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ACGME e-Bulletin

ACGME

Accreditation Council for Graduate Medical Education

The ACGME e-Bulletin is published several times per year by the ACGME and distributed to individuals in residency education. It is also available from the ACGME Web site at http://www.acgme.org/acWebsite/bulletin-e/ebu_index.asp

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OPINION PIECE

The Seventh Competency: A Tool for Procedural Training Programs

Keith Apelgren, MD, FACS

In 2003, the ACGME introduced the six competencies.[1] Residency programs are required to develop curricula for these competencies and then evaluate trainees. The previous methods of evaluation, based mainly on faculty global evaluations, are no longer acceptable as the sole method of evaluation. Instead, outcome measures with "objective" scores will be required.[2] This paradigm shift has caused consternation and resistance by many program directors, especially in the surgical specialties. Overall, the change will be for the better, once we know what we are supposed to teach and how to evaluate whether the resident has mastered it.[3] Curricula for these six competencies and evaluation tools are still in the development stage. However, there is a major area of education that is not given enough attention in these new competencies, namely technical expertise.

In surgical residency programs, gastroenterology, cardiology, interventional radiology, and other "hands-on" programs, procedural competency is a major factor in determining overall competence. A surgeon who communicates well, knows how to practice within a system, is medically knowledgeable, and is professionally responsible, may still be incompetent if she/he can't operate. The current competency of "patient care" has one subheading of "procedural skill" within nine areas to be evaluated. To satisfactorily fulfill the nine areas of Patient Care Competency, residents are expected to:

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families;
- Gather essential and accurate information about their patients;
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment;
- Develop and carry out patient management plans;
- Counsel and educate patients and their families;
- Use information technology to support patient care decisions and patient education;
- Provide health care services aimed at preventing health problems or maintaining health;

- Work with health care professionals, including those from other disciplines, to provide patient-focused care; and
- *Competently perform all medical and invasive procedures considered essential for the area of practice.*

A resident could possibly be competent in all other areas and thus be competent in "patient care" while being procedurally inadequate. I propose that the ACGME and its Review Committees should add a seventh competency to the current six for programs which teach procedures. It would be called "Procedural Competence." It might include subcategories of pre-procedure evaluation, Informed Consent, performance of procedures with alternatives, post-procedure care, and long term follow-up. Currently Informed Consent is considered part of the Professionalism competency[4] that includes the following skills a resident must acquire:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest, accountability to patients, society, and the profession; and a commitment to excellence and ongoing professional development;
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, Informed Consent, and business practices; and
- Demonstrate sensitivity and responsiveness to patients' age, sex and disabilities.

Alternatively, Informed Consent could logically fit under the seventh competency. The subheadings listed under professionalism above do not naturally link with informed consent, and residency and fellowship programs without procedural education may not need to assess this competency.

Adding a seventh procedural competency seems logical in light of what hospitals ask in assessing a new residency graduate. They not only want to know if the graduate can get along with others, ask for consultation appropriately, and complete medical records, but also whether that person can competently perform the procedures of that specialty.[5] Currently, program directors are asked to attest to such technical competency. In the future a more sophisticated process with numbers of cases done and complication rates may be required. This will constitute an improvement because it is inherently outcomes oriented. In the future, residency graduates may be required to provide outcome date on the procedures they have performed.

Outcome measures have already been started in one specialty,[6] and have recently been started by a national professional organization.[7] Such outcomes data will be more objective than the current methods of global assessment of technical competency by the faculty and program director. Hospitals and patients will likely scrutinize such outcomes data much more than the other competency data. The seventh competency of "Procedural Competence" will evolve, along with the other six, as a tool to evaluate the overall competence of a graduating resident. This proposed seventh competency should be adopted because it will allow residency educators to evaluate trainees more thoroughly and accurately. ■

[1]*ACGME Competencies at http://www.acgme.org*

[2]*Traverso L.W., Someone else is measuring our outcomes. Editorial. Surg. Endosc. (2004) 18:72-74.*

[3]*ACGME Competencies and outcome assessment-toolbox. http://www.acgme.org*

[4]*ACGME Web site: http://www.acgme.org/outcome/comp/compfull.asp*

[5]*E.W. Sparrow Hospital, Letter to Program Directors, Lansing, Michigan, May 2006.*

[6]*The Society of Thoracic Surgery Database at http://www.sts.org/*

[7]*American College of Surgeons outcomes Web site, http://web2.facs.org/partners/loginpbls.cfm*

ACGME RESPONSE

Six Competencies, and the Importance of Dialogue with the Community

David C. Leach, MD

Dr. Apelgren has written a thoughtful piece on procedural competency. His title is intriguing, and raises the question whether the ACGME should name a seventh competency. While appreciative of the quality of the article I would answer "no" for the following reasons.

First, whenever we deconstruct a phenomenon we lose something of the phenomenon. Knowing this, we went ahead and deconstructed competence into six competencies. We did it in order to measure and to focus on competence through six particular lenses. Procedural competence fits under one of the six – the broader construct of patient care. While each specialty is invited to parse more specifically, the profession as a whole has accepted the six. To create a more specified model may cause us to lose even more of the phenomenon. For example, some people may be masters at procedural skills yet novices in delivering bad news – a communication competency. The relevance of the work is dependent on an integrated version of the competencies, whereas measurement relies on a speciated version of the competencies. The paradox cannot be resolved easily. The more the competencies are specified the less relevant to the whole they become.

Second, a major function of the competencies has been to provide medicine with a common language for all specialties – those heavily immersed in procedures and those in which physicians perform no or only minor procedures. The six competencies have achieved this end nicely. All in the profession can have conversation about the work of medicine using common language. Adding a seventh competency would fragment the community into those for whom it applies and those who are spared.

Nonetheless, Dr. Apelgren raises cogent points that are highly relevant to procedural specialties. Any given specialty is invited to respond to the challenges imposed by the competencies in ways that make sense. That is one approach. The ACGME's role is to preserve the whole. ■

ACGME Institutes Online Requests for Changes in Resident Complement for All Review Committees (RCs)

Rebecca Miller, MS and Jeanne K. Heard, MD, PhD

The ACGME has been transitioning from a paper-based to web-based system through greater use of the Accreditation Data System (ADS). The goal is to decrease some of the burden of paper submissions, increase the consistency of processes across RCs, and support the roles of the DIOs and GME Committees in complying with the Institutional Requirements (must approve various requests prior to submitting to the ACGME). In keeping with this transition, beginning on July 1, 2006, all requests for changes in resident complement must be submitted through ADS. Staff of all RCs *will not accept requests* submitted via paper or email.

To officially initiate a change (i.e., increase/decrease) in the ACGME-approved resident complement, program directors/coordinators must login to ADS and select *Request Change in Approved Positions* from the menu on the left. For many specialties, a decrease can be made without significant documentation; however increases will require additional documentation and DIO approval *prior to* RC review. Complement change requests will be electronically sent to the DIO for approval. The sole exception is during a request for increase made during site visit preparation when the DIO's approval is indicated through his/her signature on the Program Information Form. After the DIO has approved the complement change request, the materials submitted in ADS are forwarded to the RC for review and a final decision. Program Directors and DIOs will be notified by the Executive Director of the RC's final decision.

Programs must be fully accredited to be considered for a complement increase; programs with a status of probation or warning are not eligible for an increase. Some specialties will require a site visit for complement change requests depending on the details of the request. There is some variability in the documentation required by each specialty, and for this reason the specialty-specific requirements are provided in ADS, as well as on the RCs' web pages.

The following are examples of the documentation required:

- Educational rationale for change;
- Current block diagram;
- Proposed block diagram;
- Faculty to resident ratio;
- Descriptions of major changes since last ACGME review;
- Response to previous citations; and
- Case log reports or clinical data (as applicable).

The ACGME leadership believes that this change will benefit programs, institutions, and review committees. Please contact webADS@acgme.org for questions regarding the Accreditation Data System or contact the appropriate RC team for content related questions. ■

Subspecialties that Require Completion of the Competency and Assessment Form (CAF)

On July 1, 2006, the Review Committees for several added subspecialties required that programs provide information on teaching and evaluation of the six general competencies at the time they undergo a site visit. The information is provided to the ACGME and your assigned field representative via the *Competency and Assessment Form (CAF).* For subspecialties requiring completing of the CAF, the document is available via the Accreditation Data System (ADS). In addition to all core and Transitional Year programs, programs in the subspecialties shown below are expected to complete the CAF. ■

Table 1

Subspecialties Requiring Completion of the CAF, Effective July 2006

Family Medicine (120)
Geriatrics (125)
Sports Medicine(127)
Internal Medicine (140)
Cardiovascular Disease (141)
Critical Care Medicine (142)
Endocrinology, Diabetes & Metabolism (143)
Gastoneterology GI (144)
Hematology (145)
Infectious Disease (146)
Medical Oncology (147)
Nephrology (148)
Pulmonary Disease (149)
Rheumatology (150)
Geriatric Medicine (151)
Interventional Cardiology (152)
Clinical Cardiac Electrophysiology (154)
Hematology/Oncology (155)
Pulmonary/Critical Care (156)
Internal Medicine Sleep Medicine (52014)
Neurology (180)
Neruology Pain Medicine (181)
Neuromuscular (183)
Child Neruology (185)
Neurology Neurodevelopmental (186)
Neruology Clinical Neurophysiology (187)
Neurology Sleep Medicine (52018)
Otolaryngology (280)
Otolaryngology Neurotology (286)
Pediatric Otolaryngology (288)
Otolaryngology Sleep Medicine (52028)
Pathology (300)
Selective Pathology (301)
Blood Banking/Transfusion Medicine (305)
Chemical Pathology (306)
Cytopathology (307)
Forensic Pathology (310)
Hematology (311)
Medical Microbiology (314)
Neuropathology (315)
Pediatric Pathology (316)
Pediatrics (320)
Pediatrics Sleep Medicine (52032)
Preventive Medicine (380)
Undersea/Hyperbaric Medicine (398)
Toxicology (399)
Psychiatry (400)
Psychosomatic (409)
Psychiatry–Sleep Medicine (52040)
Surgery (440)
Vascular (450) Integrated programs only[1]

[1] *Integrated programs only in which residents complete 5 years of vascular surgery education following completion of an MD or DO degree, see http://www.acgme.org/acWebsite/RRC_440/440_445memo.pdf*

ACGME Eliminates the Need to Attach Letters of Agreement to the Program Information Form (PIF)

The Common Program Requirements (II.B.2), which apply to all residency and fellowship programs, stipulate that programs prepare a letter of agreement that:

1. Identifies the faculty who will assume both educational and supervisory responsibilities for residents;
2. Specifies their responsibilities for teaching, supervision, and formal evaluation of residents;
3. Specifies the duration and content of the educational experience; and
4. States the policies and procedures that will govern resident education during the assignment.

Until recently, many review committees (RCs) required program directors to attach all or a sample of these letters to the program information form (PIF) for the committee's review as part of the accreditation process. In an effort to reduce some of the paperwork burden for program directors, the RCs recently changed this policy. Beginning *August 1, 2006,* program directors *should not attach* the program level letters of agreement to the PIF for a continued accreditation review. However, all of these letters must be available on-site at the program. During the site visit the ACGME field representative will 'spot check' the letters for the required elements noted above. In addition, letters of agreement must be included in the documents submitted for an application for a new specialty or subspecialty program. ACGME staff is in the process of revising all PIF instructions to reflect this change for all PIFs completed after August 1. The members of the ACGME field staff have been informed of the new plan as well. For more information about Program Letters of Agreement, please see the ACGME Web site; click on ACGME FAQ on master affiliation agreements and program letters of agreement. ■

ACGME Forms Competency-Based Portfolio Advisory Committee

Jeanne Heard, MD, PhD

The use of a resident learning portfolio is a potentially significant improvement in the effort to gather organized evidence about residents' achievements in the six competencies. ACGME has formed an Advisory Committee on Competency-Based Portfolios (CBPAC) to explore development of a learning portfolio in graduate medical education. The committee is chaired by Paul Batalden, MD, Director of Health Care Improvement Leadership Development in the Center for Evaluative Sciences and Program Director of the Dartmouth-Hitchcock Leadership Preventive Medicine Residency Program at Dartmouth Medical School. Dr. Batalden chaired the Advisory Committee that developed the Outcome Project about a decade ago. The CBPAC is composed of representatives from the Residency Review Committees, American Board of Medical Specialties, National Board of Medical Examiners, medical professional societies, program directors, ACGME field representatives, and medical educators with expertise in portfolio assessment and experts in information technology.

The Committee will undertake the following activities:

1. Examine the need for a learning portfolio;
2. Determine the general elements and attributes of a learning portfolio for each of the stakeholders;
3. Establish principles that will guide the development of the learning portfolio; and
4. Recommend the types of policies that should be developed with implementation of the learning portfolio.

Information about the success of ACGME approaches using data, and on the implementation of major changes in GME, including the Outcome Project and the common duty hour standards, will provide background for this work. The final product will be a report with recommendations on the use of learning portfolios, which will be presented to the ACGME Executive Committee of the Board of Directors in November 2006. ■

The Internal Medicine Review Committee's Efforts to Streamline and Reduce Burden in Accreditation

William Rodak, PhD

ACGME recently concluded a strategic planning process that led to the adoption of four ACGME strategic priorities:

1. Foster innovation and improvement in the learning environment;
2. Increase the accreditation emphasis on educational outcomes;
3. Increase efficiency and reduce burden in accreditation; and
4. Improve communication and collaboration with key internal and external stakeholders.

One of the enabling approaches to meet the third priority of increasing efficiency and reducing burden in accreditation is the active engagement of lean production and management[1] to improve the flow of the work. In the beginning of 2006, the ACGME hired ASI Consulting Group to work with the Internal Medicine Review Committee (IM RC) Team. ASI examined the accreditation process, ranging from the review committee requesting that a program submit documents for re-accreditation to the ACGME/RC sending the notification letter. The consultant was charged with applying lean management techniques to reduce by 30 percent the work of staff, to be achieved by eliminating unnecessary loop-backs and non-value added steps in the current process.

At the first meeting with key staff of the IM RC team, a high level process map was developed. It had eight steps:

1. Send blank review forms to program/institution;
2. Accept completed forms returned;
3. Conduct site visit;
4. Prepare RC review package;
5. RC member reviews program;

6. Create review meeting agenda;
7. Make accreditation decision; and
8. Communicate RC decision to program/institution.

Staff estimated that there were about 87 steps in the total process.

At the second meeting, all IM RC members worked at populating the high-level steps with their current activities required to do each major step. At the third meeting, the detailed current step map was refined with identified impacts and effects as each step of the process was examined and labeled. The two meetings were highly informative, letting the members of the IM team know the work is accomplished and how their contribution relates to the whole. It also exposed redundancies that could be removed from the process.

The final current state map contained 267 processes. Sixteen (5.9%) were identified as adding customer or business value. Typically 5 percent of the steps in a detailed process map are truly added value. The other steps are either unnecessary, represent re-work (checking for or correcting errors), or are interim steps that cannot be eliminated. Customer added value steps are those for which the customer (resident, program, RC member, public) would be willing to pay for if given the choice. ACGME/RC value added steps are other steps which must be kept regardless of value considerations. They include components of the work vital to regulatory, policy, and procedure compliance.

Eleven areas of improvement, which are the result of removed or modified unnecessary or re-work steps, were suggested by staff that should meet the goal of reducing their work by 30 percent. Some of the more visible proposed changes include:

1. Replacing the scan sheet resident questionnaire that has been used for accrediting internal medicine programs for the past 14 years with a shorter web-based questionnaire;
2. Not requiring site visits for new subspecialty applications;
3. Using the ACGME's new EVE/ADaM (Efficient and Very Effective Accreditation Data Management) data management system instead of the Computer Assisted Accreditation Report (CAAR) software for the accreditation of the internal medicine subspecialties; and
4. Sending adverse accreditation notices by e-mail to the program instead of by facsimile.

In addition, in the coming months, all signed notification letters will automatically be posted on the Accreditation Data System (ADS), as part of the program's file and the program and DIO will be notified by e-mail.

Staff also developed visions for its process maps for 2007 and 2010. The 2007 vision included some of the changes enumerated above. In addition, the IM RC team will be tracking the improvements effect on the work and on the time staff spends on tasks. The team also will record errors that occur in the new process, and perform a root-cause analysis to examine whether any system issues are the underlying cause of the problem, as well as make recommendations for changes. The Executive Director will track incidents of errors, and assess the system after the implementation of corrective solutions, to ensure the cause of the error is addressed. The 2010 vision looked at the integration of EVE/ADaM into the accreditation process and the implementation of the ACGME's four strategic goals, to broaden the focus to the other three strategic priorities. ■

[1] *Ohno Taiichi.* The Toyota Production System: Beyond Large-Scale Production. *Portland, Oregon: Productivity Press, 1988.*

ACGME Resident Survey Update

Rebecca Miller, MS

The resident survey was conducted again this year from January to May, 2006. This was the third year of the ACGME's 3-year plan to survey residents and fellows. This year was the first year that core and subspecialty programs having fewer than 4 residents or fellows were included. The survey asks residents to evaluate duty hours, general competencies, learning environment, supervision, and evaluation in their residency program. In response to feedback from previous years' administration, several of this year's questions were slightly revised to provide clarification.

In this year's survey, 48,176 residents and fellows in 4,703 programs were scheduled for participation. Of those, 42,870 residents and fellows completed the survey, for an overall completion rate of 89%. The average time to complete the survey was approximately 9 minutes.

As programs completed the survey, aggregate data reports for each program became available for the ACGME's field representatives. Members of the field staff verify and clarify the survey data, and use it to guide the resident interview during the program site visit. If a sufficient response rate (at least 70% response in programs having at least 4 residents and fellows) was reached, aggregate data reports are made available electronically (via ADS) to program directors and designated institution officials. This information offers an opportunity for program officials to discuss aspects of the program with their residents and fellows, and may assist with program improvement, and help programs prepare for their site visit.

The ACGME is currently analyzing data and generating reports from these data. Initial analyses of data from the 2004 and 2005 administrations suggest that the survey is both reliable (i.e., responses from the same programs are consistent from year to year) and valid (i.e., a comparison of survey responses with citation data shows a high degree of agreement). These analyses will be repeated and refined with the addition of 2006 data.

Development of the next version of the survey is currently underway. The ACGME has received input from many constituents and continues to work with members of the field staff, RC members and staff, program directors, and residents to develop a sharper and more defined survey for implementation in January 2007. In addition, ACGME has retained a survey development expert to finalize next year's survey wording and format. ■

Educating Physicians for the 21st Century: An Update on the ACGME's E-learning Project

Barbara Joyce, PhD

"Educating Physicians for the 21st Century" is an educational initiative developed by the ACGME and designed to assist program directors and faculty in implementing the Outcome Project, including increased understanding of the six competencies, development of assessment tools, and engaging in continuous improvement in residency programs. It is composed of two educational offerings.

The first is a series of PowerPoint presentations, each with a Facilitator's Guide that program directors can use as a faculty development tool. These PowerPoint presentations, each approximately 30 minutes in length, are intended to be delivered at educational retreats, departmental conferences, or as part of the departmental faculty or educational meeting. Program directors are encouraged to combine slides from the various PowerPoint presentations to create a customized PowerPoint presentation for their program. Each Facilitator's Guide provides Speaker's Notes, Discussion Questions, Resources, and activities to guide program directors in presenting this information. The first two PowerPoint presentations, with the Facilitator's Guide, are posted on our Web site at http://www.acgme.org/outcome/e-learn/e_powerpoint.asp. The remaining modules are expected to be completed shortly.

The second educational offering, a series of five web-based modules, is currently under development with an expected completion date of Winter 2007. These web-based modules contain similar information to the PowerPoint presentations but include enhanced resources. These web-based modules are designed to be used as self-directed learning modules for individual faculty to familiarize them with the Outcome Project, assessment concepts and tools, and continuous program improvement. Each module will last approximately one-half hour. These modules will be most useful for programs that have faculty at multiple sites, community faculty who precept residents, or faculty who are unable to attend an educational retreat or faculty meeting and need to acquire basic information about the Outcome Project.

The topic areas included in both the PowerPoint lectures and the web-based modules include:

- **An Introduction to Competency-based Residency Education**
  This offering contains an overview of Common Program Requirements, ACGME timelines for implementation of the competencies, key points of competency-based education, and a brief description of the six competencies.

- **Implementation of the Competencies**
  This offering contains an overview of the six competencies highlighting practical ideas for teaching the competencies and encourages guided discussion by program faculty to generate ideas for educational program improvement.

- **Writing Goals and Objectives; Curriculum Planning**
  This offering contains an overview of curriculum planning, writing goals and objectives, and integrating the competencies into a specialty-specific curriculum.

- **Developing an Assessment System**
  This offering includes an overview and example of an assessment system with recommendations for types of assessment tools programs should be using. The model proposed in this module reflects the current thinking of the ACGME. Example evaluation tools and resources from the ACGME Web site are also included.

- **Educational Quality Improvement**
  This offering includes an overview of educational quality improvement methods focused on using aggregate data to improve educational programming. Examples for meeting this requirement will be presented using a data-based framework that includes internal evaluation, practice indicators, and national specialty-specific benchmarks.

The PowerPoint presentations and web-based modules are designed to develop foundation knowledge about to the Outcome Project. The content of both the PowerPoint presentations and web-based modules is peer-reviewed internally as well as externally by a group of program directors. This extensive vetting process has been done to ensure the content is useful and practical to program directors and faculty and to determine the content accurately represents the current thinking of the ACGME.

A blast e-mail notifying the ACGME Community will be sent once an offering is posted to our Web site. You can also check our Web site at http://www.acgme.org/outcome/e-learn/e_powerpoint.asp for updates. ■

ACGME and ABMS to Hold Joint Conference on Assessing and Improving Patient Care

A conference on *Assessing and Improving Patient Care,* co-sponsored by the American Board of Medical Specialties (ABMS) and the ACGME, will be held on November 2–3, 2006 at the Sofitel Chicago O'Hare Hotel in Rosemont, Illinois.

In addition to presentations by national speakers, including Elizabeth McGlynn, PhD, MPH, from the RAND Corporation, F. Daniel Duffy, MD of the American Board of Internal Medicine, and Ed H. Wagner, MD, MPH, Mac Coll Institute for Healthcare Improvement, the conference will feature a poster session aimed at providing a forum for the presentation and discussion of topics related to assessing and improving patient care. Topic areas of interest include:

- Tools to assess the quality of patient care provided by residents and physicians in practice;
- Improving patient care;
- The chronic disease model and improving patient care;
- Practice redesign;
- Closing the quality gap; and
- Using incentives (pay-for-performance/pay-for-participation) to improve patient care.

Abstracts on these topics are invited. Accepted abstracts will be presented during a poster session scheduled for November 2, 2006, 6 to 9 pm. The format will allow for extended discussion with attendees. The abstracts will be reproduced in the conference syllabus. Dimensions of the space available for each poster will be approximately 6 feet in height by 5 feet in width.

Description of Abstracts

Abstracts should report completed or in-progress research or projects that contribute to knowledge about assessing and improving patient care. If you plan to submit an abstract, consult the AMBS' Web site at http://www.abms.org/Downloads/Conferences/CallForAbstractsPosterSessions052605.doc.

All submissions must be received at the ABMS office on or before *August 25, 2006.* Send your submissions electronically to: Karen Back, kback@abms.org (faxed submissions are not acceptable). If you have questions, contact the ABMS at (847) 491-9091 or at the e-mail address above. ■

Annual Conference of the Royal College of Physicians and Surgeons of Canada to be held September 28–30, 2006 in Ottawa

The 2006 Annual Conference of Royal College of Physicians and Surgeons of Canada, to be held September 28–30, 2006 in Ottawa will focus on assessing physician competencies and offer resources and solutions to some of the program challenges of medical educators. Medical educators from other nations are invited to attend the 2006 Annual Conference. Opportunities for attendees include:

- Learning about best practices in implementing and assessing CanMEDS physician competency framework in undergraduate and postgraduate medical education, and continuing professional development;
- Obtaining new resources for teaching and evaluating medical residents and students based on competency frameworks; and
- An occasion to network with international colleagues to come up with solutions to program challenges.

A complete lineup of speakers and topics is available on the Royal College's Web site at http://rcpsc.medical.org.

For additional information about the conference visit http://rcpsc.medical.org or contact Dianne L. Dodds, CMP, Senior Meetings Administrator, The Royal College of Physicians and Surgeons of Canada at (613) 730-6232/1 or (800) 668-3740. ■

ACGME Conference to Design the Optimal Learning Environment for Residents, September 8–10, 2006

The ACGME is holding a conference to design the optimal learning environment for residents, which will be held September 8–10, 2006 in Rosemont, Illinois (near O'Hare Airport). This is a design event, intended to allow the education community to participate in the design of the future learning environment for residents.

The conference includes presentations from national speakers, including Hubert Dreyfus, PhD, University of California at Berkeley; Tina Foster, MD, MHP and Elliott Fisher, MD, MPH both from Dartmouth Medical School and Mary Hitchcock Medical Center; and Emily Patterson, PhD, Ohio State University. Attendees will also participate in hands-on sessions that will allow them to contribute to the design of the resident learning environment of the future.

Review the conference brochure and register online at https://acgme.emeetingsonline.com/emeetings/websitev2.asp?mmnno=106&pagename=ATTENDEE ■

The ACGME Web site is the Source of Current Program and Institutional Requirements

Beginning in 2006, the ACGME Web site www.acgme.org is the sole source for the current ACGME program and institutional requirements. Because many of these requirements are updated during any given year and requirements for new specialties are added, this information is no longer published in the American Medical Association's *Graduate Medical Education Directory,* which is updated only annually. The goal is to ensure that the information on the ACGME requirements available to programs, sponsoring institutions, and other interested parties is accurate and up-to-date. ■

Efforts to Inform Residents about the ACGME's Role

Julie Jacob

The ACGME's mission is to "improve health care by assessing and advancing the quality of resident physicians' education through accreditation." However, many residents do not know what the ACGME is, what it does, or why this is relevant to their education.

That is why the ACGME is reaching out to residents to inform them of what the ACGME does and direct them to the resources for residents on the Council's Web site. A new online resident newsletter, *Resident Review,* debuted last February. The newsletter includes brief articles on ACGME projects and functions, as well as opinion pieces written by residents, a list of upcoming meetings of interest to residents, and definitions of accreditation terms. The next issue of the quarterly newsletter will be posted later this summer.

In another outreach effort, the ACGME recently sent Designated Institutional Officials (DIOs) copies of simple posters designed to be placed in call rooms and other places where residents gather. The posters summarize the role of the ACGME and how the organization is relevant to residents. Future plans for reaching out to residents include the production of a brief presentation on DVD explaining what the ACGME does and how it helps residents by setting the standards for residency education and reviewing and accrediting programs and institutions that sponsor graduate medical education.

For details on any of these projects, or to suggest other ways to increase resident awareness of the ACGME, please contact Julie Jacob, communications manager, at juliej@acgme.org ■

Judith Armbruster, PhD, Retires after 23 Years of Service to the ACGME

Judith Armbruster, PhD, Executive Director of the ACGME Review Committees for Anesthesiology, Diagnostic Radiology and Nuclear Medicine announced her retirement this month. Judith has been with ACGME for 23 years and served as Executive Director for several review committees over that period. She became expert in classic accreditation models and brought a wealth of experience to Review Committee and ACGME deliberations.

Dr. Armbruster also was active in the international community, representing the ACGME at the Royal College of Physicians and Surgeons of Canada and annually at several European Medical Education meetings. She has an international reputation and is sought out for her accreditation expertise. Program directors will miss the tremendous support that she has offered them, and Review Committee members will miss the clarity of her guidance.

No one can replace Dr. Armbruster, but the leadership of the Department of Accreditation Committees will work actively on identifying a successor. In the interim, Steve Nestler, PhD and Linda Thorsen, MA, both experienced Executive Directors, will provide support for the three review committees. ■

Meet the Newest Members of the ACGME Field Staff

Over the past 10 months, the ACGME has hired and oriented four new accreditation field representatives. All have completed or are near completing their extensive orientation, and are or will soon be conducting independent program reviews. The four new members of the ACGME field staff come with an extensive background in graduate medical education, which will benefit the accreditation process and the programs they will review.

Thomas S. Renshaw, MD earned his BS and MD from Ohio State University. After internship at Riverside Methodist Hospital in Columbus, Ohio and service as a flight surgeon in the US Air Force, Dr. Renshaw completed his orthopaedic surgery residency at University of Michigan Medical Center and fellowship training in pediatric orthopaedics at Newington Children's Hospital in Newington, Connecticut.

Dr. Renshaw is certified by the American Board of Orthopaedic Surgery. He most recently was Professor and Chief of Pediatric Orthopaedics and director of the residency program at Yale University. He has served in a number of professional and scientific societies. His research interest is enhancing bone healing and he has published extensively.

Carl L. Stanitski, MD received his bachelor's degree from Bloomburg State College in Pennsylvania. He worked as a high school teacher of physics and English and coached basketball and track before earning his MD degree from Jefferson Medical College in Philadelphia. He completed internship at Jefferson Medical College Hospital, and residency and fellowship education in Orthopaedic Surgery and Pediatric Orthopaedics at the University of Pittsburgh, the University of Southern California–Rancho Los Amigos Hospital and Children's Hospital, Boston.

Dr. Stanitski's career has spanned roles as a staff associate at the National Institutes of Health, Associate Professor at the University of Pittsburgh, Chief of Orthopaedic Surgery at Children's Hospital of Michigan, and Professor of Orthopaedic Surgery at Medical University of South Carolina. He has served as an examiner of the American Board of Orthopaedic Surgery, has been Chair of a number of committees of the American Academy of Orthopaedic Surgeons, and has served on a number of editorial boards.

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William T. McKinney, MD, received a BA degree (cum laude) in psychology and chemistry from Baylor University–Waco and his MD degree from Vanderbilt University. He completed residency education in psychiatry at Bowman Gray School of Medicine, Winston–Salem and at the University of North Carolina School at Chapel Hill, North Carolina and Stanford University. Dr. McKinney has held positions at the National Institute of Mental Health (NIMH), the University of Wisconsin School of Medicine, where he served on the Psychiatry faculty and as chair of the Department of Psychiatry.

In 2006, Dr. McKinney retired from his position as Asher Professor of Psychiatry at Northwestern University Medical School, where he held the position of Director of the Asher Center for the Study and Treatment of Depressive Disorders, and was a member of faculty of the Northwestern University Institute for Neuroscience and the Center for Sleep and Circadian Biology. Dr. McKinney has served as a consultant, member or board member of many university and research institutions. He has served on the editorial boards of a number of journals and has published numerous articles and several books. ■