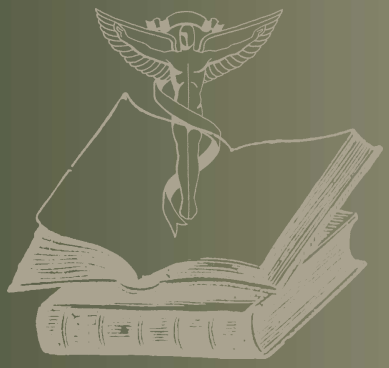

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ACGME BULLETIN March 2001

Accreditation Council for Graduate Medical Education

The **ACGME Bulletin** is published four times a year by the **Accreditation Council for Graduate Medical Education.** The **Bulletin** is distributed free of charge to more than 12,000 individuals involved in graduate medical education. The Bulletin is also available from the ACGME's World Wide Web site at http://www.acgme.org. Inquiries, comments or letters should be addressed to the editor.

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Executive Director's Column:

David C. Leach, MD

The Courage to Teach: Living Divided No More

It is said that happiness occurs when one's daily activities are aligned with one's values. Conversely, unhappiness descends when daily activities are in conflict with deeply held values. Many program directors are unhappy. Last year their turnover rate was nearly 30 percent. It will not be news to program directors that they are asked to cope with a seemingly irresolvable conflict: improve the quality of the residency program; and cover the house. To do the first they must hire the best possible residents; to do the second they must fill all slots in the program.

It will not be news to program directors that they are asked to cope with a seemingly irresolvable conflict: improve the quality of the residency program; and cover the house.

Ed Hundert, M.D., the recently inaugurated dean at the University of Rochester School of Medicine, has said that whenever we use the word "cover" as in "cover the curriculum" or "cover the house" we can be assured that there is little education going on. Perhaps as a psychiatrist he is interested in what is going on under the "covers." The dualism of education and service are served by deeply held values now poised in conflict. When approached as either/or, program directors are in a "no win" situation. Daily activities are forced to be in conflict. Unhappiness results.

Once residents are hired primarily to meet service needs several sources of unhappiness emerge. The administrative burden becomes greater and is under-appreciated and potentially under-addressed. Conversations are frequently conflict-laden. Faculty previously interested, capable, and willing to teach become less available. Competing service obligations provide a convenient excuse. Already compromised by a delivery system that ubiquitously compresses time, conversations so essential to good teaching become less frequent. Remediation begins on day one.

This bleak picture has an alternative. There is a hidden wholeness beneath the paradoxical dualism of service or education. Clarity about the purpose of graduate medical education is necessary. The values that support both patient care and education are robust enough to resolve the paradox. The purpose of graduate medical education is to improve patient care. Parker Palmer, in his book *To Know as We Are Known* quotes Abba Felix, "to teach is to create a space in which obedience to truth is practiced." Our profession has long claimed the ability to discern the truth and the courage to obey it.

Challenging in the current environment is the ability to "create a space," and yet space can be found if it is clear to all that patient care is better because of it. "Covering the house" is replaced by "caring for the house." Improving patient care becomes a unifying theme.

At its February 2001 meeting the ACGME established the **Parker J. Palmer Courage to Teach Award.** Parker Palmer, author of several books including *The Courage To Teach,* is particularly interested in social movements and the power that is released when individuals have the courage to follow internal values. He has documented the remarkable things that occur when people chose to "live divided no more." Palmer has also applied his observations to a highly successful teacher formation program, a program now being applied nationally, and one that may be adaptable to medical education.

Challenging in the current environment is the ability to "create a space," and yet space can be found if it is clear to all that patient care is better because of it. "Covering the house" is replaced by "caring for the house."

The criteria for the award, which will recognize outstanding program directors who provide to the rest of us an example of how to live divided no more, will soon be published and nominations will be sought. We anticipate that about ten awards will be granted each year. Program directors from all disciplines will be considered. We hope to identify and celebrate program directors who are driven by classic values and who have found a way to render a toxic environment harmless. We are looking for these program directors to exemplify the joy in work and learning that accompanies alignment of behavior and values. Stay tuned.

Profile of an Individual with "The Courage to Teach": An Interview with John Fishburne, MD

Ingrid Philibert

The preceding article by Dr. Leach announces the creation of the **Parker J. Palmer Courage to Teach Award** for outstanding program directors who are an inspiration to others. The award's primary importance is that it will recognize individuals for their contribution to resident education, an area some believe is not as well rewarded among academic physicians' competing pursuits of teaching, research and patient care.

We anticipate that a good number of nominations will be forthcoming. Exemplary program directors who have demonstrated their dedication to resident education exist, even in the current challenging environment. Dedicated program directors can be found in all medical disciplines and the wide variety of settings where medical education occurs. There is no single prototype. What is common to all members of this group is a deep concern for the education of their residents and for the residents themselves. One example of an individual who has contributed significantly to the education of residents for nearly 20 years is John Fishburne, MD, program director of the obstetrics-gynecology residency at the Maricopa Integrated Health System, Phoenix. Dr. Fishburne is a member of the ACGME Board of Directors, representing the Council of Medical Specialty Societies. Prior to this current role on the ACGME's Board, he chaired the Residency Review Committee for Obstetrics and Gynecology. He brings to the ACGME nearly 20 years of experience as academic chair, program director and individual involved in and deeply committed to GME. He was recently interviewed for the ACGME Bulletin.

***Question:* Can you tell me about your years in graduate medical education?**

Dr. Fishburne: I have been a program director intermittently since 1983. I started when I became Chair of Obstetrics and Gynecology at the University of Oklahoma and I remained in that role until 1993, when I passed the responsibilities to the vice chair, in part to prepare him for the chairmanship. In 1997, I became department chair and program director at the Maricopa Health System. One year ago, I retired from the chairmanship, but remained as program director. The chair's position is rewarding but entails a lot of administration and coordination. Being program director has always been my first love.

At the same time I understand GME and the educational process is critically important for an academic department chair, because patient care and education are inseparable. Now that I no longer have a chair's administrative demands, my work is nearly exclusively "for the sake of education." At Maricopa Medical Center, the members of the faculty have no private patients. We are there solely to teach the residents.

Question: What is the origin of your dedication to teaching?

Dr. Fishburne: I come from a family of teachers. Thus, when I became interested in medicine, I naturally gravitated to the educational side of it. In addition, I had an internship experience I did not like, and much of my career has been a reaction to this: How can I make the education experience better for others?

Question: To what do you attribute your national recognition in the field of GME?

Dr. Fishburne: I attribute it to caring about residents, about their learning and about them as individuals, and to wanting the best possible educational program for them. I also attribute it to my willingness to take on just about anyone to ensure good education for the residents. Finally, I believe that my role as a former RRC member has added to my effectiveness. Being a member of the RRC on one hand is a reward for an individual's contribution to education, on the other hand it offers tremendous opportunities to learn about medicine, about education in general, and about the training of residents across the country. I have learned how good or how inadequate a given residency program can be, and how profoundly this impacts the education and lives of the residents. I know that attention to the learning process has a significant positive effect on program quality. During my days as a member of the RRC, I rarely reviewed a program from which I did not learn something that improved my own program. I do not view myself as a 'national resource,' but I guess I can help improve education by serving as a consultant to residency programs. The Council on Residency Education in Obstetrics and Gynecology (CREOG) invites a number of former members of the RRC to advise residency programs. CREOG consults are generally done at some time prior to an ACGME site visit. Their goal is to assist the program in preparing for the visit and in related improvement efforts.

Question: Who has influenced you?

Dr. Fishburne: Two obstetrician-gynecologists have influenced me profoundly. They are Warren Pierce, MD, who taught me a lot about the discipline, and Charles Hendricks, MD, who mentored and influenced me in his role as department chairman for the latter part of my residency and for my early years on the University of North Carolina's faculty. He taught me a great deal about academic obstetrics and gynecology, and about the importance of education.

Question: What has continued to make the role of program director exciting for you?

Dr. Fishburne: My heart has been in the day-to-day contact with the residents, watching their progress, from entering as novices to four years later when, through their interaction with the faculty, patients and each other, they depart as capable obstetrician-gynecologists. In addition, there is the special pride in the administrative chief residents, being part of their growth and development as academic physicians. Conversations with my colleagues have indicated that they are excited by the same aspects of interacting with the residents that have kept me involved in education for so many years. Similarly, the issues that concern them are nearly identical to those hat concern me — dealing with the resource constraints, including constraints on faculty time for teaching, and the quest to attract high-quality residents to the program.

My heart has been in the day-to-day contact with the residents, watching their progress...

Attracting qualified residents is a challenge for many programs, given the shrinking pool of applicants for obstetrics-gynecology, and the fierce competition for high-quality candidates. There are aspects of a program that assist in recruitment. A dedicated program director, a knowledgeable and caring faculty, and facilities and other program resources are important. Also important is the climate of the program, specifically the degree of collegiality and collaboration among the residents. Maricopa's physical facilities, which are patient- and resident-friendly, help in our recruitment. Attracting and retaining qualified faculty has become more difficult, in part due to the nature of academic salaries, and the demands on academic physicians.

The dual demands of recruiting good residents and retaining and encouraging teaching faculty make a program director's life different and more complex than it was just a few years ago.

The dual demands of recruiting good residents and retaining and encouraging teaching faculty make a program director's

life different and more complex than it was just a few years ago. Underperforming residents, residents with problems or unhappy residents can consume a huge amount of a program directors's time and energy. Residents who do well in their program add joy to a program director's life. At Maricopa, we have a cohesive resident groups, because the residents are thoroughly involved in the recruitment process, including participating in the structured interviews and the scoring of each candidate. The goal is to select residents who work together well, are willing to assist each other, and form a cohesive group.

***Question:* What advice would you give to a new program director?**

Dr. Fishburne: My first piece of advice would be to pay special attention to recruitment. Second, involve your residents, be accessible and meet with them on a regular basis. We have open sessions with the residents with the goal of sharing information and having an open discussion of the issues. Problems can be addressed and resolved in these sessions. Another way to enhance communication flow is to hold a resident retreat, especially if the residents can be completely freed from clinical duties for this period.

My third recommendation is to get involved with your specialty's national program director group. Attend the meeting and make your voice heard. In summary, you should never think that your activities occur in a vacuum. You should always involve residents to the greatest extent possible, as well as your faculty. In addition, you should link to information, support and a network of colleagues with similar interests by becoming active in program director groups and other groups dedicated to graduate medical education.

ACGME News

Jack Boberg, PhD, to Retire; ACGME Seeks New RRC Executive Director

Marvin Dunn, MD

After 18 years with ACGME, Dr. Jack Boberg has announced his retirement this summer. During his long tenure with the ACGME, Dr. Boberg has been an outstanding RRC Executive Director. Currently he is responsible for the RRCs of Surgery, Thoracic Surgery and Ophthalmology. There is much more to say about Dr. Boberg but that will wait for the next edition of the Bulletin.

This short announcement of Dr. Boberg's upcoming retirement appears in this issue of the Bulletin to inform the medical education community that the ACGME is initiating a search for a new RRC Executive Director. We cannot expect to "replace" Dr. Boberg, only to have someone to succeed him. Exactly which RRCs the new Executive Director will be responsible for will be determined later as we identify the particular expertise and experience of the new person. This also means there will be shifts in the responsibilities for several of the current Executive Directors.

Among the qualifications required for the Executive Director position is a proven administrative background and a PhD or equivalent degree. In addition, professional experience in higher education or with the processes of higher education is highly desirable. It is essential that the individual have an energetic and thorough approach to all assignments and have highly developed written and oral communication skills. The demonstrated ability to serve as a member of a team and as a team leader is critical. As this position also involves serving as a liaison between the RRCs and various internal and external groups, proven interpersonal and diplomatic skills are essential. Travel is required several times a year. The ACGME is a committed Equal Opportunity Employer.

If you are aware of individuals with these qualifications and who may be interested, please encourage them to apply or you may send their name (preferably with a CV) to Marvin R. Dunn, MD, Director of RRC Activities, Accreditation Council for Graduate Medical Education, 515 North State Street, Suite 2000, Chicago, Illinois 60610.

Field Staff News

Thomas Sumner, MD, joined the ACGME field staff in January 2001. Dr. Sumner is board-certified in pediatrics and radiology, and sub-board certified in pediatric radiology. He received his MD from the University of Rochester, New York, followed by residency training in pediatrics and in radiology at Yale-New Haven Hospital, and a fellowship in pediatric radiology at the Children's Hospital Medical Center, Cincinnati. From 1976 until now, he has been in academic practice in pediatric radiology at Wake Forest University School of Medicine.

On a sad note, two retired members of the field staff who were known to many programs passed away in recent months. Gertrude Stern, MD, accreditation field representative from 1981 to 1994, died in October 2000, and Francis Heck, MD, ACGME accreditation field representative from 1981 to 1998, passed away in February 2001.

ACGME Bulletin Editor's Occasional Column:

A Role for Medical Education in Helping Cross the "Quality Chasm"

Ingrid Philibert

The Institute of Medicine (IOM) recently released its second report on health care quality, entitled, "Crossing the Quality Chasm: A New Health System for the 21st Century." The report follows the 1999 Report, "To Err is Human: Building a Safer Health System" and continues the work of the Institute's Quality Initiative, created in 1998. Its goal is to identify and reduce the gap in quality between the best care and the average care available. The report highlights deficits in the system, including duplicate efforts in some areas and gaps in others that cannot be explained, and the system's failure to take advantage of the knowledge, ability and strengths of all types of health professionals. Its authors note that the reasons for these quality deficits are not related to the proliferation of managed care, but lie in the complex structure of the nation's health care system. The report provides specific recommendations for how the nation's health care delivery system needs to change, emphasizing six major aims: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.

To address these quality problems, the report calls for making quality, and efforts to monitor and improve it, a global goal of health care organizations, health professionals and purchasers of health care. It also recommends the creation of a $1 billion "innovation fund" to make far-reaching changes in the system in the coming five years. The report includes detailed recommendations for improving care, including the development of action plans to improve care for 15 chronic conditions, such as cancer, asthma, heart disease, and diabetes. Another proposed improvement concerns the information infrastructure in health care, and the need to phase out use of handwritten clinical information by the end of the decade. A third recommendation involves the convening of a summit on the restructuring of clinical education in medicine, nursing, and other health professions. Several recommendations call for needed changes in medical education and clinical practice.

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The IOM Report contains an extensive discussion of "complex adaptive systems," which exist at all levels of the health care enterprise. A single resident, engaged in a process of learning, is a small complex system, involving cognitive processing, pacing of the learning, adaptation, integration, and response to his or her environment. A residency program is a complex system of a somewhat larger size. Moving up the scale there is the clinical department, the teaching hospital, the integrated health care organization and, at the most macro level, the US health care system, totaling 13.5 percent of the Gross Domestic Product. A key recommendation by the report's authors is that the health care system as a whole should become better at responding to the cues and demands of its environment, that it should adapt to these demands. Education will be the key, potentially to an even greater degree than was emphasized in the report.

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Medical education is a complex system that continuously needs to adapt to the demands of its multiple constituencies — residents, medical students, the organizations and settings that employ physicians, and patients. Significant change across the continuum of medical education has already begun to occur. For the past several years, there has been a growing movement to focus medical education on the skills, knowledge and attitudes needed for medical practice. This has begun to change undergraduate medical education, but to an even greater extent it is beginning to revolutionize graduate medical education. For practicing physicians, it is changing a periodic effort to recertify in a specialty board to a broad-based, continuously ongoing process of maintaining and enhancing clinical skills. In September 1999, prior to the release for the first Report of the IOM's Quality Initiative, the ACGME and the American Board of Medical Specialties (ABMS) approved six General Competencies for physician education and practice: patient care, clinical knowledge, interpersonal skills and communication, professionalism, practice-based learning

and improvement and systems-based practice. Collectively, these competencies will contribute to bringing about some of the changes in the education and preparation of physicians called for in the report. They will do this by focusing medical education and efforts to maintain practice skills on the key attributes of a high-quality physician.

The IOM Report calls for a focus on health care outcomes, by asking that "health care organizations, professional groups and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury and disability..." In medicine, educational outcomes have emerged as the heart of current efforts to assess and improve the quality of education.

The general competencies will formally be used in the accreditation of residency programs after July 1, 2002 and are beginning to permeate board certification process for practicing physicians. In the near future, resident education will focus on practice-based learning and improvement and systems-based practice - concepts that are the heart of the IOM Report. At the same time, teaching faculty will have to be familiar with these

The general competencies will formally be used in the accreditation of residency programs after July 1, 2002. In the near future, physicians in educational programs will learn practice-based learning and improvement and systems-based practice—concepts that are the heart of the IOM Report.

concepts, to enable them to be taught to residents. This will spread deeper understanding of these concepts to faculty physicians, which will further contribute to facilitating the improvements called for in the report. Finally, use of the general competencies by ABMS' member boards in maintaining certification will ensure that all physicians are familiar with quality improvement, the systems nature of health care and safety as a systems property, the importance of communication, and other aspects of a 21st century health care system mentioned in the report. Thus, implementing the competencies will contribute to the effort to "cross the quality chasm."

The IOM emphasizes the need for system-wide change, in a system that comprises approximately 6 million individual health care workers (IOM Report). Education will be the key, as regulatory scrutiny, financial incentives and other means for achieving a 21st Century health care system cannot succeed in the absence of individuals' ability to perform the functions needed and to understand the impact of the system on their role and their impact on the system. This short article discussed physician education - an important area, but only a part of the system and the individuals in it that will be in need of additional education. Meeting the educational needs of this very large and diverse group will be challenging, given existing and very real constraints of time and resources.

Time is critical, as no one wishes to wait 20 years for this new health care system to emerge. Yet, educating 6 million health care workers to the degree that will be required to bring about system-wide change will take time. In addition, concern voiced by some health care leaders in their comment on the IOM Report is that bringing about broad-based quality improvement requires the involvement and collaboration of all parts of the system and that the process will be time-consuming. A question that remains is whether the three to five years referred to in the report will be sufficient time to allow these multiple, time-consuming processes to permeate the nation's health care system.

Institute of Medicine. Crossing the Quality Chasm. A New Health Care System for the 21st Century. Washington DC: National Academy Press, 2001.

AAMC Releases Report on Core Competencies

In the introduction, Dr. Jordan Cohen, President of the Association of American Medical Colleges, calls it "an idea whose time has come." In December 2000, the Association of American Medical Colleges (AAMC) released its report on the Graduate Medical Education Core Curriculum. The report represents a collaborative effort of two AAMC constituent groups, the Group on Educational Affairs (GEA) and the Group on Resident Affairs (GRA). It identifies five core domains that cross all medical disciplines: biomedical ethics, scholarly medical practice, communication in medicine, medical professionalism, and the health care system. The goals are to familiarize the readers with the core curriculum concept, and to assist institutions in developing and sharing core curricula. The report mentions the move toward core competencies by the ACGME and the ABMS, and notes that both core curricula and competencies aim at identifying and facilitating the learning of the knowledge, skills and attitudes physicians must demonstrate for the independent practice of medicine.

2001 Edition of the "Green Book" Released

Fred Lenhoff

What is green and read all over? It is the *Graduate Medical Education Directory* (GMED), or *"Green Book,"* of course. The new 2001-2002 edition of the popular reference is now available from the American Medical Association (AMA). This year's edition contains listings for 7,714 ACGME-accredited programs in 107 specialties/subspecialties. The *Green Book* also includes: (1) information on 220 combined specialty programs in 15 specialty areas; (2) 1,686 teaching institutions; (3) ACGME Institutional and Program Requirements for 112 specialties/subspecialties (including five newly approved subspecialties); and (4) board certification requirements of the American Board of Medical Specialties (ABMS).

The *Green Book* is also available in a CD-ROM version —the *Graduate Medical Education Library on CD-ROM*. The CD version offers advanced search functions and a Web browser interface that allows for quick, easy access to all program and institution data and 30,000 hyperlinks. The CD-ROM also includes archival copies of the Green Book since 1996-1997. Also available is the *GMED Companion: Supplemental Data for Choosing Your Residency Program,* which features key data on 4,200 specialty programs, such as program setting, salary, start dates, hours of duty per week, and curricula, displayed in a grid format for easy comparison between programs.

Fred Donini-Lenhoff is the Editor of the Graduate Medical Education Directory ("Green Book"). The directory is published by the Division of Medical Education Products of the American Medical Association. To order the "Green Book," call the AMA at 800 621-8335. GME program directors can obtain copies of these products at special discounted prices.

Other AMA Publications of Interest to Individuals in Graduate Medical Education

For a limited time, ACGME Bulletin readers can purchase copies of the AMA's Cultural Competence Compendium at only $25, a 50 percent savings over the $50 cover price. This 460-page resource guide is intended to help physicians learn how to provide respectful, patient-centered care by adjusting their attitudes and behaviors to account for the impact of emotional, cultural, social, and psychological issues on the principal medical complaint.

To order, call Enza Messineo (e-mail: enza_messineo@ama-assn.org) at 312 464-5333 or fax your request to 312 464-5830. To learn more about the Compendium, visit www.ama-assn.org/diversity.

Reprints of the article "Growth of Specialization in Graduate Medical Education," published in the September 13, 2000, Journal of the American Medical Association, are available free of charge from the AMA. The article discussed the history of GME in the early 20th Century, including standardization and accreditation, its growth during and after World War II, and the variations among specialty/subspecialty areas as tracked by the ACGME, ABMS, and AMA for the purposes of accreditation, certification, and tracking physician practice.

Reprints are available by contacting Fred Donini-Lenhoff at 312 464-4635 (e-mail: fred_lenhoff@ama-assn.org.

Award-Winning Posters from the 2001 Mastering the Accreditation Workshop

In conjunction with its 2001 annual Mastering workshop, the ACGME issued the third invitation for posters to facilitate the sharing of information of value to the education process. The posters were presented at a poster session and reception held during the meeting. The judges awarded first, second and third place. To enable a broader audience to view the content of these winning posters, their abstracts are presented below. In addition, three "honorable mention awards" were given. The first poster that received an honorable mention addressed the role of residency coordinators in enhancing GME. It was submitted by C Carruth; J Cook; C Ebnet; T Enger; K Hain; V Huebner; G Rink; and L Thornton from the Mayo Graduate School of Medicine. The second poster discussed the perceived importance and adequacy of training of the general competencies, and was submitted James T. Li, MD, Mayo Foundation and Chair, Residency Review Committee for Allergy and Immunology; June Smith; PhD, National Council of State Boards of Nursing; Doris Stoll, PhD, and Susan Swing, PhD, ACGME. The third honorable mention went to a poster on the importance of an annual retreat in surgical residency education, submitted by A Swivedi, MD; F Chahin, MD; V Patel, MD, FACS; Y Lakra, MD, FACS; Y J Silva, MD, FRCS(C) from North Oakland Medical Centers and Wayne State University.

First Place:

SELF EVALUATION: A VALUABLE EDUCATIONAL TOOL

S. Aboubakr, MD and B.A. Dubaybo, MD John D. Dingell. VAMC and Wayne State University School of Medicine.

The ability of trainees to progress in a satisfactory manner is influenced by their perception of their ability to acquire and utilize new knowledge and skills. In addition, the

rigor of teaching by faculty is colored by their perception of the ability of trainees to amass new knowledge and skills. Furthermore, trainee evaluation by training programs is a subjective process which is frequently influenced by the perceived ability of trainees. At this time, self evaluation is not widely utilized by educational programs to correct biases induced by self perceptions and teacher perceptions. We hypothesized that there is a discordance between trainees perception of themselves and that of their mentors. We adapted a self evaluation questionnaire in which 17 trainees rated their abilities in 63 skills which evaluate their communication skills, organization, information management, human relations, science and research potential, areas thought important in postgraduate education. A scale of 0 to 6 was used with 6 representing superior ability. Eight faculty members were asked to rate the same trainees using the same questionnaire and their mean scores compared to those of trainee self ratings. Discordances were identified when the mean scores differed from self scores by more than 1. We observed significant discordance in 12 of 17 trainees, and significant differences in rating among faculty members. The rate of discordance was more in earlier years of training. We conclude that differences in perceptions between trainees and mentors exist and need to be incorporated into evaluation forms to improve the validity of these tools.

Second Place:

USING STANDARDIZED ORAL EXAMINATIONS TO EVALUATE GENERAL COMPETENCIES IN EMERGENCY MEDICINE TRAINING

Earl Reisdorff, MD; Dale Carlson, MM; Oliver Hayes, DO; Gregory Walker, MD; Bruce Reinoehl, MD. Ingham Regional Medical Center, Michigan State University Emergency Medicine Residency, Lansing, MI

Program Requirements for Residency Training in Emergency Medicine mandate that "formal evaluation of each resident...must include oral and written examinations." Michigan State University, Emergency Medicine (MSU EM) program conducts monthly oral case simulation of standardized oral examinations as part of each resident's evaluations. EM-2 and EM-3 residents role-play through unknown clinical scenarios. These are similar to the oral certification examination conducted by the American Board of Emergency Medicine (ABEM). Faculty who are ABEM examiners are prohibited from participating. The residents are evaluated on a variety of topics including: case proficiency; history and physical; laboratory; x-ray; other data; medical interventions; procedures; diagnostic conclusions; overall examination technique; and overall medical care. They are scored on a 1 (poor) through 10 (excellent) ordinal scale. General Competencies (GCs) are evaluated in this process (e.g., patient care and medical knowledge). With the introduction of the GCs, the former case evaluation form was amended to directly assess GC acquisition for patient care and medical knowledge. For example, "Medical Intervention" is referable to the GC patient care. Communication was added to the revised evaluation tool. Items without any reference to GCs, e.g., Overall Examination Technique are not assigned to a GC category. Those elements of the evaluation tool pertaining to GC assessment (patient care, medical knowledge, communication) are totaled and an average score for each is determined. These evaluations are included in the residents' files and are reviewed during the residents' six-months evaluation with the program director.

Third Place:

INCORPORATING THE CORE COMPETENCIES.

Rita Patel, MD; Erin Sullivan, MD. University of Pittsburgh.

A comprehensive approach to incorporate the core competencies into the residency program requires the horizontal and vertical integration of different modalities of instruction. It is necessary to use a consistent, practical, and multi-faceted approach to ensure that teaching of the core competencies occurs throughout the curriculum and at all levels of training. Topics such as professionalism and systems-based practice were incorporated into the existing lecture series. Residents were encouraged to participate in departmental, university and national committees (e.g., ethics, education), and teach in pre-clinical courses for medical students. In addition to lectures and clinical education, four non-traditional teaching methods are utilized for the purpose of teaching patient care, medical knowledge, interpersonal and communication skills, and practice-based learning and improvement: (1) human simulation, utilizing a full-bodied, computer controlled mannequin; (2) case-management, a problem-based-learning-discussion method; (3) oral examinations, based upon material utilized for certification purposes; and (4) evidence-based-medicine, utilizing clinical dilemmas faced by residents. A series of faculty development sessions, including a departmental retreat, were held to develop faculty skills in instruction using the four different techniques mentioned above. Experienced faculty utilized those very same techniques to instruct others in teaching by these non-traditional methods. Recognition that both faculty and residents require education about the core competencies and guidance through the process of implementation is vital for success.

RRC/IRC COLUMN

Changes in the Requirements for Pathology, Diagnostic Radiology, Neuroradiology and Surgery

The ACGME approved revisions to the Program Requirements for Pathology, to become effective July 1, 2001. The revision includes the addition of the language on the General Competencies. For Pathology, the standard ACGME competency language was modified to reflect that pathology does not involve the establishment of a clinical relationship with the patient as a whole.

Also approved were revisions to the Program Requirements in Diagnostic Radiology and Neuroradiology, to become effective January 1, 2002, and for Surgery, to become effective April 13, 2001.

Council Extends Deadline for Incorporating the General Competencies Language into Program Requirements

The Council extended the date by which all Program Requirements must include language on the General Competencies to July 1, 2002. The ACGME also approved the addition of the General Competencies language to the following Program Requirements: Dermatology, Plastic Surgery, and Transitional Year.

All new requirements, including those with the addition of the General Competencies language, can be found at the ACGME's site on the World Wide Web (http://www.acgme.org). Program requirements that have been approved but are not yet in effect are located within each RRC web page, under the subheading "Approved but currently not in effect."

Other Highlights from the February 2001 ACGME Meeting

ACGME Adds Second Resident Representative

The ACGME voted to add a second resident member, to enhance the ability of resident representatives to attend all committee meetings and provide a resident perspective on issues being addressed. At the June 2001 ACGME meeting, the Council of Resident Members will elect a Chair, and he or she will serve as the second resident member, attending the ACGME meetings and participating in discussions, without vote.

ACGME Explores Benefits of an Approach to Aggregate "Common Program Requirements"

The ACGME Committee for the Review of Program Requirements reviewed a draft of proposed Common Program Requirements. The draft includes all requirements that use identical or comparable language across the specialties, with the goal of highlighting uniformity and consistency where they currently exist. Areas where common language can be found are institutional relationships, program director qualities and responsibilities, scholarly activity, and resident, faculty and program evaluation. A plan calls for aggregating these common requirements, either in a separate document for all specialties or as the first section in the Program Requirements for each specialty.

ACGME Chair Emphasizes Importance of CEO Involvement in Education

ACGME Chair R. Edward Howell, Chief Executive Officer of the University of Iowa Hospitals and Clinics announced that one of his three initiatives as Chair of the Council is to promote greater involvement of CEOs in medical education, including efforts to support clinician-educators. The two additional areas of special focus for Mr. Howell are increasing support for program directors to reduce program director turnover, currently nearly 30 percent annually, and to better serve the public. To begin work on the Chair's first initiative, the ACGME will convene a group of CEOs of teaching hospitals and the members of the RRC Council of Chairs at a retreat in May 2001 to discuss accountability and institutional responsibility in graduate medical education.

ACGME and JCAHO Discuss Role of Resident Supervision in Education and Patient Care

The goal of the revised JCAHO standards is to ensure appropriate supervision of residents in their role as patient care providers.

The ACGME and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) have been engaged in a dialogue to develop congruent requirements for resident supervision that meet the dual goals of fostering education and ensuring safe patient care. At the February 2001 ACGME Meeting, Paul M Schyve, MD, Senior Vice President, JCAHO, presented draft JCAHO standards on the supervision of residents. The goal of the revised JCAHO standards is to ensure appropriate supervision of residents in their role as patient care providers via (1) a requirement that teaching hospitals establish a process for supervision of all residents in their provision of patient care by a licensed independent practitioner with appropriate clinical privileges; and (2) a mechanism for effective communication between the committee(s) responsible for graduate medical education and the medical staff and governing body. Plans call for the ACGME to add to or amend its institutional requirements to correspond to these JCAHO standards.

ACGME Explores Public Release of Data on Resident Work Hours and Invites Comments

A topic that received considerable discussion at the February 2001 ACGME Meeting is resident work hours and the mechanisms that could be used to insure that institutions comply with the ACGME's requirements.

In the October 2000 Bulletin, Dr. Leach noted that "a crucial question that remains is how much and what kind of information the ACGME should provide to the public." A related topic that received considerable discussion at the February 2001 ACGME Meeting is resident work hours and the mechanisms that could be used to insure that institutions comply with the ACGME's requirements. Among the solutions proposed was the public release of the names of institutions with work hour citations or, potentially, the number of hours residents work in a given program. Advantages and drawbacks of such a public release were considered. Advantages include that this would inform applicants' choices, may contribute to this high-priority issue being addressed, and respond to public concern about resident overwork and fatigue. Drawbacks that speak against a public release of this information include that it could inhibit RRC action, that accuracy of the data may be less than desirable, that the data might remain after the issue has been addressed, and that it might be ill advised to single out one type of citation.

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To further inform the ACGME's ongoing discussion of this issue, we would like to invite all interested and affected parties to make comments to the ACGME Bulletin. Comments should be addressed to Ingrid Philibert, Editor, ACGME Bulletin, and may be sent by mail, fax (312/464-4098) or electronic mail (iphilibert@acgme.org). Please send your comments by May 10, 2001 to allow us to aggregate them for discussion at the June 2001 meeting of the ACGME.

RRC Meeting Dates

Meetings Held in the Remainder of 2001

March 29-30	Preventive Medicine
March 29-31	Anesthesiology
March 30-31	Pathology
April 1-4	Pediatrics
April 5-6	Neurology
April 18-19	Institutional Review
April 20-21	Transitional Year
April 26	Medical Genetics
April 27	Nuclear Medicine
April 27-28	Psychiatry
May 9-10	Plastic Surgery
May 19-21	Dermatology
May 21-23	Family Practice
May 31-June 1	Urology
May 31-June 2	Obstetrics/Gynecology
June 1-4	Internal Medicine
June 15-16	Ophthalmology
June 17-18	Orthopaedic Surgery
June 21-22	General Surgery
June 29-30	Neurological Surgery
July 13-15	Internal Medicine
July 27-28	Thoracic Surgery
August 13-14	Otolaryngology
August 24-25	Physical Medicine & Rehabilitation
August 28-29	Radiation Oncology
September 14-15	Pathology
September 14-15	Allergy & Immunology
September 20-21	Transitional Year
September 20-24	Internal Medicine
September 21-23	Emergency Medicine
September 23-25	Family Practice
September 25	Medical Genetics
September 28	Colon & Rectal Surgery
October 3-6	Diagnostic Radiology
October 4-5	Preventive Medicine
October 4-6	Obstetrics/ Gynecology
October 11-14	Pediatrics
October 14	Dermatology
October 18-19	Plastic Surgery
October 17-18	Institutional Review
October 19-20	Psychiatry
October 25-26	General Surgery
November 2	Nuclear Medicine
November 8-10	Anesthesiology
November 15-16	Neurology
December 6-7	Urology
December 7-8	Ophthalmology

Meetings Held in Early 2002

1/10-12	Orthopaedic Surgery
1/18-19	Thoracic Surgery
1/21-23	Family Practice
1/25-28	Internal Medicine
2/21-23	General Surgery
2/28-3/1	Mastering the Accreditation Process
3/5-6	Radiation Oncology
3/14-16	Diagnostic Radiology
3/22-23	Transitional Year
4/4-6	Pathology
4/7-10	Pediatrics
4/11-13	Anesthesiology
4/13-14	Dermatology
4/17-18	Institutional Review
4/26	Nuclear Medicine
6/27-29	Orthopaedic Surgery