

It is an unreasonable requirement to convene a panel of the best experts none of whom have conflicts of interest, as they likely will have been consulted by others because of their expertise. However, those expected to read and abide by conclusions and recommendations contained in the documents have the right to know of real and apparent conflicts.

I suggest that the ASA provide the readership with complete funding and disclosure information for expert-authored practice parameters, standards, guidelines, and recommendations, and that readers not automatically dismiss documents provided by appropriate experts when produced using a thorough and appropriate process.

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### In Reply:

We thank Dr. Weiskopf for his letter concerning our Editorial View.<sup>1</sup> We agree with him that conflict of interest is a complex issue. Nevertheless, Dr. Weiskopf has chosen to ignore our most important concern. **Guidelines and practice parameters should not be promulgated by groups**

**without standing.** The primary reason we criticize guidelines and practice parameters offered by "shadow" organizations is that there is no large national or international medical organization that vets their work. For whom and for what purpose are these guidelines and practice parameters being created when they do not arise from a relevant national or specialty society? Why should physicians be encumbered by guidelines or practice parameters the contents of which have not been vetted by physicians in open fora at national or international medical meetings? Why should physicians be encumbered by guidelines or practice parameters that were initiated and funded by a company, not by a relevant national or international medical association?

We have served on task forces that have created guidelines and practice parameters. It is a difficult job, and it must be done correctly, without undue influence from sponsors with vested interests. There can be problems even when relevant organizations sponsor guidelines if they provide conflicting recommendations.<sup>2</sup> Groups without standing should find another line of work.

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### In Reply:

Dr. Weiskopf's letter raises important issues about disclosure and transparency that have received much attention from the American Society of Anesthesiologists (ASA) in recent years.<sup>1</sup> We have developed, refined, and implemented a Conflict of Interest policy aimed at informing all those acting in an official capacity for ASA of real or potential conflicts:

*A member of the American Society of Anesthesiologists (ASA) shall not serve as an officer, director, alternate director, committee member, representative to another organization or in another appointed position if that service would involve a conflict, real or apparent, with any other relationship or arrangement, financial or otherwise, participated in by the member or the member's family. ASA requires each member nominated to serve, as indicated above, to disclose his or her affiliations and execute this statement.*

*Disclosure of a member's affiliations is intended to assist ASA in resolving conflicts of interest. An affiliation with another organization does not necessarily mean that a conflict of interest exists or that the affiliation would unduly influence the member in his or her nominated position.*

*A listing of affiliations will be distributed or made available to all respective members of the Board, committee, task force or*

other relevant body to which the member is appointed or elected.\*

No member is eligible for appointment to a position within ASA without providing this information, including speakers and planners involved in ASA continuing education activities. In the current year, more than 1,300 members have done so. All members of our governing bodies and committees have been provided access to a database of their peers' disclosures and encouraged to familiarize themselves with its contents. Committee chairs are held responsible for informing their committees of potential conflicts and managing them during committee deliberations. Depending on the circumstances, conflicts may result in a member abstaining from debate or vote or being excluded from a project altogether. At a minimum, all collaborators are aware of potential conflicts.

To date, the development of all ASA practice parameters, guidelines, and advisories have been funded exclusively by ASA, an expenditure on behalf of our members typically in excess of \$500,000 annually.

We consider these efforts fundamental to ensuring the quality of our work and the confidence of members and the public in it.

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## Back to the Future: Redesign of the Anesthesiology Residency Curriculum

*To the Editor:*

I wish to thank Dr. Kuhn<sup>1</sup> for her recent editorial highlighting the need for a more dynamic anesthesiology residency curriculum.<sup>1</sup> Dr. Kuhn suggests that our curriculum be changed such that our trainees have either a pain or critical care focus. In other words, part of the CA3 postgraduate (PG) training year would be structured to permit residents to acquire additional perioperative skills. Although I strongly support her desire to give program directors greater flexibility in designing more individualized training pathways and her call to employ competency-based milestones in determining resident advancement, I am concerned that her proposals may not be sufficiently radical to truly transform our residency programs. Dr. Kuhn bases her suggestions upon retention of our 4-yr residency training continuum and our 1-yr

subspecialty fellowships. But is our current training continuum the most effective way to develop perioperative physicians?

I would suggest that perhaps we look to our internal medicine colleagues and to our own past to restructure our training continuum to produce anesthesiologists equally adroit at intraoperative anesthetic delivery, anesthesia care team supervision, and perioperative medicine. Before the mid 1980s, the anesthesia training continuum was of 3 yr duration—equal in training length to general internal medicine. When I completed the then new CA3 (PG 4) year in 1988–89, that year was largely spent much as Dr. Kuhn suggests as a clinical fellow in one or two specialty areas. Over time, requirements increased gradually, making the CA3 year less and less an opportunity for advanced training and more and more like what it was, another year of residency often centered upon clinical service obligations. Consequently, the ability to provide subspecialty training during the CA3 year was lost, leading to a proliferation of 1-yr, PG 5 fellowships. Unfortunately, these 1-yr fellowships are primarily clinical in nature and often do not permit trainees the time to develop a scholarly focus.

Perhaps it is time to return basic anesthesiology training to a program of 3-yr duration. Upon completion of this 3-yr curriculum, and assuming competency objectives are met, anesthesiology residents would be prepared to provide the spectrum of individual physician-delivered intraoperative anesthetic care independently. After the PG 3 year, anesthesiology trainees would next complete an additional, mandatory 2 yr of training in critical care medicine, pain medicine, anesthesiology research, or an anesthesiology subspecialty. New programs in hospital medicine and emergency medicine in combination with anesthesiology might be developed similar to those already available with pediatrics. Other residents might use part of the PG 4 and PG 5 years to undertake graduate education in management, health policy, clinical effectiveness, or adult education theory. During the final year of training, residents would receive formal instruction and practical experience in midlevel supervision. After completion of the 5-yr continuum, the resident would only then be eligible for American Board of Anesthesiology certification in anesthesiology and would likewise be able to obtain a subspecialty qualification in an anesthesiology-related discipline, certification by another American Board of Medical Specialties board (if enrolled in a combined program), or awarded an additional academic degree for advanced study. Because the core basic anesthesiology training would be completed during the PG 1–3 years, residents' time during the PG 4–5 years would be protected from service demands and devoted exclusively to specific, individualized advanced training. Under such a structure, the 1-yr clinical anesthesia fellowships now offered would no longer be necessary and could be eliminated because those activities would now be incorporated into a 5-yr training continuum. Because different programs have different areas of subspecialty expertise, it is likely that residents would be able to complete their PG

\*ASAPotentialConflictOfInterestFormat<http://www.asawebapps.org/MemberLaunch.asp>. Accessed May 8, 2010.