was uncommon.
- Across sites, hand-offs within anesthesia and surgical teams during the procedure were rarely standardized.
- Across and within sites, the anticipated responsibilities of surgical and anesthesia residents and fellows during the surgical procedure were seldom communicated to the operating room team.
- Across sites, few formal or structured interventions were in place in the operative and procedural areas to prevent or reduce surgical resident, fellow or faculty member fatigue.
- In instances of disruptive and disrespectful behavior in the operative and procedural areas, there were operating room personnel who noted that although reported, these behaviors were persistent or chronic in nature.

Conclusion

The findings from this set of visits provide new insights into the operative and procedural areas through the lens of clinical learning environments for resident and fellow physicians. The findings highlight opportunities to convene new conversations to explore how increased communication among all members of the clinical care team around learning objectives, expected roles, actions, and behaviors for each operative procedure may improve team performance while optimizing both learning and patient care.

References

¹Kuhn, Catherine M., Robin C. Newton, Marian D. Damewood, James R. Zaidan, Robin Wagner, Nancy J. Koh, and Kevin B. Weiss, on behalf of the CLER Evaluation Committee, the CLER Operative and Procedural Subprotocol National Advisory Group, and the CLER Program. CLER Report of Findings 2021: Subprotocol for Operative and Procedural Areas. Chicago, IL: Accreditation Council for Graduate Medical Education; 2021.

