

COMMENTS TO WHITE PAPER SURVEY

	think this is an excellent start. I hope there will be practical information included for departments starting a simulation program. Eg, space requirements, personnel qualifications to run the program, financial considerations, how to evaluate a simulator before purchase, etc. This is often where "starter" programs get bogged down.
	Interesting proposal. Will only apply to limited centers with sufficient resources to maintain a program
	Would love to have access to a simulator on a regular basis.
	I'm in full time clinical practice, a program similar to pilot simulator training would be helpful
	I favor site visits as a part of the approval process.
	<p>This was all fluff. Who cares how it is organized. The real items of interest would be the curriculum. I would be very interested to see 10 REALISTIC learning situations where a simulator would actually be of use.</p> <p>Are we going to simulate healthy patients having sudden disasters? Not realistic at all.</p> <p>Machine failures? Much more likely to be realistic.</p> <p>Sick patients tolerating anesthesia and/or surgery poorly?</p> <p>I've been practicing for 30 years, examined for the oral boards, and I'm always impressed how unreal the typical clinical problem scenarios are.</p>
	I read the white paper and find it to be well thought out and thorough. I have no further comments or criticisms. I think that this is a very good start.
	I support the Simulation Training for Practicing Anesthesiologists
	Good approach. I think that program directors should have adequate credentials, and be licensed in the state that they work. Having a simulation program headed by individuals with questionable credentials is not acceptable.

	<p>Perhaps I missed this in the document, but would the simulation exercises be standardized? In other words, would each program have their own developed scenarios or would all programs use the same scenarios? One option for the ASA (or ABA form MOCA?) might be to have approved scenarios that any program would use. Only those scenarios that are approved would "count".</p>
	<p>ASA through its Simulation committee should work with ACGME to make simulation an integral part of all Anesthesiology training programs.</p>
	<p>It is not clear whether you are interested in the reactions of those of us who are not in active practice</p>
	<p>Not clear whether this opportunity applies only to those in active practice. I can see that it could be very useful to them.</p>
	<p>I am very enthusiastic about the direction the ASA is going with simulation education. I have 2 comment:</p> <ol style="list-style-type: none"> 1. When new graduates join the staff here at Baylor, almost without exception they will experience an acute life threatening complication with a patient. It will have a fairly basic etiology but they will not have been exposed to it before and will not react in the proper way. 2. Anesthesia graduates have twice as much training as NASA space astronauts and 8eight times more than a long haul airline pilot. they use simulation technology to provide excellent hands on training in a shorter period of time than the anesthesiologist. They show the value of this technology.
	<p>I HAVE EARLIER BEEN INVOLVED AS PARTICIPANT AND TEACHING THE SIMULATION. I personally feel its a good start nationally. The biggest problem with including SIMULATION as part of ABA MOCA will be the loss of non critical environment of simulation. Simulation is for developing a person's skills not to evaluated them</p>
	<p>Thank you for Simulation Saturday. While I greatly enjoyed the experience and can see plenty of educational value, I doubt that the resources exist to run every one of us through enough different scenarios to legitimize simulation as an accreditation tool.</p>
	<p>It would be beneficial for all practicing anesthesiologists and most likely be able to reduce perioperative complications and mortality and morbidity risks. It would offer us the privilege of being the only specialty with this type of continuing education. Perhaps this would also lower malpractice premiums as a bonus! I am in full support of our Society developing this into a reality. Thank you!</p>

	I do not believe simulation should be used as a requirement for MOCA recertification, or if it is, those obtaining their initial ABA certification prior to instituting this requirement should be 'grandfathered' and not subject to passing a simulation test as part of recertification.
	I would encourage ASA to establish a reasonable process to evaluate and support quality simulation programs. The expense of completing these courses is enough that ASA validation would be helpful to the membership in selecting programs of value.
	This is a very interesting process that our residents and of course the faculty as well, are all interested in participating
	This process looks very expensive.
	I strongly support ASA endorsement and implimentation of the proposed Simulation Education, and center accreditation. I support both CME offerings and research development in simulation training for both initial certification and recertification (MOCA). Beyond the workgroup, I request that regional USA opportunities become available for simulation training and involvement by ASA members (non-residents) during the development phase.
	I would like to participate as an instructor or be involved in whatever manner you deem appropriate. I have been @ Children's Medical Center in Dallas since 1984 and have taught residents@ in the anes., ped., and ER programs. I have a practice that also includes 10% adults. Please coctact me if I can help.
	I am completely supportive of this proposal and feel that ASA-approved simulation education is essential to our specialty. I am eager to become involved in this process.
	I am interested in incorporating simulation as a part of my continuing education experience in anesthesiology. I have not had any experience with simulation as a teaching / learning tool however I can imagine that simulation would be an effective means of learning information in the discipline of anesthesiology.
	Overall, I think simulation is exciting and potentially likely more clinically relevant as a measure of what it should take to be a Board Certified Anesthesiologist. I am concerned, however, that by formalizing simulation to this extent prior to being validated with actual demonstrable clinical

	<p>outcomes may be going a bit too far. I am also concerned that community Anesthesiologists are going to be "shut out" of the process (as demonstrated by the fact that almost all of the representatives on this committee are from academic centers). I would be most interested in seeing a clear vision statement included with the white paper --it seems very broad and over-reaching including items such as facility and instructor certification, MOCA, and Physician leadership in medicine as a whole. Overall, I find simulation exciting and have experienced excellent sessions as a resident; however, I'm not entirely comfortable with the white paper in its current form.</p>
	<p>this white paper certainly addresses the concern related to quality of simulation training activity. in general, these requirements will assure high quality educational activity at simulation centers. In my view this type of quality initiative would only be necessary if some type of mandate was developed by the ASA allowing members to be certified or re-certified in the practice of anesthesia (ie if simulation were to become a MOCA activity). Unless and until this ASA/ABA type of input occurs, I believe that there is adequate control over curriculum content by the participants/CME procedures that already exist. A simulation center that offers ineffective educational activities will not get participants to pay to take their courses. The CME approval process is adequate at present to address the quality concerns related to simulation. In many respects, this simulation director believes that this white paper seeks to restrict curriculum development at a time when far too little curriculum activity exists in the use of simulation. Innovation and research into effectiveness is key to the acceptance and use of simulation in medical and anesthesia education. The tone of this white paper is that a known static curriculum exists and that there is no need for additional programs. If the only role for simulation is to teach one type of curriculum, then this white paper addresses concerns related to the quality of the education received for these type of courses. The quality concerns are far too narrow in focus and leave little room for much needed curriculum development and innovation that should occur in the field of anesthesia and medical education.</p>
	<p>ASA should continue current efforts to lead in the development of this educational modality. ASA has historically and currently maintains high levels of integrity necessary for success in these endeavors.</p> <p>Funding for site visits: I would support increase in ASA dues to help pay for visits. This is way to "vest" membership in this process. Since all simulator program costs will be passed along to the consumer/student, this might be a way to reduce these costs somewhat, and encourage broader participation.</p> <p>I think more emphasis should be made on ABA certification of instructors. Otherwise there is some risk of the sim programs becoming similar to ACLS programs where you have students with much greater qualifications and competence than the instructors.</p>

	great idea!! Best to have well structured credentialing system in place.
	Very well done!
	An interesting, though expensive idea. Where will the funding come from? Will there be enough centers? Could this also be done in part on computer programs at home?
	The proposal looks good. The ASA should pursue this.
	Why is it necessary that an instructor have an academic appointment to participate in the Simulation Process?
	Very interested! We have a brand new simulator and state of the art facility in our medical school where we presently teach advanced life support to our students and emergency OR situations to our residents.
	Your document is excellent. I am fully in favor of your efforts. At Stanford, I am leading an effort to use simulation as an educational aid in the training of residents and fellows and maintaining the competency of community anesthesiologists. At the national level, I am leading the formation of the "Pediatric Anesthesia Simulation Interest Group".
	A national standard should be established for simulation education based on current knowledge and then modified as new research findings warrant change. Simulation centers should be accredited if they meet those standards.
	I cannot find any comprehensive standard list of "clinical situations/scenarios" that comprise the "accepted" list of Simulation Training protocol.
	I cannot find any comprehensive standard list of "clinical situations/scenarios" that comprise the "accepted" list of minimum Simulation Training protocols. What comprises this list? For example, STD Situation#1 -Esophageal intubation; STD Situation#2 - Bronchospasm; STD Situation#3 - IV Line malfunction; STD Situation#4 - Incorrect Drug administration; etc...
	I think it would be a very good idea to offer simulation cme.
	SOUND APPROACH TO CONTINUITY OF CLINICAL EDUCATION
	Most consumers will be anesthesiologists interested in MOCOMP or the various state licensing requirements. One would assume that resident teaching would be limited to those centers that

	<p>actually develop a simulation center. While I'm aware of several papers in the anesthesia literature that not unexpectedly have evaluated simulation as an effective method for crisis management (MH diagnosis, arrhythmia and airway management, etc) are there outcome data that compare it favorably with other teaching techniques, especially for non-crisis learning? Given that many states require a minimum of 'lecture format' CME hours, will this count as lecture format? Are there data to make cost comparisons with other forms of CME - will this cost competitive enough that it won't price itself out of the market? Will the Feds try to work this into the Medicare QA program?</p>
	<p>I think it's great and about time. I wish I had had it. Thank you.</p>
	<p>No thank you!!!! I was involved with administering simulator instruction at the University of Iowa - Dept of Anesthesia - Simulation Center. I am not interested in this method of instruction as an instructor or as a participant for recertification. I see this as merely something for the ASA to be pushing, generate publications, promote as the end all of education and we are at the forefront, and for the centers to use as a profit making venture. No thank you!!!!</p>
	<p>outstanding idea.other industries have been using simulations for years. time for us to get on board and develop our own</p>
	<p>ASA should stay on the forefront of Simulation education. Much needs to be done to improved the kind of education and the methods to provide the education within limited financial restraints.</p>
	<p>the paper appears non bias and continues to reinforce the respect and high quality that is associated with ASA designated educational opportunities</p>
	<p>excellent work. it seems the group has covered all angles.</p>
	<p>EXCELLENT INITIATIVE. GROUND BREAKING AND ESSENTIAL TRAINING FOR ANESTHESIOLOGISTS</p>
	<p>Well conceived simulators would be a valuable adjunct to cme</p>
	<p>I was one of the first residents to train on "SIM ONE" at LA County way back in 1967. In my practice years I devoted much time to patient safety and better monitoring. New simulation programs fascinate me.</p>

	<p>I feel the ASA should proceed with this exciting and innovative method of teaching physicians. Simulation training is absolutely required in my brother's industry (the airlines) and the similarities between flying and anesthesia are numerous and often quoted. Simulation has also become an important part of the teaching curriculum in parts of Europe (The Royal College of Surgeons in Ireland comes to mind)</p>
	<p>It would be great to provide everyone with state of the art simulation technology plus it may save lives.</p>
	<p>Your paper should discuss known benefits of simulation in medicine or in other fields, as presented in published research.</p>
	<p>Having participated in the simulator program sponsored by the Brigham/MGH, I can attest that it is a tremendous learning opportunity.</p>
	<p>Enthusiastic about this new approach to CME. I would urge that access to the program NOT be limited to one fixed day of the week (e.g., Saturday ONLY).</p>
	<p>great idea</p>
	<p>overdue but welcome-Consider networking with UPS in Louisville, Ky. as they have a well established simulation program already functioning</p>
	<p>Simulation training and use for CME will become standard in most medical disciplines, including anesthesiology. I feel our society must take the role described in the white paper.</p>
	<p>I applaud this effort; I'd hope to see the training and programatics shared and expanded (share-ware and free-ware with appropriate authorship credit) as scenarios and their evaluative components are developed; I'd also hope to see these endeavors endorsed by this working group as creative and highly valued/promoteable academic activity--(in my mind the development and implemetation of simulator scenarios and evaluations, a functional stable center are as or more valuable than case reports, non-peer reviewed articles, PBLD's, poster presentations etc). If industry wishes to co-sponsor this endeavor--I think the "cleanest" way is via centrally funded grants for good proposals, or as partial tuition reimbursement offerings at centers, administrated via your committee to minimize conflicts of interest. I'd love to see a presentation for medical center/hospital administrators to encourage them to co sponsor more centers--ours have been too concerned with wanting a budget/a bottom line, and a guarantee that they actually make money--the on site training value seems undervalued A nationwide membership of 1 or more anesthesia faculty per simulator is highly desireable, as are some workshops to help programs develop sound well-managed and stable centers...(we are in our infancy in my dept and struggling w/set-up, funding etc.--we "bought the horse" which is the</p>

	<p>cheap part, and failed to plan fully for "the stable, the vet, the caretaker and the food bill"). I'd welcome any "how to" resource info you have available. Thanks!</p>
	<p>1 additional comment as I've completed this already: You need to acknowledge and work hand in hand with the SEA and their simulation committee; we spend too much time duplicating efforts and committees</p>
	<p>The American Osteopathic Board of Anesthesiology investigated the possibility of using simulation equipment for part 3 of our board certification process, in lieu of on-site visits. Standardization and technology at the time discouraged us from continuing. I believe that using simulation to enhance CME would be an excellent idea to pursue. I note in the White paper that there is no mention of D.O.'s for instructors. This could alienate many of your members who are either ABA or AOBA certified and definitely qualified to serve as instructors. I hope that the committee is able to continue this process to use simulation as an adjunct to CME, but not as a mandatory required portion of Certification. At least not for several years until the entire process has been validated.</p>
	<p>I feel that this is a most appropriate initiative for the ASA as a leader in patient safety. The committee is to be commended for setting this up in a most thorough and thoughtful manner.</p>
	<p>Overall the paper is well written and complete. My only suggestion is that there be more specific direction as to evaluation, namely that the evaluation should be mainly outcome evaluation of the students, based on performance, as measured by specific objective and subjective criteria, not by the students' own judgement of their progress. The outcome criteria should be consistent with actual clinical practice, not just improvement on the simulator. I realize that this is difficult to do, but it is critical to establish reliability, content validity, construct validity and criterion validity. This is especially important if simulation is to be used for ABA certification in the future.</p>
	<p>The document as a whole demonstrates a great deal of thought and effort.</p>
	<p>Definite need for standardisation of simulation</p>
	<p>Need for standardisation of simulation. Once again ASA is in forefront. Congrats</p>
	<p>I would welcome simulation instruction if it were available at reasonable cost and reasonable distance.</p>

	I applaud your efforts. Please don't forget to include pediatric simulation as you develop this.
	Simulation has the potential to quickly cover many important scenarios with no one being at risk. Having been through simulation one is more prepared to face the real thing, even if you have killed the dummy.
	Interesting white paper but I do believe the ASA must stop trying to be politically correct and mandate that the Program Director and instructors of any simulation training course/program be PHYSICIANS, Anesthesiologists, and ABA board certified. I left US Navy service in 2000 and at that time the CRNA lobby group within military medicine was already deep into planning for taking over simulation centers for the military. This attempt to usurp physician practice will not stop. Attempts are underway to set up CRNA pain management "fellowships" in military medicine. This does not stop with anesthesia. When I left I needed a mandatory physical examination performed by nurse practitioners!!! Even procedures such as colonoscopies are being done in the military by advanced practice nurses (>60% of those procedures at the Bethesda Naval Hospital in 2000).
	<ol style="list-style-type: none"> 1. I'm very favorably impressed with this work so far. We need simulation. 2. Partner with others interested in simulation (ACGME, ABA), to avoid future conflicts. 3. Most anesthesiologists do not work in university settings, yet almost everyone on this committee is from a university. What about government and private hospital-based anesthesiologists?
	I believe if appropriately done the simulator instruction will prove to be an asset. I do not have any further comment on the paper
	<p>I think that ASA approbation of education of all types is appropriate. This is a model I would like to see extended to the many pain workshops that occur annually.</p> <p>I have only the reservation about ASA liability if the program doesn't continue to live up to its obligations to the ASA in terms of averred quality. Also, if a "graduate" of the simulator educational event goes on to injure a patient or patients, what is ASA liability?</p> <p>Great work!</p>
	I think expanding simulation into continuing education is a superb idea!
	I think that this is the logical way in which the anesthesiology specialty needs to proceed. Our Specialty is often compared to Air traffic controllers and pilots, all very highly technical occupations requiring rigorous hours of training and maintenance of skills, all of which use some type of simulation for instructional purposes.

	<p>I believe that this tool needs to be used as an instructional device ONLY and NOT as a testing device.</p> <p>unfortunately I can see the handwriting on the wall and this too will be used as an evaluation tool for the courts and litigation in the future as a determination of competency or perhaps even as a part of board certification. If the lawyers get hold of this information I think it would be just another nail in the medical profession's coffin.</p> <p>In residency I participated in some simulation training and thought it was some of the best training I had because there was no pressure and you were able to go back and LEARN FROM YOUR MISTAKES. You were actually able to rehearse for that unthinkable catastrophic event. BUT I do not believe that performance in the simulator is any indication regarding performance in a real situation.</p> <p>I am an advocate of simulation teaching but I believe we need to keep it in perspective because it does have its inherent sort falls.</p>
	<p>Coordinate with surgery,nursing,etc to have single certifying body.</p>
	<p>Feel this is useful and interesting adjunct to residency and cme programs.</p>
	<p>I am completely in favor of our specialty leading the way with organization and implementation of simulation in medicine. I experienced simulation in the Navy in the aviation community. I was involved with our hospital acquiring SimMan/Baby just this year, and will be involved with applications. I am going to the Laerdal Sim course in June, and am considering the CMS Instructor course. Thank you for all your efforts in pursuing this lead.</p>
	<p>I believe it is a necessary component to a well rounded initial education in anesthesiology. I also feel it will be valuable as a tool in continuing medical education throughout ones career.</p>
	<p>Well Thought Out. I will attend a simulation workshop in the future. Thank you for standardizing the process and requiring the high commitment to quality.</p>
	<p>Adam Levine is at the Mount Sinai School of Medicine (which has an affiliation with NYU)</p> <p>Accrediation could work but must be done very professionally or it will rapidly loose credibility.</p>

	<p>You might consider running an accreditation workshop at either the ASA or as a free standing course</p>
	<p>Emory University School of Medicine</p> <p>highly interested in simulator program development.</p> <p>A "must" for the specialty of Anesthesiology</p>
	<p>I have experienced simulator instruction and found it to be very helpful.</p>
	<p>good plan to implement</p>
	<p>I FIND SIMULATION LEARNING A POWERFUL TOOL IN TEACHING REPETITIVE TASKS MORE THAN IN STIMUALTING ORIGINAL THOUGHTS.</p>
	<p>The process of standardization in simulation is inevitable. We might as well be on the forefront rather than following other specialties.</p>
	<p>Simulation is no better than teaching residents to use their knowledge base to create/rehearse scenarios in their heads. Up until the last decade, the best minds in anesthesia were not the product of simulation teaching, but were those who could grasp the concept of 'what if' when preparing for cases or going over the cases of the day. Simulation programs will be an expensive way to pull factoids and cookie-cutter responses from residents, unless the simulations are designed to teach residents to PREDICT what will happen. The difference between an anesthesiologist and a technician IS the ability to predict. I have seen simulations run where there is a set pattern and only one response is sought. Consequently, the resident learns that if X, then Y - when we really know that in life, there are many qualifiers and many diverse responses. The key is to teach residents to master the physiology of patients combined with the pharmacology of the meds vis-a-vis the patients physiology. It can be done without a simulator. I fear that most programs will pay huge sums for a simulator and an initial consultation, and they will quite simply return to their usual way of 'training' residents. Credentialling sites is a pipe-dream considering that we allowed residency programs to graduate persons of poor skills in the recent past...and that certain members listed on the original portion of the paper have little to recommend them. The specialty would do better to understand the real mechanisms of mastery and how to test for mastery,rather than test for specious information that shows how much a person can memorize rather than how well a person takes care of patients. (Which is why the oral boards can sometimes catch those who passed the writtens but in fact have no judgement in how to use/master the information.</p> <p>While I believe that sometime later in the future, simulation will be especially useful in weeding out the inept, discovering which medical students might be most useful, and practicing precise</p>

	<p>scenarios such as MH, failed airway, etc, simulation should not at this time become the landmark tool for teaching. Giving first graders computers has now been found not to teach students to read, but can enhance those who have already been taught.</p>
	<p>I think that the content of the simulation is extremely important. There has to be clinical relevance in the simulation. In so far as possible the objectives of the simulation should be defined by actual events. For example, simulation of MH events should be verified by comparison to actual events described over the MH Hotline or reported in the MH Registry.</p>
	<p>Very good development. My suggestion: to preface a course to be attended in person with a required web-based section. This would save time and money, could even be anonymous as long as the participant wanted it to be, allow the participant to do perhaps necessary remedial work so as to get the maximum benefit from the course attended.</p>
	<p>Residents, 3rd and 4th year Medical students in Anesthesiology and ACLS</p>
	<ol style="list-style-type: none"> 1. Funding is a tricky issue, particularly w/ regards to equipment, instructors, time, etc. 2. It is essential to include CME credit as an incentive for both instructors and for participants. Obtaining and setting up such credit is expensive (and has increased dramatically, both in cost and difficulty over the last 3-4 yrs). I am hesitant to endumber the ASA w/ such a task and in point of fact, the entitiy itself as a non-profit, would probably not qualify as a candidate for such a task. 4. W/ regards to instructors: it is essential to have excellent instructors. Nonetheless, if surveyed, you would be surprised to realize the paucity of active ASA members who have actually had acces to such training. Moreover, I believe if such a program were to be established that more instructors should be trained to maintain geographic availability. (I, myself have not had the opportunity to use such equipment and would be proud to learn and to become an instructor.) 5. Is this "white paper", at any time, going to be presented to the HOD? If so, as an active member of the ASA for over 20 yrs (numerous comm.,et.--you can check w/ Ron Bruns if you have questions about me!), I may be able to help you make this document more "user-friendly" if you intend to present as an action-item or resolution to the HOD (House of Delegates).
	<p>Regional courses in which simulation is used to educate and update practioners in the management of routine and emergency anesthetic procedures</p>
	<p>The ASA should be at the forefront in simulation for CME, teaching and skills asesement.</p>
	<p>Simulation will become increasingly important in education and certification. ASA needs to continue its supportive role. Financial aspects for course providers and participants need to be carefully sorted out.</p>

	has to have enough CMEs to justify the cost
	The document appears well thought out and prepared. Simulation is an excellent learning tool and I hope this project will advance in the near future.
	This is an idea that is long past due. We do indeed risk losing the initiative here. There are multiple groups as you note that wish to lead or at least to be at the lead. I suggest that we do not do provisional status for anyone. I suggest that using a known model like the RRC under the direction of a subsection of the ACGME is probably for the long term the best solution but in the short term not workable. Therefore I recommend adding a representative from the ACGME to our committee in order to aid in this transition. Rita Patel would be an ideal candidate in my opinion. That way we could act as a trial board for the ACGME along with surgery and whomever else wished to come along. That does not solve the nursing issue but perhaps a similar representative from the nursing education community could be found. Gail Wolfe at Pitt is a well respected educator and could possibly function here as well. Thanks again for getting this started and I am quite happy to help in any way shape or form...
	It was very stimulating education .I encourage to everyone to get the simulation course. sincerely,
	The ASA Workgroup on Simulation Education is to be congratulated on its efforts toward ASA approval of simulation programs. The background and proposal are clearly delineated. I have personally worked through the entire ACCME approval process to grant AMA Category 1 CME credits for simulation. The workgroup document follows pretty directly from the ACCME requirements but is loose in a few areas, especially related to potential conflicts between financial support and the CME content. I suggest closely reviewing the ACCME application in order to more easily satisfy ACCME requirements.
	I am skeptical that there is a need to credential simulators especially when they are associated with academic centers. I guess I can understand it if they are private free standing simulation centers. Does the ASA really think there will be private free standing centers not associated with academic departments?
	I think this is a fantastic idea to standarize, promote and facilitate simulation while helping the center self financial growth by providing CME courses beyond the Department boundaries.
	THIS WHITE PAPER DOES NOT ADDRESS WHAT CONTENT WILL BE TAUGHT IN ASA-CREDENTIALLED SIMULATION PROGRAMS. SIMULATION IS IDEAL FOR CERTAIN TYPES OF CONTENT; SIMULATION IS OF DOUBTFUL BENEFIT IN SITUATIONS WHERE THERE IS NO CONSENSUS ON MANAGEMENT. IN OTHER WORDS, IT IS DIFFICULT TO EVALUATE

	<p>THIS WHITE PAPER SINCE WE DO NOT KNOW HOW SIMULATION WOULD BE USED BY ASA. THE SURGEONS USE SIMULATION TO TEACH MANUAL SKILLS (LIKE LAPAROSCOPIC SURGERY). THEY DO NOT USE SIMULATION TO TEACH MANAGEMENT STRATEGIES (AS IS SO OFTEN THE CASE IN ANESTHESIA). THIS IS AN IMPORTANT DIFFERENCE.</p>
	<p>Rather thorough document. The concept of a computer simulation for the purpose of CME is long overdue, given the availability of technology for many years.</p>
	<p>Overall - the proposal does not identify any provisions for self reporting major changes to the program. For example, what happens if the program director leaves one month after the approval is granted? Also, if new courses are added, are they included under the umbrella?</p> <p>Pg 3 - the definition of instructor could be too restrictive. They acknowledge later that there may be a need to accredit instructors independent of this program approval process. Introducing new faculty as instructors may be problematical.</p> <p>Pg 4 - the definition of simulation should probably explicitly list virtual reality. Also, would a fresh tissue lab be considered simulation?</p> <p>Pg 6 - (Educational offerings) This limits the ability of new programs to be approved. This applies to other items later, such as the concern under risks on page 16.</p> <p>Pg 7, #4 - the instructor competency might be challenging to set up, track and document.</p> <p>Pg 7, #5 - this implies that commercial operations will be challenging to get approved.</p> <p>Pg 8, #9b - this would be two separate sets of data for most organizations, which would have to be merged in some meaningful manner.</p> <p>Pg 9 - funding for the approval process brings up an additional point: what will fall under the scope of the approval certification? If a school offers pain management courses and airway management courses, is it all under one program, or is that two separate programs? If one, who is the director, what happens to new classes and new instructors, etc? If two, then are there two separate fees charged?</p> <p>Pg 10 - will the reapproval process require a site visit? If not, will there be a reduced fee?</p> <p>Pg 16 - under risks, they mention that programs will offer CME without ASA approval. Since new programs need two years of data before applying for approval, all new programs will offer CME without ASA approval for some period of time. This may discourage programs from starting in areas were there might be established, competing programs.</p>

	<p>INTERESTING CONCEPT</p> <p>HAS SIMULATORS BEEN VALIDATED?</p>
	<p>WHMC currently utilizes a METI Human Patient Simulator for internal training of anesthesiology, EMT, ACLS/ATLS, air transport physicians and a host of other medical personnel. I do not think CME or training outside anesthesiologists should be a requirement. Joint training efforts should be addressed more specifically. Instructor certification should be separated from program approval.</p>
	<p>This document is a good start toward an accreditation process for simulation centers. It is important to move ahead with this and to try to emphasize an interdepartmental approach rather than anesthesiology by itself.</p>
	<p>I am delighted that our Society is taking a leadership role in endorsing and fostering simulation-based education.</p>
	<p>great framework and good start</p>
	<p>Very in depth position statement we would benefit from a centralized resource</p>
	<p>This sounds like a great idea on paper. I have significant concerns on the ability to have this be a program that does not have political and financial ramifications that overshadow the ethics of the whole thing.</p>
	<p>Implement it for ABA Oral Board Exam</p>
	<p>I almost fell asleep before I finished reading the whole thing at one time. It's a good idea and the result of a lot of work. I have been in contact with Dr. Dale Morgan and dep't head Michael Todd at SUJ, and partly as the result of this, I have arranged to donate from my estate for the furtherance and support of their simulator program there. I am now retired, but I trained with Dr. Morgan, both in medical school and Stu Cullen's department.</p> <p>I have one adverse comment on the "white paper". On occasion, it seems to invite a struggle with the surgeons. Is this wise?</p>

	<p>White paper seems well thought out. Wondering why we are limiting efforts to CME, and not including resident education (as the surgeons are)</p>
	<p>The points of the paper seem well-considered. I have no particular preference concerning the three methods of accreditation discussed.</p>
	<p>Good overview paper. In my role, assessing system error for events and acting upon the findings is crucial. Simultaion goes far to assist in the process and maintain patient safety.</p>
	<ol style="list-style-type: none"> 1. program director - phd in what? why is this a requirement? the simulator owner will have to provide salary support for the phd. why can't an anes faculty serve in this position? 2. simulation is too time and resource intense. we found that it took two op[erators more than one hour to cover one or two sumulations allowing for discussion after each with the student. 3. based on my own experience, i will not travel to a meeting site, spend money on airfare, lodging, meals, and a course fee for such a low yield activity. it is not worth the money. 4. do you realize that in a department of 30 faculty, someone is going to be non-productive in the operating room thirty times a year for whatever the course duration is? we can hardly get vacation time as it is. 5. if i were back in private practice, i wouldn't even consider paying for or flying to a simulation site. 6. evidence based practice ---show me the data that simulation makes a difference before you embark on something the JCAHO will force down our throats some day. 7. i won't spend money on this activity 8. one can learn to fly a jetliner by purchasing microsoft flight simulator. 9. pilots buy into simulation becasue it might save their butt too not just the passenger (patient), planes cost \$50 million dollars, and they can pass the cost on to the passengers. we can't do that 10. how can you enforce simulation certification? you couldn't make some of us old guys agree to recertify. 11. doctors are the world's worst pilots and businessmen. pretend your committee is studying a project to "sell" to the board of trustees. WHERE IS YOUR BUSINESS PLAN??? you seem to have the cart before the horse. 12. i believe that it will be so time consuming and expensive that it will fail AFTER YOU ATTRACT THE ATTENTION OF KNUCKLEHEADS IN GOVERNMENT who will demand that we continue to internally fund such an activity. 13. i suspect that most of the people who would attend a simulator course probably don't need the experience. the ones that won't attend hurt patients every day in situations that the rest of us deal with daily without skipping a heartbeat. 14. i suggest that you spend your time and our time and money on the development of PC-based simulation possibly with the addition of networked and/or video conferencing (minimal cost to any department) oversight by an instructor for rare critical events. you'll have a smaller budget, get

	<p>more participation, allow us to participate at our leisure without spending a fortune on such a project</p> <p>AGAIN YOU MUST BE FISCALLY RESPONSIBLE IF YOU PLAN TO DEMAND THAT I SPEND TIME AND MONEY ON THIS . PLEASE SHOW US A BUSINESS PLAN. DREAMING COSTS MONEY.</p> <p>I would be willing to help on an pc-based system if you managed to get this far in my negative comments.</p> <p>p.s. i could never understand why the recertification process did not include the compliation and distribution of "new and important" information related to our specialty by members with special interest in the areas that could be accessed over the internet prior to taking the examination. can you tell me??</p>
	<p>It is admirable that the ASA is interested in arranging CME opportunities involving simulation. Overall, that is a good objective. However,</p> <p>1) I don't believe our members would ever want to see a **requirement** that some of their CME be done on a simulator. This is a high-stress, somewhat artificial environment, involving a significant investment of time by many individuals. As an OPTION for CME, I believe it is useful.</p> <p>2) I am concerned that the process for obtaining "ASA Approval" of a simulation center, could become onerous, (like that of ACGME review process), thus inhibiting any center that lacks a huge infrastructure, from offering educational opportunities.</p>
	<p>Comments on ASA Anesthesia Simulation Programs White Paper of 3/13/2006</p> <p>The basic thrust of the argument reads like creating an IRB-like approval process for simulation-based clinical education. If this is a fair approximation of the goal, do keep in mind how cumbersome the IRB process can be. One of the key reasons that clinical simulation, especially anesthesia simulation, has progress as far and as fast as it has is because there has been little in the way of prior approval – passionate and risk taking individuals have just gone and done it, learned from their mistakes, and pressed on. IRB-like prior approval will kill this innovation. Too solid of framework becomes an impenetrable barrier to movement in any direction.</p> <p>Any IRB-like evaluation distills down to three simple questions:</p> <p>Do you know what are the right and wrong behaviors? Will you only do the right ones? Are you telling the truth, now?</p>

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Definitions

Simulation - it is a verb, a far more inter-active verb than just method. The definition should reflect that unlike most teaching methods, simulation's unique and most important contribution is real-time responses to learner actions, responses designed to reinforce desired behaviors.

When is Variance an Error? A crucial tenet of all clinical judgment is deciding when a variance has become an error in need of correction. All factual knowledge and tactile skills lay dormant prior to taking this decision. Most of the time expended in advanced clinical studies is devoted to this process. Simulation is an ideal venue for offering learners competency-matched interactive experiences from which they can strengthen their own decision-taking. The ASA Workgroup should consider decision taking as a primary goal of any accredited simulation-based program.

"It would be imprudent to forfeit this eminence."

Chasing primacy for its own sake is like dogs chasing a car: what is the first dog going to do once he's caught it? Push for clinical education-wide simulation based education when and where it is the best way to teach, and lobby for flat, pan-tribal leadership and goal setting processes.

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Instead of asking for funds from every program to pay for a few strangers to pass go/no-go judgment, consider requesting every program that wishes to be evaluated contribute one individual to the pool of site visitors, and have their program pay for that person's efforts on behalf of the evaluation process (see NIH grant review study sessions). The total number and composition of any visiting team could be intentionally composed of individuals with a range of backgrounds and experiences. The more junior members will have experiences rich in valuable lessons learned, and return home to share them with their home program. In this way, political, budgetary, and integrity issues, as well as the real goal, improving competence in simulation execution, will be addressed with minimal pain and anguish.

Nothing is more toxic to patient safety than traditional inter-tribal hatred. Most of the Iof M errors started when the patient fell into the gaps between tribes. Anything to reduce the gaps and foster inter-tribal cooperation is to be applauded and advanced. Anyone promoting tribal-specific mandates that extend one hair-width beyond that tribes' specific skills is suspect (including the simulation tribes) of podium theft.

Are on-site visits the only way to collect information about a simulation program? Could this costly (in time and money) process be augmented with replay of recorded sessions? Since debriefing with review of audio/video recordings should be a required component of any certified program, all applicant programs should already have this capability. Furthermore, review of such recordings will clearly reveal what is and is not being captured by the recording/reviewing apparatus.

Requesting program budgets is worse than a pointless exercise. Many institutions have very large grain funding models, and often the actual costs of any one activity are never determined, and those that are are not likely to be for public disclosure. A scatter plot of funding/student hour would look like the wound pattern from a shot gun, with an r-squared approaching zero (I have no hard quantitative data, merely eight years of lusting after all the federal funds lavished upon the numerous simulation warehouses and museums that I know about).

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parties are clueless about how to tell the difference between an active and productive simulation program and a museum for simulation manufacturer's gear, be very wary about just what kinds of information you want to collect and promote.

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The most important component of any simulation program are the people, whereas the gear and space comes in far second. Credentialing should focus more upon how well individuals are learning than what they have learned. One of the best ways I know of fostering learning is visiting other programs and presenting their most favorite discoveries. Perhaps this document could encourage learning as a fundamental requirement for credentialing.

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I particularly like the 9 criteria listed for becoming an approved simulation center. My particular concern is that at my institution, the center is run by Dr. Neal Seymour, a general surgeon. Individual departments are currently vying for time at the simulator. I believe that I will be hard pressed to create an ASA approved simulation center offering courses under these circumstances.

	<p>Also, if I were to apply for such privileges, I would like pre printed forms made available to all centers seeking application. That is to say, the application process should be standardized; each of the 9 sections should have paperwork to complete.</p>
	<p>Very appropriate goal. Simulation learning is the way to go!</p>
	<p>How closely does simulation competence and performance relate to actual clinical competence and performance? How does one acquire instructor training?</p>
	<p>enjoy the crisis management, debriefing and problem solving!</p>
	<p>An important initiative for ASA, and one where we should attempt to maintain the lead over other specialties if possible, but I am less than sanguine about surgeons for instance allowing anesthesiologists playing a role in their training. I fear that manpower and pay issues that will drive this push will be difficult obstacles to overcome, and that ultimately simulation based training will be driven by the evolving technology and profit motive for those doing it. Lastly, I believe that simulation training can be rather subjective, so care must be exerted to avoid this element.</p>
	<p>Timely idea, well thought out and detailed plan.</p>
	<p>It's the future. Snags will appear, and they will need to be eliminated.</p>
	<p>Since almost everyone has access to a computer, wouldn't it be easier to have computer simulation programs that one could do at home? There is a lot of time and expense involved in going to a center.</p>
	<p>The amount of fiscal support will be of paramount importance in establishing a successful Center.</p>
	<p>Borderline cases should be asked to make the necessary corrections before being approved in order to maintain a high level of standards. No provisional ASA certification should be issued. Also lobbying to assure that only ASA approved continuing education programs be permitted to assure maintenance of competency in anesthesia before some government official does it on</p>

	<p>your behalf. We have this in Canada though the Royal College of Physicians and Surgeons of Canada.</p>
	<p>Overall, an excellent well thought out white paper considering all sides of the issue. There is one section that gave me pause on page 6 #2 under criteria. Based on the stated criteria: a Center must have been in existence for 2 years to be considered. My center, MSSSC, would not even be considered. The MSSSC possesses all of the other desirable attributes listed. Several Universities have finally embraced simulation on a grand scale and recruited experienced simulation faculty from other programs and would have the same dilemma. Think Mayo Clinic that opened only 1 year ago but is already a leading center. My state of the art facility will open 5/4/06 and has the benefit of > \$12 million grant funding to sustain us for the next 7 years. My expertise as a simulation educator has been recognized by various groups through publication and speaking invitations including ASA simulation workshops. I have the support of the entire Cleveland academic Anesthesia community and their combined simulation expertise. Thanks for listening.</p>
	<p>1) Concern that the committee may have a predominant academic center focus. Community-based programs will have more and more utilization as simulation technology becomes more affordable. These programs may have technology (e.g. curriculum, AV, simulators) that is portable and not require dedicated simulation center floor space. 2) Multidisciplinary simulation that focuses on the team/communication/system probes vs. task competencies may have a "director" that is not an anesthesiologist. Discrimination of both of these types of programs may not be in the best interest of supporting community-based anesthesiologists' involvement and participation. 3) Just as the question of CME programs that continue to offer simulation without ASA "designation", is the expectation that all of these simulation programs will have either CME approval or operate within an AGGME framework? Or will there be ASA approved simulation programs that have not jumped the hoops of CME accreditation?</p>
	<p>While I agree that simulation is a very powerful and superior learning modum than the current conventional lecture, we should perhaps slowly integrate simulation exarcises into our current cme format for a trial or "test run" with requested feedback from participants. I also feel that we should be careful in creating a sensible environment conducive to learning and not one where individuals who are participating in simulation feel "stage fright" or humiliation as was often the case when the first MEGACODE stations for ACLS originated for certification.</p>

	The anesoft programs that were presented for home use seem very instructive and easy to use-- we demo'd ACLS and Anesthesiology scenarios.
	Plan is solid
	Excellent paper permitting us to go ahead. Congrats to those who put this together.
	I like the idea of the accreditation process for simulation centers. I'm supportive of the white paper recommendations. Thanks for all the effort.
	I agree in principle with much in the paper. I was part of a discussion group at recent SPA/AAP winter meeting, chaired by Alvin Hackel, M.D. I hope subspecialty groups, such as pediatric anesthesiology will be represented on any committee formed and that approval of programs takes into account special training needs of subspecialties.
	Thank you for your simulator
	Simulation is a fine way to learn. I hope you are not creating too much paperwork with your initiative.
	Under Definition of Course, "specifically one intended for ASA members" should read "specifically one intended for anesthesia providers". This would be consistent with the emphasis on teamwork noted in IOM's Crossing the Quality Chasm. Has the Committee invited nurse anesthetists to participate? It seems to me that both the AANA and ASA may be inhibiting the development of teamwork in anesthesia care teams. Why not take a less parochial position on the establishment of Simulation Centers?