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Editor's Introduction:

Ingrid Philibert

In his opening article for the Spring 2003 *ACGME Bulletin*, David Leach, MD, juxtaposed the ACGME general competencies and the effort to reform resident duty hours. In keeping with the point-counterpoint between two important ACGME initiatives, the other articles in the issue are devoted either to the Outcome Project or are relevant to the effort to reform resident duty hours. What emerges from these articles is information on two major thrusts of the ACGME and their relevance – in tandem – to ensuring the quality, safety and effectiveness of graduate medical education. The articles by Drs. Flynn and Mills, respectively, refer to residency education in general surgery and ophthalmology, yet many of the points they make are applicable to other accredited specialties.

This issue of the *Bulletin* includes a listing of the new telephone numbers for all ACGME staff. The second insert is a short survey of the readership. The intent of the survey is to collect information on readers' needs and preferences to continually enhance the content and presentation of this publication. We ask for your assistance in this by completing and returning the survey.

Executive Director's Column: Two Conversations About GME

David C. Leach, MD

As we think of physicians as a group, the quality of life for our patients and ourselves is related to the quality of the conversations in our lives. Medicine has been called a cooperative art; it

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cooperates with the body's natural tendency to heal. The outcomes of care depend on the patient, the doctor and the quality of their relationships with each other and with colleagues and others who care. Teaching is also a cooperative art. Teachers cooperate with the mind's natural tendency to ascend to the truth. The most important variables in a residency program are the quality of the individuals who inhabit the program, and the quality of their relationships with one another. Some relationships facilitate learning; some inhibit it. The conversations within a residency are representative of the formation of the residents in the program.

The ACGME participates in many conversations about residency programs. Formal conversations with member organizations, appointing organizations, RRCs, program director groups, groups of residents, institutional officials and the public occur on a regular basis and cover a wide range of topics. The diverse points of view enrich and strengthen the accreditation process. We also have conversations that are mediated through the program and institutional requirements and their interpretation. Examples of two recent ACGME initiatives are revealing.

The competency initiative involved naming the competencies most meaningful to physician practice; developing some initial assessment tools; and building a support network for ongoing conversations and learning as this initiative evolves in the graduate medical education community. The American Board of Medical Specialties (ABMS), individual specialty boards, RRC members, focus groups of program directors and residents, and the public all contributed to this development. A phased approach was chosen. When the general competencies began to



David C. Leach, MD

be used as an accreditation tool, the conversation between the ACGME and the field went something like this:

ACGME: "We invite you to respond to the challenge of assessing the competence of your residents." *Program Directors*: "What would you like us to do?" ACGME: "We don't really know; do something and we'll let you know if you did the right thing." *Program Directors*: "You've got to be kidding."

The duty hour initiative provoked a contrasting set of conversations. Groups advocating for fewer duty hours, federal and state regulators and legislatures, the public and others had established a predetermined formula for the reform of duty hours to be imposed on all programs. The majority of our communities agreed that something had to be done, and conversations with sleep scientists, those fluent with the New York experience, experts in the various specialties, and various groups advocating different positions helped clarify exactly what that was to be. The resulting conversations with the field went something like this:

ACGME: "We will tell you exactly what to do to reform duty hours." *Program Directors*: "That won't work for my program." ACGME: "Every program must do exactly the same thing." *Program Directors*: "You've got to be kidding."

The competency initiative was framed as an invitation and was intentionally ambiguous, whereas reform of duty hours was thought to require a prescription and clarity. In the language of Glouberman and Zimmerman (1) competence was framed as a complex phenomenon, whereas the standards to reform duty hours were framed as a complicated problem. In Gouberman and Zimmerman's model, complex problems are solved from within and complicated problems require solutions external to the system. Complex phenomena use values as organizing principles, whereas complicated phenomena require rules and values are less useful. Their examples are illuminating. Sending a rocket to the moon is complicated; raising a child is complex. The former requires formulae, and as problems are encountered rules based on science are very helpful. Formulae are of limited use in the latter problem – raising a child. Being guided by one's values organizes the responses to the nearly infinite possibilities and situations presented by a child, while rules, even if informed by science, may actually inhibit intelligent adaptation.

When phenomena are complex, the solution emerges by intelligent adaptation from within the system; when they are complicated the system must accommodate external solutions. It is too early to predict the field's response to duty hours, but the response to the competence invitation has been exuberant. What have we learned so far? Some sample lessons: competence is a habit; the capacity to make good clinical judgments is the real product of competence. We have also learned that competence is acquired along a continuum. At first, we look to rules for guidance, but as we become competent we depend more and more on the particular context of a given patient. Attaining competence also requires feeling bad about one's mistakes or "lack of competence." Finally, competence is relational; it is developed in the microsystems of care more than in formal lectures.


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These are not new observations, but thoughtful teachers in the field have clarified them as relevant to medicine.

The competency initiative has provoked deep thinking about the formation of physicians. Medical education is becoming recognized as a valid intellectual activity, supportable by grants, peer review publications, and academic promotion. This rich response may be related to the fact that competence has been viewed as a complex rather than complicated phenomenon.

The initiative about duty hours was framed as a prescription; the underlying assumption as complicated. The regulations constitute formulae largely developed external to residency programs, which will be applied to all of them. Enforcement will be inexorable and, if done too rigidly, may have toxic effects. Intelligent adaptation could be inhibited by the inflexible nature of the rules. Creative intelligence can emerge but will be dependent on conversations between RRCs, program directors, residents and the broader community as well as a firm commitment to design safer and more effective systems. The complicated can become complex. Fidelity to patient and resident safety, to good learning for good healthcare, can establish the trust needed for intelligent adaptation to occur. We cannot stop yet. Rules are not enough, and ultimately we need to be guided by our values and our interest in better learning for better health care. Health care is a complex system; safety and effective learning demand ongoing conversations, reflection about emerging experiences, and integrity worthy of trust.

"Fidelity to patient and resident safety, to good learning for good healthcare, can establish the trust needed for intelligent adaptation to occur."

¹ Complicated and complex systems: What would successful reform of Medicare look like? Sholom Glouberman and Brenda Zimmerman. Discussion Paper Number 8; Commission on the future of health care in Canada. July 2002. 

Restructuring Surgical Training

Timothy Flynn, MD

A number of events have recently come together that have stimulated those interested in surgical education and practice to reconsider how surgeons are educated. As a result, it is increasingly clear that as surgeons we have an opportunity to redefine our training and in doing so redefine the role of the surgeon in the care of patients.

Some of the factors that have brought us to this point are well known. Not unreasonably, surgeons feel that much of the impetus for the duty hour restrictions is aimed at us, and our training that has traditionally involved long hours and stressful work. Although there has been a gradual decline in applicants to surgery over the last several years, the results of the National Resident Matching Program (NRMP) for the past two to three years made us realize that the number of medical students interested in surgical training and a career in surgery may not be sufficient to replace those retiring or leaving practice in the coming years. Like many trends, the factors that affect the ebbs and flows of the surgical workforce are multifactorial. Some elements, such as our own behavior as faculty members and role models, are within our own control. Other components, such as the admission policies of the medical

schools, reimbursement declines for practicing surgeons and the popularity of specialties purported to be more conducive to "life style" are beyond our immediate reach. At some level, surgeons feel they have become the victims of shifts in generational attitudes about work and career. Nonetheless, we must function in the environment in which we find ourselves, and must find a way to preserve what we feel is essential to the identity of surgeons and to surgical practice.

Within the surgical community, there has been increasing pressure to respond to the decline in applicants to subspecialties by shortening the overall training time and providing the opportunity for individuals to enter into specialty training before finishing the full five years of a general surgery training program. The American Board of Surgery (ABS) recently proposed an Early Specialization Program (ESP) that would allow programs with both a general surgery training program and programs in vascular and pediatric surgery to configure the final 24 months of the five years of surgical training in a flexible fashion, to allow for ABS certification and either vascular or pediatric surgery certification in a total of six years, compared to the seven years required today. Programs with both surgery training programs and either vascular or pediatric surgery in good standing with the RRC for Surgery would be able to apply to the RRC with a plan that ensures that their residents have all of the experiences necessary to be qualified to practice surgery. This would include 12 months as Chief Resident and meeting the case volume standards defined by the RRC. For the time being, only vascular and pediatric training programs are included in this Early Specialization Program, and residents must complete all of their training in the same institution.

This ESP proposal is not without controversy. Program directors are concerned about the mechanics of implementing a system where multiple tracks are possible, and the number of residents at the senior level for any given year may not be predictable. Potentially on a more fundamental level, program directors are concerned about the apparent "double dipping" for those entering vascular or pediatric surgery. They feel the ESP approach will diminish the status of the individual with the full

five years of "general surgery" training. Although the proposed ESP approach actually increases the number of required months in the essential content areas in the first 48 months, the perception that residents in the ESP program will get the same certificate for less work is hard to change.

It is likely that the push to specialization will expand. Already, training programs exist in surgical oncology, breast, endocrine,

transplant, and gastrointestinal surgery, minimally invasive surgery, and a host of other areas. More than one-half of the graduates of surgical training programs currently pursue additional training.

Some want to establish an economic niche, others feel uncomfortable with the breadth of general surgery and want to master a narrower topic; a third group sees subspecialization as the route to a more balanced life style. One option to configure training would be to expand the ESP program to other areas of specialization, including to specialties such as Thoracic Surgery, which are not under the certification auspices of the American Board of Surgery. Thinking more radically, another route that could be considered is to establish a system involving a core training for all surgical disciplines from which individuals could enter subspecialty training in any of the surgical fields. This would be curriculum driven and could involve summative testing for an individual to progress.

All of these issues, in some way, are external to the content of the programs themselves. Yet, there are a number of individuals who see this atmosphere of change as an

opportunity to rethink what constitutes "a surgeon" and how we can better train those who will come after us. As the surgical community looks at the changes in practice over the last two decades, we see a huge shift in the style and substance of how surgeons practice. Twenty years ago, our daily work consisted of maximally invasive, open procedures done in multi-functional acute care hospitals. Today, many of these procedures are performed on an outpatient basis, and some are not being done by surgeons. Many of us are asking what this means for the scope of surgical practice — what it is that defines the specialty. I was brought up to think of myself as "an internist who operates", but arguably recent trends in education have focused on the surgeon's role in procedures and episodes of care. Increasingly, senior leadership in surgery believes that we should not allow ourselves to be relegated to a technicians' role, but should be involved in the total care of patients with diseases in which surgeons traditionally have special expertise. Surgery as a specialty should be defined by the illnesses we treat, rather than by the procedures we perform. As surgeons, we should master all of the skills and techniques available to care for these patients.

The shift in educational emphasis from the traditional time-based "you follow me around for five years and you will learn a lot" to "show me you are competent" has opened up a new way of thinking about how these concepts apply to surgical training. We feel that medical education across the spectrum from entry to medical school through training and into the realm of practice is increasingly focusing on educational outcomes, and that we should embrace this as a part of the restructuring of surgical training. As an example, a focus on attainment of a set of competencies makes the use of simulators and incremental, structured testing very attractive. A national curriculum could be developed that would reduce the variability in training, and provide the basis for

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training cycles, earlier specialization, national curriculum, competency testing and more are on the table and all are welcome to join in the debate.

Timothy Flynn, MD, is surgery program director and designated institutional official at the University of Florida in Gainesville. Dr. Flynn is the chair of the Association of Surgical Program Directors; he has served on the ACGME Work Group on Duty Hours and the Learning Environment. 

Moving Beyond Professionalism: Mining for Bioethics and Humanities in the ACGME General Competencies

David J. Doukas, MD

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Introduction

The winds of change currently permeate the education of all residents in the United States. The ACGME has promulgated a set of general competencies for all residents training in accredited programs, which includes a major thrust focused on bioethics and professionalism. The ACGME's *General Competencies* globally address many relationship-based ethical roles and responsibilities of physicians. The Competencies contain a specific section on professionalism. Beyond that, the entire document is woven with a sustained thread of medical ethics throughout all of its sections. The intent is to imbue each physician with those skills, rules, and aspects of character that will be a foundation for humane, ethical, professional conduct. Professionalism does indeed go beyond ethical principles, accounting for competency and commitment to excellence and, most of all, implying a virtue ethics account of medical practice.¹⁻³ The need to address the central place of virtue ethics in house-staff education is apparent, and we now have the right tool for the job – the ACGME *General Competencies*.

Professionalism in the ACGME General Competencies

Rather than take an overt "ethics" approach, ACGME opted

determining competency in the areas deemed essential for practice.

Virtually all of the major organizations in the discipline of surgery are discussing these issues of surgical training and practice. There is a sense that we have the opportunity to make substantive changes in the content and form of surgical training. Shortened

for "professionalism" as the main emphasis of its nomenclature. However, outside the "Professionalism" section there are numerous training requirements for ethical conduct. The ethics-professionalism agenda, then, needs to be approached in two steps: first, what constitutes professionalism; and, second, what medical ethics components are imbedded in the other general competencies?

The section on "Professionalism" requires *demonstration* of "professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population." This demonstration highlights excellence in one's clinical knowledge, skill, and commitment to the ethical precepts needed to be responsive to patients and society. Concepts of virtues are highlighted, including the need to be self-effacing and respectful of persons, while also demonstrating compassion and integrity. Further, residents must demonstrate a "commitment to ethical principles," including informed consent and refusal, confidentiality, and aspects of business ethics. Finally, this section requires aspects of cultural sensitivity, and provides footing for the other sections by requiring training in both deontology and virtue. The ACGME does not stop its ethics emphasis with the section on professionalism, though. To not look beyond this section would result in missing many aspects of ethics and professionalism that the *General Competencies* offer. In the section entitled "Patient Care," residents are entreated to provide compassionate care as well as appropriate and effective (i.e., beneficial, prudent, and therapeutically parsimonious) treatment. This treatment is rendered with not only effective communication (needed in the consent process), but with a caring and respectful affective component.

The section entitled "Interpersonal and Communication Skills" asks physicians in training to demonstrate their ability to communicate with patients, patients' families and medical colleagues. The phrase "therapeutic and ethically appropriate sound relationships with patients" implies not only what the physicians must do, but also proscribes breaches of professional conduct (though not explicitly articulated).

In the section entitled "Systems-based Practice," residents are asked to understand the larger healthcare system, how they have an impact on that system, and vice versa. This tacit nod to the principle and virtue of justice includes the knowledge of how healthcare costs can be controlled, yet not at the expense of quality healthcare (the classic dilemma of social versus patient agency is thus introduced). The delicate balance between serving the needs of the patient is thereby highlighted, concurrent with an understanding of how to work with the healthcare system for the benefit of both patient and system. The ACGME has considered the integration of these components of character into the formation of physicians as important as education on

"Concepts of virtues are highlighted, including the need to be self-effacing and respectful of persons, while also demonstrating compassion and integrity."

autonomy, beneficence, and justice. Despite its virtue-based strengths, if inspected closely, some components of virtue ethics are still found wanting. Missing is *practical wisdom* (phronesis), the ordering virtue that discerns how the virtues can be used to best effect. Other virtues left unmentioned include *sincerity* and *fidelity to trust*. Despite these omissions, the curriculum laid out in the *General Competencies* offers much to the development of resident professionalism and ethics education. These virtues and others will naturally arise from the discussions to follow.

“Missing is practical wisdom (phronesis), the ordering virtue that discerns how the virtues can be used to best effect.”

Responding to the ACGME General Competencies

This is all quite a bit for residents and fellows to become familiar with during their training, given competing demands for the pedagogical goals of many diverse training programs. The essential building blocks of investigating professional and ethical development can help ensure better clinicians as a result. One study noted that those residents who had higher professionalism (virtue based) assessments were also more likely to be clinically competent.⁴ How well are residencies prepared for the implementation of the ACGME requirements? The growing literature on residency curricula in professionalism and bioethics suggests that the process of educational reform has begun. Several authors have put forward approaches of teaching ethics, virtue, and professionalism in programs of internal medicine, orthopedics, and palliative care, to name a few.⁵⁻¹¹ Not to diminish these efforts, which are laudable, their relative rarity in the peer-reviewed literature would lead one to suspect there is a two-fold problem: lack of a common program and lack of players. Residency programs will likely experience growing pains with these new requirements, given lack of both ethics-trained faculty and time to implement them as educational modules. This seems to show that longitudinal, integrated ethics education will be needed.¹² It also implies role modeling a life-long commitment to professional (read: ethical, virtuous, and competent) conduct.¹³⁻¹⁴

As there has not been an integrated, multi-specialty attempt to construct a common basis of residency education, there is no guidebook to follow. The ACGME has disseminated a suggested toolbox of the multiple methods considered most optimal to impart this wisdom. Rest assured, reading a book or watching a video will not suffice for a rigorous consideration of ethics and professionalism. The multi-modal approach will likely have observational, chart audit, standardized patient, small group, and even the occasional didactic lecture to meet the requirements. Methods themselves are likely to vary as some institutions can ill afford expansive and detailed educational requirements (e.g., differences in faculty expertise). It will also require validated measures to see that residents are indeed professional in their conduct.¹⁵ A lack of appropriately trained faculty in some programs may make attempts requiring observational data, or even small group assessment, difficult. One possible solution may be collaboration among community programs and academic medical center faculty. Responses to the new ACGME requirements may be similar to the invention and spread of the institutional ethics committee. The ethics committee began with

an ethically justifiable goal but proved more difficult for some institutions than others.

What ultimately made the ethics committee a reality? In some instances, cases (e.g., *Quinlan*) and laws requiring their existence (as in Maryland) helped their founding. In most cases, though, it was the mandate created through JCAHO review and accreditation requiring their existence that facilitated their creation and sustained growth. Likewise, the ACGME General Competencies require ethics and professionalism training.

One Organization's Response

What are we to do now? The American Society for Bioethics and Humanities (ASBH) has initiated a response. Hosted at bioethics.org of the University of Pennsylvania,¹⁶ and linked at the ACGME, ASBH, and the National Reference Center for Bioethics Literature, an educational open source project (online at the time of this publication) has been posted on the Internet. This bioethics education consortium will serve as a conduit of the ASBH Task Force on Graduate Medical Education in Bioethics and Humanities and is presently collecting and reviewing syllabi of residency faculty in that content area. The syllabi are being posted as a response to the ACGME *General Competencies* once the task force has reviewed them. Why do this? Before going out into a new and relatively unknown world (i.e., an integrated curriculum for tens of thousands of residents), it is best that we see where pioneers and explorers have gone with failure and success. This author is concerned because despite a call for syllabi sent to ASBH, the Association of American Medical Colleges (AAMC), and various medical specialty organizations over several months, there is a dearth of syllabi on medical ethics and humanities. The lack of previous work on integrating medical ethics and humanities into residency education leaves programs with the daunting task of doing something that has not been done often, and without validation methods for educational soundness. ASBH will continue to collect and review these syllabi, for although they come from disparate residency programs, there is commonality in the core concepts conveyed.

The next phase of the ASBH Task Force is to see how principlism, virtue ethics, and other ethics and humanities teaching methods can fit and successfully compete with the manifold areas of residency education. ASBH's Task Force has currently assembled "Competency Teams" to address four competencies of **Patient Care, Interpersonal and Communication Skills, Professionalism, Systems-Based Practice** — that are imbued with medical ethics and humanities content. We will design core content and reading modules, as well as suggest the means of observational assessment noted in the ACGME Toolbox in the evaluation of residents. These modules can lend themselves to the individualized development of curricula in residency programs nationwide.

The other concern regarding the ACGME's goals is the sparse number of teachers for this new requirement. Despite the many new Master's and PhD programs in bioethics, the United States is currently in a vulnerable position regarding teachers and observers of residents. What is needed now is a sustained,

coordinated training of the trainers for residency programs.

The goals of the ACGME are to guarantee that each physician who has trained in an accredited program has an ethically and professionally sound foundation for future clinical practice. One hopes that, with concerted efforts by residency programs and bioethics educators, we will soon see success and excellence as

the fruits of the ACGME's catalytic labors.

"The goals of the ACGME are to guarantee that each physician who has trained in an accredited program has an ethically and professionally sound foundation for future clinical practice."

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Strengthening Professionalism

Audiey Kao, MD, PhD

Defining Professionalism

The flurry of published studies on physician professionalism over the last five years, and the promulgation of accreditation requirements for professionalism can create the perception that professionalism is the newest buzzword in medical education and training. Such a perception is far from the truth. The American Medical Association (AMA) was founded 156 years ago with the stated goals of developing a code of ethical conduct for physicians and establishing standards for medical education. Those goals were foundational, in 1847 as they are today, in defining professionalism in medicine.

Throughout its history, the AMA has worked consistently to define professionalism and to disseminate the principles that embody the definition. One of its principal means for defining and promulgating professionalism has been the *AMA Code of Medical Ethics* [www.ama-assn.org/ceja]. Greatly influenced by the work of Thomas Percival (1740-1804), the *AMA Code* was the world's first national codification of professional ethics. In fact, the *Code* was considered revolutionary because it replaced the variously interpreted ethics of gentlemanly honor with explicit standards of behavior for medical professionals.¹ Of historical note, many are aware that this year marks the 50th anniversary of the discovery of the genetic structure of life, but fewer may know it is also the 200th anniversary of the publication of Percival's expanded code where the expressions of "professional ethics" and "medical ethics" were coined. Thus, in many ways,

"This year marks the 50th anniversary of the discovery of the genetic structure of life, but fewer may know it is also the 200th anniversary of the publication of Percival's expanded code where the expressions of "professional ethics" and "medical ethics" were coined."

2003 represents an important historical landmark not only in the science, but in the art of medicine.

The *AMA Code* is an "old" publication, yet it remains relevant and practical through continual revisions and updates. Composed of seven practicing physicians, a resident, and a medical student, the AMA Council on Ethical and Judicial Affairs (CEJA) is the steward of the *Code*. Each year, CEJA writes Ethical Opinions on a wide variety of ethical and professional issues that confront the medical profession. These Opinions, based on interpretations of the Principles of Medical Ethics, are developed through a deliberative process and become part of the *Code* upon adoption by the AMA House of Delegates, which is composed of representatives from every state and almost every conceivable medical specialty society. Through this

process of continual refinement, the Code remains an "organic, thus imperfect" contemporary guide for physicians who strive to practice ethically – reflecting the ideals of self-governance and internal regulation that are hallmarks of professionalism.

In December 2001, the AMA authored and the House of Delegates adopted the *Declaration of Professional Responsibility – Medicine's Social Contract with Humanity*, a statement of rededication to the fundamentals of physician professionalism. The *Declaration's* nine duties and obligations speak to the world community of physicians in their different roles as clinicians, scientists, educators, and members of a civil society. The duties the *Declaration* imposes transcend physician specialties, geographic boundaries, and political divides. In this regard, the *Declaration* differs from codes of ethics used in the adjudication of ethical and legal issues by professional boards and courts of law, national and international. To date, 43 state and 67 medical specialty societies have supported or endorsed the *Declaration of Professional Responsibility*.

"In order to translate codes into action, medical students need to be educated on these matters, and physicians require continuing medical education opportunities."

Educating for Professionalism

While ethical codes and declarations are important symbols of professionalism, it is ultimately how these professional ideals and duties are realized that is essential to sustaining the public's trust in the medical profession. In order to translate codes into action, medical students need to be educated on these matters, and physicians require continuing medical education opportunities. In support of this important objective of educating for professionalism, the AMA has created several practical and innovative educational programs and products.

The Virtual Mentor, AMA's ethics journal [www.virtualmentor.org], is an online forum for examination of ethical issues and challenges confronted by medical students, residents, and physicians in the study and practice of medicine. Each monthly Virtual Mentor issue explores a theme – a medical specialty or topic such as the many roles of the medical resident – through clinical cases, journal discussions, PowerPoint® presentations and other formats that lend themselves to use by medical educators.

In conjunction with the Medical College of Wisconsin, the AMA offers physicians an online Fellowship program in ethics and professionalism. Using distance-learning tools, students in the online program take courses that are taught by faculty in different institutions. Thus, this online program provides an opportunity for physicians on Institutional Review Boards, Privacy Boards, and ethics committees, or those who want to learn more about applied ethics to learn from experts in different fields and geographic locations. Students can earn credit toward a Master's Degree in bioethics. In addition to the online fellowship, there are CME offerings on topics of ethical relevance and import available through the AMA.

Finally, the AMA is partnering with medical schools to develop Strategies for Teaching and Evaluating Professionalism (STEP). Our receipt of applications for partnership from more than one-third of US medical schools attests to the interest medical educators have in evaluating and improving the teaching of professionalism to the next generation of physicians. Learning and practicing professionalism are life-long activities, and the AMA plans to extend the reach of STEP to graduate medical education. Realizing the limits of formal curriculum, residency programs must discover innovative ways for reinforcing the knowledge and values that physicians have acquired in medical school in order to fulfill accreditation competencies. Service learning will provide such opportunities.

Professionalism in Action


The AMA's Caring for Humanity initiative is an action plan for expression of professional values. Through Caring for Humanity, physicians can share their time, expertise, and resources with colleagues in this country and abroad who need their support. The first Caring for Humanity project, WorldScopes has provided stethoscopes donated by US physician, medical students, and medical organizations to countries around the world from Afghanistan to Thailand.

"Currently in planning is Caring for Humanity's next project, devoted to increasing access to care by strengthening a part of America's public health safety net – the free clinic system."

Currently in planning is Caring for Humanity's next project, devoted to increasing access to care by strengthening a part of America's public health safety net – the free clinic system. We hope to work with residency programs to help enhance opportunities for service learning in those communities where residency programs currently provide much (often uncompensated) clinical care. The AMA hopes to leverage its institutional name and recognition in gaining needed support and supplies for free clinics and, at the same time, to encourage residents to volunteer their services in those clinics. We will need to hear from and partner with residency program directors for assistance in accomplishing this important goal.

Building upon its foundational commitment to physician conduct and medical education, the AMA has dedicated its resources and intellectual assets for more than a century and a half to promoting professionalism among US physicians. Today, the AMA is acting to extend the means for educating new physicians about professionalism and to increase opportunities for enacting professionalism in the service of humankind.

Audiey Kao, MD, PhD, is the Vice President, Ethics Standards, of the American Medical Association.

1. Baker RB, Caplan AL, Emanuel LL, Latham SR. *The American Medical Ethics Revolution. How the AMA's Code of Ethics has transformed physicians' relationships to patients, professionals, and society.* Baltimore, MD. The Johns Hopkins University Press, 1999. 

Professionalism: Progress in the Field


This issue of the ACGME Bulletin features the preceding contributions by two guest authors who reflect on professionalism and highlight the efforts of their organizations to promote its teaching and assessment.

Below are several other information resources on professionalism.

Learn more about "Practice-based Learning and Improvement and Systems-based Practice" by viewing the presentations from the ACGME/IHI invitational conference held in December 2002 now located at http://www.acgme.org/outcome/conferences/ihi_present.asp.

Check "Other Related Links" at <http://www.acgme.org/outcome/new/links.asp> for two new excellent resources under "Practice-based Learning and Improvement." Both also are helpful tools for learning skills related to "Systems-based Practice."

www.webmm.ahrq.gov is an online journal and forum on patient safety and health care quality featuring expert analysis of medical errors reported anonymously by readers, interactive learning modules on patient safety ("Spotlight Cases"), and forums for online discussion. CME credit is available.

<http://qualityhealthcare.org> is an interactive knowledge environment open to healthcare professionals around the world to make progress in performance and improvement activities. 

Competence vs. the Competencies

Richard P. Mills, MD, MPH

Starting some years prior to the implementation of the general competencies through the Outcome Project, the ACGME began to require that a written, final evaluation be completed for each resident at the conclusion of training. According to the Program Requirements for Ophthalmology, this evaluation "should ensure that the resident has acquired skills and experience that will enable him or her to practice competently and independently."¹ Some program directors have expressed concern that this requirement asks them to certify competence of a resident graduate, with its attendant legal risks. However, a careful reading of the requirement will demonstrate that the evaluation merely testifies that the "raw material" is in place to allow competent and independent practice, and that the individual practitioner is responsible for the actual accomplishment of competence.

Consider two examples that help to illuminate the difference:

Case 1: A star resident has excellent evaluations in all six competencies, including professionalism. The resident enters practice with an established surgeon, known for performing cataract surgery on patients who have no visual disability. The new practitioner adopts similar behaviors that would cause an independent evaluator to give an "unsatisfactory" grade in the Professionalism competency.

Case 2: A resident receives a satisfactory final evaluation in all six competencies. However, he develops a herniated cervical disk with loss of some function in his dominant hand. He

continues to operate in his private practice, and a patient suffers a serious complication during cataract surgery, resulting in a malpractice complaint.

In both cases, different circumstances pertained during residency than during subsequent practice. The program director can testify only to behaviors and circumstances that were in place during residency, but he cannot speak to the practitioner's subsequent performance, which did not demonstrate professional competence. Only in the event that unsatisfactory performance has been documented during residency, and remediation to a satisfactory grade was not achieved, yet still a satisfactory final evaluation was given, should there be cause for concern about liability for the program.

"Only in the event that unsatisfactory performance has been documented during residency, and remediation to a satisfactory grade was not achieved, yet still a satisfactory final evaluation was given, should there be cause for concern about liability for the program."

On the other hand, programs that are not sufficiently vigilant about resident performance early in training can find themselves discovering that a senior resident is lacking in one or more competencies, without sufficient prior documentation to justify the withholding of a satisfactory final evaluation. We hope that as ongoing evaluation of the competencies is implemented, this situation will occur less frequently. To prevent its occurrence, it is extremely important that all evaluators not be afraid to grade performance as substandard, especially early in residency, leaving ample time for remediation. It is also important that programs provide graduated responsibility, especially in surgery, so that early identification of difficulty with surgical skills can be identified. Finally, both examples involved graduates who demonstrated deficiencies in professionalism. This highlights the importance of educating and evaluating residents across all six general competencies, including professionalism.

In the final analysis, competence is impossible for any entity to certify at the completion of training. The compromise required by the RRC is for program directors to certify that the essential competencies for the practice of ophthalmology have been satisfactorily demonstrated.

¹Program Requirements for Ophthalmology, Residency Review Committee for Ophthalmology, ACGME, section XX.

Dr. Mills is the Professor and Chair of the Department of Ophthalmology of the University of Kentucky, and a member of the RRC for Ophthalmology. 

The Residency Complaint Process - A Tool for Improvement

Marsha A. Miller

The goal of the ACGME's complaint process is to improve residency education programs. The results show that the ACGME is achieving this goal. **Table 1** shows the residency complaint data from September 2001 through September 2002, disaggregated by types of complaints received; and resolution of the complaints. **Table 2** shows the accredited specialties involved. **Table 1** shows that, as in prior years, the majority of complaints related to duty hours and the working environments and lack of an appropriate grievance process. Of the 38 complaints received in 2002 (20 fewer than in 2001), 23 were dismissed, some because of insufficient evidence, others because the allegations were unsubstantiated. A number of additional complaints were also ultimately dismissed because program directors and/or institutional officials, who investigated the allegations from a program or institutional perspective, found that the violations were unintentional and quickly rectified them.

"The ACGME and the RRCs are eager to work with programs and institutions that recognize their shortcomings."

The ACGME does not wish to cite programs or affect the accreditation status of programs that strive to improve resident education. The ACGME and the RRCs are eager to work with programs and institutions that recognize their shortcomings; they wish to help those programs improve by continuing to monitor changes until there is evidence of successful implementation.

The three complaints forwarded to the RRCs have all been warned of probation and placed on a short review cycle. The goal of the residency complaint process is not to punish programs, but to improve resident education and patient care. 

Table 1
Types of Complaints Received by the ACGME
September 2001-September 2002

<i>Complaint</i>	<i>Frequency*</i>
Inadequate work environment and excessive duty hours**	14
Inadequate or no due process/lack of grievance procedures	13
Inadequate supervision or lack of supervision	7
Lack of resident evaluation and feedback	7
Inadequate number of conferences	7
Inadequate teaching or lack of teaching	6
Discrimination	4
Outcome of Above Complaints	
Dismissed	23
Forwarded to RRC for Action	3
Site Visit Scheduled	2
Letter Placed in File to be Monitored at Next Site Visit	5
Pending	5

ACGME Compliance with HIPAA Privacy Regulations

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) take effect as soon as April 14, 2003. These regulations establish rules and procedures for most health care providers to follow in order to protect the privacy of patient information identifiable to particular patients. As the ACGME does encounter and use such information on occasion during its accreditation activities, it intends to enter into "business associate agreements" with its sponsoring institutions and clinical sites, as necessary to comply with the privacy regulations for the performance of its accreditation function. These agreements prescribe conduct for the ACGME designed to ensure that the privacy of such information is maintained.

The need for a business associate agreement is determined by the health care provider that is a "covered entity" under the privacy regulations. Most sponsoring institutions and clinical sites, where residents perform supervised treatment of patients, are covered entities, and should have business associate agreements with the ACGME in order for the ACGME to access protected health information (PHI) during its accreditation activities. However, under the privacy regulations, it is up to the sponsoring institution and the clinical site to determine whether each requires a business associate agreement with the ACGME.

"The need for a business associate agreement is determined by the health care provider that is a "covered entity" under the privacy regulations."

In order to streamline this process, the ACGME has developed a form business associate agreement for use by sponsoring institutions and clinical sites. This agreement is identical to one that the ACGME is about to enter into with the Veterans Health Administration. The ACGME has also developed a representation form for sponsoring institutions to submit to ACGME, signifying that those elements of the program that

Table 2
Breakdown of Complaints Among Specialties with Five or More Complaints
September 2001-September 2002

<i>Specialty</i>	<i>Number of Complaints</i>
Internal Medicine	9
Family Practice	6
General Surgery	5
All Others	18
Total	38

* Numbers do not equal total number of individual complaints (38), because most complainants alleged more than one violation.

** Inadequate work environment refers to no call rooms, unavailable faculty, lack of food service, etc.

require a business associate agreement with ACGME in order for ACGME to access PHI have in fact signed business associate agreements.

The ACGME focus in this endeavor is its ability to perform its accreditation function. If, after April 14, 2003, the lack of a business associate agreement from a sponsor or clinical site impedes this ability, relating to a site visit, the resident case logs, or other accreditation function, the RRC or IRC, as appropriate,

will consider the extent and nature of the impediment, and will determine the course of action to take, up to and including adverse accreditation action.

For more information on the ACGME's HIPAA business associate agreements, please review the HIPAA information on the ACGME's Web site, www.acgme.org/HIPAA. Questions about the ACGME's HIPAA business associate agreements should be sent to hipaa@acgme.org. 

RRC/IRC COLUMN

ACGME Approves Program Requirements Revisions, Recognizes Procedural Dermatology and Begins the Process for Recognition of Sleep Medicine

The ACGME approved the recommendation of the Committee for Review of Program Requirements to approve the major revision of the Program Requirements for Internal Medicine, and the Program Requirements for Geriatric Psychiatry, Addiction Psychiatry and Forensic Psychiatry. The effective date for the above revisions is July 1, 2003. The Council also approved the Program Requirements for Endovascular Surgical Neuroradiology, with an effective date of April 11, 2003, and approved Procedural Dermatology as an ACGME-recognized subspecialty, as well as the Program Requirements for Procedural Dermatology, effective February 11, 2003.

The ACGME also approved the recognition of Sleep Medicine as a new multi-disciplinary specialty for the purpose of developing a draft set of Program Requirements for review by the RRCs and Program Requirements Committee and, ultimately, ACGME approval.

Approval of Common Program and Institutional Requirements Relating to Resident Duty Hours

The ACGME approved the revision of the Common Program Requirements for resident duty hours, which represented the culmination of the extensive process of developing common minimum duty hour standards that apply to all accredited programs. Major highlights of the standards include a limit of 80 duty hours per week averaged over 4 weeks; the requirement that one (24-hour) day in seven be free from all educational and clinical responsibilities; that in-house call be scheduled no more frequently than every third night, and that hours spent in the hospital after being called in during call from home are counted toward the weekly duty hour limit.

The new common duty hour standards also state that adequate time for rest and personal activities must be provided, which should consist of a 10 hour time period provided between all daily duty periods. The standards place a limit of 24 hours on continuous duty, with residents permitted to remain on duty for up to six additional hours for didactics, transfer of care, and to maintain continuity of medical and surgical care. The standards stipulate that no new patients may be accepted after 24 continuous hours on duty. For this standard, each RRC is able to either accept the common definition of a new patient ("a patient for whom the resident has not provided care during the preceding 24 hours") or develop a definition that is appropriate to the given specialty. The standards also call for education of residents and faculty about fatigue and its management, and for institutional support to reduce residents' time spent on non-educational, repetitive and routine activities. The Council also approved the revisions of the Institutional Requirements for duty hours. These standards, which define the obligations of sponsoring institutions for developing policies and procedures related to duty hours, and for monitoring of hours in all accredited programs, will also become effective on July 1, 2003. Finally the ACGME approved the procedures by which RRCs may grant individual programs exceptions of up to 10 percent to the 80-hour weekly limit on duty hours.

A Growing Number of Specialties Use the Electronic Part 1 of the PIF

In 2001, the ACGME began the process of creating an electronic version of the program-specific demographic information used in the accreditation process. Called Part 1 of the program information form (PIF), this section of the PIF is electronically populated from data provided annually by programs and sponsoring institutions via the Web Accreditation Data System (WebADS). Using WebADS, programs are able to retrieve Part 1 of the PIF under the "Site Visit Information Section." At the time of the site visit, programs simply retrieve, review and print this portion of the PIF. Programs then proceed with the completion of Part 2 in the traditional fashion, using a word processing document that is found under the program information form section on the ACGME Web site (www.acgme.org). Programs can also view the electronic Part 1 of the PIF at any time, using the WebADS system.

In early 2003, a growing number of specialties have been re-organized to use the Web-based Part 1 of the PIF. They include Plastic Surgery, Pediatrics, Emergency Medicine, Obstetrics and Gynecology, Psychiatry, Family Practice, Otolaryngology, Radiation Oncology, Transitional Year, Anesthesiology, Neurology, Child Neurology, and Physical Medicine and Rehabilitation.

Other Updates from the February 2003 ACGME Meeting

ACGME Selects Members for its Ad Hoc Subcommittee on Duty Hours

The ACGME approved the charge and announced the membership of a new Ad Hoc Subcommittee on Duty Hours. The Subcommittee is chaired by D. David Glass, MD, who recently completed his tenure as chair of the ACGME Monitoring Committee. Its membership includes ACGME directors, including public directors, residents and the chair of the RRC Council of Chairs. The Subcommittee's first meeting will take place on March 21, 2003, to begin to meet its charge of advising the Board of Directors on matters related to the implementation of the duty hour standards and enforcement processes. Among its first activities, the Subcommittee will develop draft recommendations for how the ACGME will monitor programs and institutions for compliance with the duty hour standards.

New Appointments

The ACGME approved the appointment of Mr. Roger Plummer to fill a public director vacancy created by the resignation of Ms. Kay Huffman-Goodwin, initially to complete the unexpired term. Two new appointments to the Institutional Review Committee were Carl Getto, MD, for a three-year term, and Agnes Chen, MD, resident member, for a two-year term. The Council also approved the reappointment of Kimball Mohn, MD, and Marc Wallack, MD, to the Transitional Year Review Committee (TYRC), and appointed Todd Tibbetts, MD, PhD, as a resident representative to the TYRC.

ACGME Formulates Strategic Communications Plan

The ACGME is initiating a plan for improving internal and external communications. A Strategic Communications Working Group, chaired by Mark Dyken, MD, ACGME Vice Chair, is exploring the elements of a communications strategy, with a report from the group expected at the June 2003 ACGME meeting. The communications strategy will consist of four major components: internal communications; communications and collaboration with the member and appointing organizations; communications with program directors, residents and medical students; and, communications with the news media and general public. Additional information about the ACGME communications can be found in the article by Julie Jacob, Communications Manager, on page 14 of this issue of the ACGME Bulletin.

AAMC Organizes An Institute for Improvement in Medical Education

Michael Whitcomb, MD, AAMC, reported to the ACGME Board of Directors that concerns about the quality of medical education have prompted the AAMC to inaugurate a new Institute for Improvement in Medical Education. An important goal of this initiative is to enable the medical education community to respond to the changing health care environment. The Institute's advisory group, headed by Joseph Martin, MD, PhD, Dean of Harvard Medical School, has been charged with setting forth strategic directions for educational reform across the medical education continuum. A report from this group is expected in early 2004.

ABIM Promotes the Physician Charter on Medical Professionalism

Harry Kimball, MD, outgoing President and CEO of American Board of Internal Medicine, presented on the development of the "Physician Charter on Medical Professionalism." The charter was subsequently endorsed by the ACGME Board of Directors. It encompasses three principles: (1) primacy of patient welfare; (2) patient autonomy; and (3) social justice. The points of the charter are presented in **Exhibit 1**.

Exhibit 1


The Commitments Expressed in the Physician Charter on Medical Professionalism

- Professional competence
- Honesty with patients
- Patient confidentiality
- Maintaining appropriate relations with patients
- Improving quality of care
- Improving access to care
- Just distribution of resources
- Scientific knowledge
- Maintaining trust by managing conflicts of interest
- Professional responsibilities

ACGME Initiates Broad-based Resident Survey

To broaden the input residents have into the accreditation process, the ACGME has initiated an Internet Based Resident Survey. In the near future, residents in accredited programs may be required to participate in an on-line survey, with questions focused on residents' clinical and educational experiences, faculty, duty hours and the general competencies. The information gathered from the survey will be used to focus the resident interviews during the site visit process. The primary benefit of this approach is that it will allow all residents in a program to comment on their educational experience, expanding beyond the group that participates in the resident interview during the on-site visit. Over time, it will produce a database of residents' perceptions of their educational program across specialties and participating institutions.

The Resident Survey will take about seven minutes to complete. It will be phased in over the next year, and will be required of all core programs with 5 or more active residents. Core programs scheduled for a site visit in the next year will be asked to participate. In order to ensure residents' ease of use and their privacy, it is important that all programs verify and confirm their residents' information through the WebADS annual update.

Additional information about the Survey may be found under the Accreditation Data System heading of the ACGME website (www.acgme.org/Resident_Survey). Questions about this survey or its administration may be directed to ResSurvey@acgme.org. 

ACGME Honors Recipients of the 2003 Parker J. Palmer

"Courage to Teach " Award



Sitting, left to right: Keith Armitage, MD; Program Director for Internal Medicine, University Hospitals of Cleveland; Bennett Vogelman, MD, Program Director for Internal Medicine, University of Wisconsin; Henry Schultz, MD, Retired Program Director for Internal Medicine, Mayo Clinic; Kathleen Watson, MD, Program Director for Internal Medicine, University of Minnesota.

Standing, left to right: C. Bruce Alexander, MD, Program Director for Pathology, University of Alabama at Birmingham; Harold Johnston, MD, Program Director for Family Practice, Alaska Family Practice Residency; Steven Feske, MD, Program Director for Neurology, Brigham and Women's Hospital; Joseph Gilhooly, MD, Program Director for Pediatrics, Oregon Health and Sciences University; John Tarpley, MD, Program Director for General Surgery, Vanderbilt University; Eugene Beresin, MD, Program for Child and Adolescent Psychiatry, Massachusetts General Hospital; Frank Eismont, MD, Program Director for Orthopaedic Surgery, Jackson Memorial Hospital.

The 2003 ACGME Annual Conference Poster Session: Initiatives in GME: Advancing the Competencies, Addressing Duty Hours

From March 5 to March 7, the ACGME held its 2003 Annual Educational Conference, attended by more than 720 program directors, designated institutional officials and program coordinators. In addition to presentations on how to master the accreditation process, the conference featured presentations on duty hours, patient safety and the general competencies. During a poster session, 59 posters were viewed by the attendees and judged by a group of judges. Below are the abstracts for the posters the judges declared the winners and posters that received Judges' Awards and honorable mentions.

First Place:

Evaluation of the Core Competencies at Baseline – An Individualized Assessment. ML Lypson MD¹; LD Gruppen PhD²; JO Woolliscroft MD². ¹Ann Arbor VA Healthcare System and the University of Michigan.²

INTRODUCTION: The ACGME requires that all residency programs evaluate the competence of their residents in the following areas: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. In order to develop outcome based assessment tools, the University of Michigan created the Post-graduate Orientation Assessment (POA). This

consisted of an Objective Standardized Clinical Examination (OSCE) for our incoming house officers. The ultimate goal of such an assessment was to develop Personalized Learning Agendas (PLA) for all of our residents.

METHODS: This tool was created and approved by the Graduate Medical Education Committee with the help of several involved faculty and residents. This was done with an educational blueprint developed by a modified nominal group process. The backbone of the OSCE was our medical student Comprehensive Clinical Assessment; this examination has been given to all of our 4th year medical students for more than 10 years. Several stations were adapted from this examination and new ones were developed. There were 8 stations on the exam and it lasted for approximately 3 hours. They included the evaluation of critical values, images, communications skills, acute medical problems and health systems issues such as safety, infectious control and evidence based medicine. The purpose was to provide the incoming interns with many of the skills needed their first nights on call. The skills assessment was included as part of the orientation to the medical center.

RESULTS: 132 first year residents from 59 different medical schools, including three international schools, and from two schools of dentistry participated in the POA. Residents from Dentistry, Emergency Medicine, Family Practice, Internal Medicine, Neurosurgery, Obstetrics/Gynecology, Orthopedics, Plastic Surgery, Psychiatry, General Surgery, Urology, Medicine-Pediatrics, and Pediatrics participated. The overall mean score on the assessment was 74.7 (s.d. 6.4).

CONCLUSIONS: The POA provides residency programs with a reliable format to measure initial skills. The residents' results were provided to their program directors as well as aggregate

results from other programs. This data has enabled program directors to develop PLA for their residents. This is the first step in continual evaluation of the ACGME general competencies.

POA Stations	Overall Mean–All Programs
Evidence-based Medicine	69.0
Pain Assessment	89.4
System Compliance	85.7
Informed Consent	58.4
Cultural Communication	72.8
Sterile Technique	89.0
Imaging	65.3
Critical Values	67.6
OVERALL SCORE:	74.7

Second Place:

From More than 110 to Less than 80 Hours: More Work for the Program Directors, A Better Educational Experience for the Residents. Joel C Rosenfeld MD, St. Luke’s Hospital, Bethlehem PA.

To meet ACGME duty hour regulations in our general surgery residency we decided to analyze the responsibilities and tasks of our surgical residents and the service requirements of their various clinical rotations. Since 1995, we have integrated physician assistants into our residency program. The program director met with the residents to examine the hours they worked in the hospital in terms of exactly what they did on each rotation. The program director also met with faculty surgeons, nurses, and administration to determine what they thought the residents should be doing. At each of these meetings, the program director explained the rationale behind the new regulations and possible models to meet these regulations. Each group had concerns. The residents were concerned that limiting their hours would decrease their educational opportunities in terms of clinical experiences and conferences. The faculty were concerned about whether the residents would be adequately trained and how much more work the faculty would have to do. All groups were concerned about patient care with residents working less hours in the hospital.

After numerous meetings with the residents, the surgical faculty, the nursing staff, and administration, a modified night float system was adopted. Instead of two residents in-house each night, from Sunday through Thursday there is only one resident on night float (6 pm to 8 am and to 11 am for Friday morning - conferences). Different residents are on call Friday night (2 residents), on Saturday day and night (24 hours – 2 residents), and Sunday during the day (2 residents). The night float resident changes weekly and is either a PGY-II, PGY-III, or PGY-IV resident. The chief residents still take call from home and come into the hospital when needed.

We started the night float system in November, 2002 to see if it would be successful and to determine if there were any problems that had to be corrected. The night float system has enabled our residents to work less than 80 hours a week when averaged over four weeks. Also, all other ACGME duty hour requirements are being met.

The modified night float system has the following advantages in a small residency.

1. Residents miss minimal patient care educational opportunities. Since our in-hospital residents do not work 24 hours continuously during the weekdays, they are able to participate in all elective surgical cases Monday through Friday. So far there has not been a significant decrease in the average number of cases done by residents. The residents are also able to attend surgical clinics and attending faculty office hours.
2. All residents can attend time-protected conferences during the morning and still meet the 80-hour limit.
3. Residents have more time to read and/or rest since they work fewer hours.
4. The night float resident is still involved in operative procedures in that he/she participates in late elective surgical cases and is involved in emergency surgical cases at night.

To make the modified night float system successful requires the following actions.

1. A commitment by faculty, nursing staff and administration that residency training is primarily an educational experience.
2. An understanding by the residents and faculty that the ACGME duty hour regulations are here to stay and that the regulations can improve the educational experience of residents.
3. More active involvement of faculty in patient care.
4. Thorough sign-out of patients by the day residents to the night float resident is paramount.

Third Place:

The Core Competency Initiative at McGaw Medical Center. GME Faculty Fellows of McGaw Medical Center of Northwestern University (presenter: Mitchell King MD).

Purpose: To compile and develop resources for teaching core competencies; to review and recommend specific evaluation tools addressing core competencies; to make the information readily accessible to program directors of all of our 72 ACGME-accredited programs.


Methodology: A grant was provided from the consortium members of McGaw Medical Center for salary support of one half-day per week over one year for five program directors or educational leaders to participate in a centralized initiative. A request for proposals was circulated to faculty educators, and five Faculty Fellows (four program directors, one educational leader) were selected from the applicant pool by an awards committee. Meetings commenced with the academic year. Other faculty members with relevant expertise are invited to meetings. Personnel of the Information Technology department of the Feinberg School of Medicine provide assistance in developing a program directors’ web page with content posted as it is developed. Individual Fellows volunteer to identify and review specific information for critique by the group at bi-weekly meetings.

Results: The first step was to edit and revise the ACGME educational objectives for competencies appropriate to different levels of trainees (junior, senior, all). Objectives for resident teaching were expanded. The modified objectives will be posted on the web in downloadable format and all program directors are encouraged to incorporate them into their existing objectives.

The second and more intensive step involves identifying educational tools for teaching and evaluating each of the individual competencies. Whenever possible, local resources are identified. Examples: an educational tape about the needs of disabled women developed by the Rehabilitation Institute of Chicago is being provided to all program directors for use in an interactive conference setting; a web-based tutorial on literature searches provided by the medical school library is being modified to provide program directors with a list of trainees who have completed the tutorial; a format for an evidence-based journal club is being modified from that used for a medical student course. Evaluation tools available both locally and nationally for the different competencies are reviewed, and a selection of recommended tools are posted for program director use. The final step will be a research endeavor to assess selected competencies

"...by the end of the '2002-'03 academic year, focused programmatic information for all competencies may be readily accessed by our program directors."

assistance to our program directors who feel overwhelmed by the prospect of accomplishing this task individually. We believe this centralized approach to resource development may be of interest to other large, academic training centers.

The ACGME judge also gave two special judges awards and four honorable mentions. The winners of the judges awards were (1) Glynn D Stanley MBChB FRCA, Boston University Medical Center, for her poster "*Use of the Objective Structured Clinical Examination for the Evaluation of Anesthesiology Residents*;" and (2) Elvira Lang MD; Brad Anderson BA; Eleanor Laser PhD, Beth Israel Deaconess Medical Center, Harvard Medical School for their poster entitled "*Advancing Competency in Interpersonal and Communications Skills*." The recipients of the honorable mentions were (1) Chandrasekhar Bob Basu MD; Saleh M Shenaq MD, Baylor College of Medicine, for their poster "*Assessment of the Impact of the Resident Duty Work-hours Policy: An Outcomes Analysis of Surgery Resident Perceptions*;" (2) Judy L Paukert PhD; Heidi Chumley-Jones MD, University of Texas Health Science Center at San Antonio, for their poster "*A Chart Audit Program Helping Residents Assess Practice Habits*;" (3) M Plews-Ogan MD; M Nadkarni MD; S Vanderkin MD; D Marineau LPN, University of Virginia Health System, for their poster entitled "*Patient Safety in the Ambulatory Setting: A System for Clinician-based Medical Error Reporting, Analysis Response and Feedback in a Residency Clinic*;" and (4) Rebecca Dillingham MD; J Samuel Pope MD; Donald Benson MD, PhD; Gerald Donowitz MD, University of Virginia Health System, for their poster "*A Dynamic Strategy for Reducing Internal Medicine Work Hours*." 

Introducing the ACGME's Communications Manager


Julie Jacob

My name is Julie Jacob, and I am the new communications manager for the ACGME. I joined the ACGME in October 2002 after working for six years as a reporter for the AMA's *American Medical News*.

One of the many things that I enjoy about my job is having the opportunity to work on a variety of interesting projects. My responsibilities encompass both internal and external communications for the ACGME, including communications with member and appointing organizations, program directors, residency review committees, residents, the media and the general public. For example, I write news releases; answer calls from reporters; coordinate production of the annual report; edit copy for meeting brochures; and write an employee newsletter – in short, anything related to communications.

In addition to my daily job responsibilities, I am also working on two long-term projects. One project is working with the strategic communications working group, chaired by Dr. Mark Dyken, and a public relations firm to develop a long-term strategic communications plan. Dr. Leach, Dr. Rice, board member Duncan McDonald (a journalism professor) and I are working with a public relations firm to develop this plan. It will be presented to the ACGME Board of Directors at its June meeting. The plan will serve as a blueprint for the organization's overall communications with its member and appointing organizations, RRCs, program directors, and the news media. It will identify the core messages that the ACGME wants to convey to its various audiences, develop the most effective channels to communicate those messages and position the ACGME as the leading voice in graduate medical education.

Another one of my long-term projects involves working with a graphic design firm to redesign the ACGME's logo and create graphic identity standards. These graphic identity standards will ensure that all ACGME publications have a consistent look that projects the ACGME's professionalism and competence, while still allowing for a great deal of creativity and variety in the designs of the annual report, *Bulletin* and brochures.

If you have any comments or suggestion on how the ACGME can improve its communications, or would just like to say hello, please call me at 312/755-7133 or e-mail me at juliej@acgme.org. I would be glad to hear from you. 

ACGME Will Co-Sponsor Conference on Professionalism, September 18-19, 2003

Fostering Professionalism: Challenges and Opportunities is a conference co-sponsored by the ACGME and the American Board of Medical Specialties (ABMS) to be held on September 18-19, 2003 in Rosemont, Illinois at the Sofitel Chicago O'Hare. Presentations by outstanding faculty and small group working sessions will focus on identifying and assessing behaviors related to professionalism across the continuum of medical education.

The conference also includes a call for abstracts that report ongoing or completed projects, investigations, and innovative strategies about fostering, teaching, and assessing professionalism to be exhibited at a reception on the evening prior to the conference itself. Registration is limited to 200 participants. Information about the conference can be downloaded from the link at www.acgme.org.

Editor's Occasional Column: Heisenberg's Uncertainty

Principle and the Accreditation Site Visit

Ingrid Philibert

*The more precisely the position is determined, the less precisely the momentum is known. – Werner Heisenberg
"Uncertainty Principle"*

In 2003, the ACGME accreditation process still predominantly offers a "snapshot" of the program on the day of the site visit. At the same time, elements of the ACGME's data collection effort are moving toward a more longitudinal assessment of programs and sponsoring institutions. One example is the incorporation of a few questions on duty hours in the Web Accreditation Data System (WebADS); others could involve conducting the ACGME resident questionnaire on an annual basis for all programs. What are the advantages of a more longitudinal view of compliance? Werner Heisenberg's (1901-1976) uncertainty principle established that there is a trade-off between the accuracy of measuring location, and the precision of measuring momentum. Applied to the accreditation process, this suggests that focusing on the exact degree to which programs comply with the standards on a given day may fail to capture meaningful information about these programs' "accreditation trajectory," their momentum in a process of continuous improvement of their educational offerings and the quality and safety of patient care.

A second reason why it may be useful to move beyond assessment of the compliance picture on the site visit day is another concept advanced by Heisenberg, who noticed that measurement of atomic particles appeared to be compromised by the presence of the measurement instrument itself. For the ACGME's approach, the site visit is analogous to that instrument and it is possible that the image of the program presented in the program information form (PIF) and on the day of the visit differs from what is experienced by a resident on an average day. Minor "brushing up," updating of documents and other elements of the program, is done by all programs in preparation for an impending site visit. Yet, most accreditation standards do not lend themselves to what Thomas Nasca, MD, Chair, Residency Review Committee for Internal Medicine, has termed "episodic compliance." The three- to five-year accreditation cycles of an average program are feasible and credible only if there is assurance that programs maintain the adherence to the standards shown on the site visit day throughout the period between reviews.

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Thus stated, the goal of accreditation goes beyond having programs that are in compliance on the day of the visit. The intent is to verify programs' ongoing compliance through the site visit and other elements of the accreditation process. In his article in the Fall 2002 *ACGME Bulletin* entitled *Less Process, More Outcome*, Dr. Leach noted that the PIF and other data elements used in accreditation "are noticed in the context of the dynamic history of the program and the institution." This recognized the dynamic nature of programs and of the accreditation process, and the goal of greater focus on a longitudinal improvement effort.

There is a third reason why compliance should not be linked to the site visit alone – the very real public attention to the issue of resident duty hours. We may expect that in 2004, the public and the groups that favored a regulatory approach to addressing duty hours will ask the ACGME about compliance with the duty hour standards. Our answer will need to be able to go beyond the subset of programs that will have been site visited under the new standards. In a very real scenario, the perception that compliance is prompted largely by an impending site visit could be toxic to the credibility of the educational community's process of self-regulation. Notably, this perception is currently neither completely accurate nor entirely inaccurate. For most programs, compliance is an ongoing effort the program makes out of a desire to offer high-quality education and patient care. For some of the others, current ACGME data sources, like the mechanism for handling complaints from residents and others (described in the article by Marsha Miller in page 9 of this issue of the *Bulletin*), are not tied to the site visit and can and do highlight non-compliance. Yet, a few programs may "operate below the ACGME's radar," and it will be important to devise mechanisms for identifying them and promoting compliance.

Another attribute of a robust accreditation process is its timeliness in the resurveying of programs with citations. As an element of the enforcement process, the promptness of the resurvey process will be critical in demonstrating that the ACGME's process for addressing resident duty hours "works." At the same time, the resurvey process can be bolstered by the addition of more ongoing data collection activities.

A potentially important measure of the quality and effectiveness of accreditation is the degree to which compliance demonstrated at the time of review is maintained in the period between assessments. There are aspects of a program that may legitimately be updated in preparation for a site visit. They should be relatively minor; the appropriate analogy being the straightening of pillows on the living room couch before company is expected. The advantages of a more ongoing data collection process, and one that is focused on elements indicative of a high-quality program – educational outcomes – was one attribute that favored the implementation of the Outcome Project. The goal was to facilitate a true assessment of the quality of a program, going beyond the "best foot forward" the program may present on the day of the site visit.