

The Accreditation Council for Graduate Medical Education publishes the **ACGME Bulletin** four times a year. The Bulletin is distributed free of charge to more than 12,000 individuals involved in residency education, and is also available on the ACGME's world wide web site (www.acgme.org) for viewing and printing. The ACGME receives and publishes letters to the editor in the interest of furthering dialogue about accreditation, program quality and matters of general interest in residency education. Inquiries, comments or letters should be addressed to the editor.

Ingrid Philibert
Editor

David C. Leach, MD
Consultant

515 North State Street
Suite 2000
Chicago, Illinois 60610-4322

Phone 312.755.5003
Fax 312.755.5498
Web www.acgme.org

Transparency and Accountability

“**Q**ui custodiet ipsos custodes.” About 2000 years ago, Romans wondered who was “watching over the guardians.” In the early 21st Century, the terms transparency and accountability have acquired both a loyal following, and a bad reputation. Some proponents feel that transparency and accountability for any organization require real-time external monitoring. Others feel that requirements for public oversight and insight have paralyzed organizations’ actions or those of the professions, largely resulting from backlash against the misdeeds of a few “bad apples.” Many individuals familiar with the ACGME’s

“Some proponents feel that transparency and accountability for any organization require real-time external monitoring. Others feel that requirements for public oversight and insight have paralyzed organizations’ actions or those of the professions.”

goals and standards are not sure how the standards and accreditation processes come into being, or how they are monitored. Who watches the ACGME? This issue of the *ACGME Bulletin* is dedicated to answering this question, and to exploring how the ACGME views transparency and disclosure in its interactions with programs and sponsoring institutions, how it monitors its decisions and seeks the input of key constituencies, and how it seeks to assess its effectiveness as an accrediting organization. ■



Transparency and Disclosure in the Postmodern Age

David C. Leach, MD

Postmodern society is characterized by a virtually limitless availability of information. Another attribute is an increased demand for public insight into all elements of societal functioning that constitute a public good, including accreditation. In this context, should the ACGME indicate those programs cited for duty hour violations on its web site? How about posting programs that have inadequate supervision? An inadequate curriculum? Lack of internal reviews? Inadequate faculty? All citations?

Periodically the ACGME and its committees discuss these and other questions related to disclosure and transparency. In the last few years the ACGME has disclosed more information on its web site. Accreditation status and cycle length are made public for every accredited program. The status speaks for itself; the cycle length requires some interpretation – cycle length varies from 1 to 5 years (some pilot studies using annual outcome data have even longer intervals between site visits). The average cycle length is 3.7 years. Programs receiving cycle lengths of 1 or 2 years have some features that have provoked a need for more attention. While this is helpful the question remains: Why haven't we put everything we know about programs on our public web site?

To accredit means to recognize and give credit to a program under review so that all may know that it has achieved certain standards, standards that are available to the public. When programs do not meet certain standards but do meet others

“...the confidential nature of the letter increases ACGME's effectiveness in facilitating improvement in residency education; it results in greater fairness to the program and sponsoring institution, and clarifies rather than polarizes conversations between the programs and the ACGME.”

peer experts determine if the program can be accredited, i.e., it is in substantial, if not complete, compliance with the standards. Substantial compliance is indicated on our web site as fully accredited. Probation or withdrawal indicates less than substantial compliance. Fully accredited programs frequently receive citations noting areas needing improvement; at present these citations are not made public.

Programs and institutions benefit from being accredited. The action is recognized by the federal government, certifying boards, and state licensing agencies enabling hospitals to receive

more financial support, graduates to sit for certification exams and to obtain a license to practice. At present the notification letter containing the details of the accreditation action and the findings of the review is considered a confidential document. The program is free to do whatever it wants with the letter but the ACGME treats it as confidential. Why? It is thought that the confidential nature of the letter increases the ACGME's effectiveness in facilitating improvement in residency education; it results in greater fairness to the program and sponsoring institution, and clarifies rather than polarizes conversations between the programs and the ACGME.

There is considerable evidence that programs improve after being cited for deficiencies; the majority of programs have resolved the problems identified during their accreditation review by the time of their next site visit. Candor is essential to this improvement effort; and third parties may threaten candor. The notification letter prompts programs and institutions to intense internal effort, effort that attempts to improve all citations and the residency program as a whole. Outside interest groups may tend to monitor a single feature of the program rather than the quality of the program as a whole. They may also be accusatory in tone, seeking blame rather than improvement. They may foster postmodernism rather than critical realism.

The ACGME has resisted postmodernism and instead favors critical realism. Postmodernism is an insidious cultural phenomenon that has gained in strength in recent decades. It assumes that reality is a social construct. It cannot be known with certainty and therefore, in a sense, does not exist. The movie “Wag the Dog” is an example of postmodernism; reality is what the media says it is. Critical realism, on the other hand, assumes that reality does exist and can be known. Medicine offers an antidote to postmodernism and is a prototype of critical realism; it is also a prototype for accreditation. Patients are real; disease is real. The presence or absence of a particular disease is not determined by anyone's opinion, but instead the disease either is or is not present. Discernment of the disease (i.e., truth) involves a disciplined process of gathering data, forming and testing hypotheses, and clarifying conversations with the patient and colleagues. Likewise, the ACGME recognizes that the features of a residency program exist in reality, and can be discerned. Good learning is not a single-issue event. It is not subordinate to “hot issues,” even important hot issues like duty hours. It is more important than spin.

The ACGME values fairness; and fairness is enhanced by candid clarifying conversations between programs and the ACGME. Adverse accreditation decisions can be appealed, first to the RRC/IRC itself, then to the ACGME through the recommendation of an appeals panel of independent experts. A

thorough review, followed by reconsideration and appeal, is justified by the seriousness of the consequences. Public notice of an adverse accreditation action may derail that process and damage the program. Although programs on probation are still eligible for financial reimbursement, a negative accreditation status likely changes the attractiveness of the program in the eyes of potential applicants.

If citations were to be made public, programs would need to be given the opportunity to ask that each citation be reconsidered and possibly appealed. The reconsideration and appeals process would consume time and resources – already the volunteers associated with the ACGME and its RRCs donate over 40,000 hours per year. In the case of citations with no adverse actions this may be wasted time. In addition, if citations became a public matter, efforts currently directed at

“Disclosure is different than transparency. The former makes findings public while the latter makes the process public.”

addressing and resolving the citation could be diverted to an appeals process, or at minimum a carefully crafted comment on why the citation was not truly deserved.

Disclosure is different than transparency. The former makes findings public while the latter make the process public. The ACGME processes are clearly indicated in our policy and procedure manual, which is posted on the web site. The process is transparent although key elements of the process are closed to both the public and the program. For example, the interviews of residents that are an important part of the accreditation site visit are confidential. The reason for this is that resident candor is enhanced, and the opportunity to intimidate or retaliate against residents is reduced. RRC meetings also are closed to the public – to enable candid and clarifying conversation to inform conclusions. Reconsideration meetings are also closed. Appeals are conducted with the program in attendance, while the deliberations of the appeals panel, and later those of the ACGME Board, are closed.

The ACGME serves the public by setting accreditation standards for residency programs in 118 different specialties. The standards are extensively vetted through the public and the many communities and constituencies within graduate medical education. All comments from the community must be addressed by the RRCs and the ACGME before the standards go into effect. Using peer experts the ACGME and RRCs also review and make accreditation decisions for the nation’s 7,800 residency programs. The results of those decisions are now made public; the processes used are made public, and the system affords opportunity for clarifying conversations about the decisions. Public trust is best served by this process, which balances the desire for transparency with the need for frank and candid dialog about high-quality education and safe and effective patient care. Together they contribute to building knowledge about good learning. ■

When Any Change Program Will Do... A Report from the Field

Paul B. Batalden MD and Tina C. Foster MD, MPH, MS

Karl Weick has observed that any change program will do, so long as it

- Animates people and gets them moving, generating experiments that uncover opportunities;
- Provides a direction;
- Encourages updating through improved situational awareness and closer attention to what’s actually happening;
- Facilitates respectful interaction in which trust, trustworthiness, and self-respect all develop equally and allow people to build a stable rendition of what they face.¹

Like most other academic medical centers, Dartmouth-Hitchcock Medical Center (DHMC), with over 30 residencies and fellowships, deals with change on a daily basis. As residents, faculty, and staff explore the six general competencies and their evaluation, Weick’s model described above seems particularly relevant. Rather than worrying over the “best” place to start, just getting started may be the key. We describe here some examples of “getting started” at DHMC, dating from both before and after the introduction of the ACGME Outcome Project, and how the principles of successful change programs infuse these activities.

Animates people, gets them moving and generating experiments

DHMC has long been active in health care improvement and has many faculty and staff experienced in leading improvement efforts. Thus, even prior to the formal adoption of the general competencies, informal electives in the improvement of practice were offered to residents by Dr. Mark Splaine in General Internal Medicine. One resident used this opportunity to work on finding evidence-based answers to questions that arose on rounds. Her skills at formulating questions, searching for evidence, and presenting her findings all improved as she recognized and worked on her process. Another resident focused on medication problems, and ultimately presented a grand rounds about her findings.

Building on Dr. Splaine’s work, Drs. Greg Ogrinc in Internal Medicine and Tina Foster in Obstetrics and Gynecology, in collaboration with Drs. Linda Headrick (University of Missouri at Columbia) and Laura Morrison (Baylor College of Medicine), began to offer a formal elective in Practice-Based Learning and Improvement (PBLI) for residents.² This four-week elective combines readings and didactic sessions with improvement work. DHMC residents have tackled issues such

as screening for depression in the transgender clinic, analyzing needlestick injuries among hospital employees, and investigating the actual follow-up patterns of patients in a “continuity” clinic. Although the short time-frame generally does not allow completion of an entire project, many residents have chosen to see their work through beyond the “proposed changes” stage. Changes resulting from these resident-initiated projects include a

“Although the short time-frame generally does not allow completion of an entire project, many residents have chosen to see their work through beyond the ‘proposed changes’ stage.”

new safety education session at resident and student orientations, and an ongoing effort to restructure and improve the teams that follow obstetrical patients.

The success of these early efforts led to the incorporation of the PBLI “elective” into the Ob-Gyn residents’ third year curriculum. Recent resident projects have led to improvements in the scheduling and admission processes of labor inductions and in an assessment of resident experience in the colposcopy clinic and development of tools to improve documentation and communication with patients seen there.

The inauguration of the Dartmouth-Hitchcock Leadership Preventive Medicine Residency (DHLPMR) has encouraged all residency and fellowship programs to look for improvement and prevention opportunities. This program combines residency or fellowship training in any of the accredited programs at DHMC with innovative Preventive Medicine training, culminating in a large-scale project to improve the processes of care and outcomes for a defined population of DHMC patients. Although this program is new, the DHMC community has embraced it.

Each of the “experiments” described has informed the design and development of others, not all of which can be described here. As these programs mature, faculty development is also of major importance. To help support them, new faculty development activities are underway. For example, a focused faculty development workshop was developed by Dr. Mark Splaine and presented to the Family Practice faculty. Offerings on topics such as “Giving and Receiving Feedback” have been offered to residents and faculty across the medical center. Faculty and resident participation in “Clinical Micro-system” workshops and courses has led to a new understanding of Systems-Based Practice and Practice-Based Learning and Improvement.

Provides a direction

The introduction of the six general competencies for residents, accompanied by growing faculty awareness that these same competencies will be addressed by their specialty boards, has provided a sense of direction, as well as, for some, an animating sense of anxiety. Ongoing discussion about what the competencies

entail and how to best evaluate them has led many departments to seriously revisit their curriculum, and to explore new methods of evaluation.

On an institutional level, this renewed sense of direction for graduate medical education is expressed in the development of a strategic template that links the medical center operations model to the work of GME. Using the same format as the medical center and its component departments, the GME office has developed a mission statement, goals for each of five areas of strategic focus, and metrics to assess progress towards those goals. Thinking about how to measure the value of GME, and about what measures will be most useful to both the institution’s governance as well as to front-line educators, has helped to foster a new sense of institutional accountability. The development of the strategic policy and metrics for GME is helping us come to a common view of our GME work both at the institution and program level. Academic medical centers face the challenge of developing ways to be sure that GME remains vital and central to their work. The general competencies serve as a compass for this sometimes challenging navigation.

Encourages updating, paying closer attention to what’s actually happening

With the realization that the competencies provide a common language, as well as the opportunity for common learning experiences across programs, the Curriculum Committee within the GME office works to find opportunities for sharing learning and innovation among departments. This has provided opportunities for programs to look more closely at what they are currently doing, and to speak with their partners in education. We are beginning to share specific tools across departments,

“The general competencies serve as a compass for this sometimes challenging navigation.”

and to better understand what sort of preparation and faculty development are required to successfully introduce tools such as checklist evaluations, videotaping, or 360-degree evaluations.

Updating occurs as feedback is solicited, reviewed, and acted upon. The Graduate Medical Education Advisory Committee’s regular review of action items from Internal Review reports helps program leadership learn about common challenges, and encourages the use of this meeting to share possible responses to them. Resident input is increasingly valued as we acknowledge that the residents in our programs are in the best position to update us about their experiences, and to draw our attention to what works.

Facilitates respectful interaction and allows people to build a stable rendition of what they face

The new DHLPMR involves all the departments offering GME at DHMC. Working across that spectrum, we needed a means of forming community across specialty and in service of

the educational objectives of the residents. We have developed a prototype web-based portfolio system to help us. This web-based resident portfolio prototype has been designed as an integral part of the residency to encourage reflection and respectful interaction. Residents use the portfolio to plan and assess their learning experiences as well as to reflect through journal-writing. Residents can select a journal reader who will read and react to their writing. The portfolio allows residents to accumulate relevant materials such as proposals, rotation “products,” evaluations, tests of knowledge, and reflective work and link them to the competencies. At the conclusion of the residency, they will have a professional portfolio representative of their accomplishments.

For the residency program itself, the portfolio provides multiple avenues for evaluation of residents, faculty, and program, and will generate a living history of the residency to aid in understanding and updating the program, developing a faithful image of what it has accomplished. As this technology spreads to other departments or institutions, it has the potential to be the nidus of meaningful, respectful interaction about the work of being a resident and educating residents, and the source of understanding about a program’s accomplishments which is grounded in reality and connected through the common architecture of the general competencies.

To sum it up, Weick offers a framework that helps us understand the changes we face as we move to better integrate the competencies into graduate medical education at Dartmouth-Hitchcock Medical Center. The value of using the “simple rules” for change described above comes from their ability to facilitate work across a variety of settings, including residency programs, to encourage novel approaches, and keep us moving in a consistent direction. We have chosen to look upon the introduction of the general competencies as an invitation to innovation and improvement and an avenue towards better knowledge of how we do our work, and how well we do it. ■

Dr. Batalden is the Director of Health Care Improvement Leadership Development, and Dr. Foster is an obstetrician-gynecologist and alumna of the VA Quality Scholars Fellowship. Both are at Dartmouth Medical School and Dartmouth-Hitchcock Medical Center.

The authors gratefully acknowledge the leadership and support of Mr. Paul Gardent and Dr. Worth Parker in these efforts, as well as the ongoing work and enthusiasm of the DHMC residency program directors, and GME staff.

¹Weick, KE, “Emergent Change as a Universal in Organizations” in *Breaking the Code of Change*, Beer, M and Nohria, N (ed), Harvard Business School Press, Boston, MA, 223–241, 2000.

²Ogrinc, G, L Headrick, L Morrison, T. Foster, “Teaching and Assessing Resident Competence in Practice-Based Learning and Improvement: A Non-randomized, Controlled Trial”. Institute for Healthcare Improvement National Forum Scientific Symposium, Orlando, FL, December 2002.

Stewardship and Accountability: The Role of the ACGME Monitoring Committee

Duncan McDonald

The statistics are compelling. If you painted by the numbers that ACGME offers in its annual report, you would produce a portrait that is both simple and complex.

It is simple in the clarity of our mission: to ensure and to improve the quality of graduate medical education in the U.S. It can become complex (some might argue even byzantine) in the application of requirements that go well beyond core competencies.

At this point, I hear Dr. David Leach intoning a “chaotic” chant.

The picture I see, as the public member chairing ACGME’s Monitoring Committee, is one of partnership and stewardship. When one considers the almost 8,000 accredited residency

“The picture I see, as the public member chairing ACGME’s Monitoring Committee, is one of partnership and stewardship.”

programs at more than 2,000 participating institutions, the challenge to be clear, comprehensive and consistent in all reviews and communications is serious, indeed.

The Monitoring Committee (MonCom) meets at least three times a year to, among other responsibilities, review the activities of Residency Review Committees and the Institutional Review Committee. This represents a key part of an “ecological chain” that links individual programs, their residents and faculty, and their sponsoring institutions to the board of directors of the ACGME – and by extension, to the members’ appointing organizations.

In meeting with RRC chairs and staff, the MonCom has the responsibility to recommend continued accreditation authority to the appropriate RRC. In meeting this charge, our committee – which includes a resident member – is obviously dedicated to the improvement of accreditation practices. One aspect of this “continuous improvement” mandate is the examination and communication of “best practices.” It is understandable, given the number of RRC meetings (63 in 2002–03) and field staff visits (1,723 in the same period), that much of what our volunteer physicians and administrators do is not regularly communicated to other groups that might benefit from such information.

In this sense, MonCom is also a “news service.” Through its discussions with RRC chairs and staff, in its reports, and in its interactions with the Council of Chairs, our committee

works hard to communicate its findings and its recommendations. It should also be noted that our members spend a great deal of time assessing MonCom's role and working on ways to improve our work. In fact, an all-day meeting was held in May to discuss our procedures and to look ahead at new responsibilities.

As we observe the first anniversary of ACGME's duty hour initiative, MonCom's agenda becomes more intensive. In many ways, our members will become "auditors" of a persistent flow of data on duty hour compliance. We will work with each RRC to monitor each committee's approach to determining

"...it is important that neither MonCom nor any other component of the ACGME becomes singularly focused on the duty hour issue."

levels of noncompliance with duty hour standards. This means, of course, intensive analysis of data from program directors and from resident surveys. It means, too, that MonCom must be watchful of how RRCs enforce these standards and how they act on follow-up site visits and on prior citations.

Of course, it is important that neither MonCom nor any other component of the ACGME becomes singularly focused on the duty hour issue. We all have so many more issues and standards to embrace.

Our mission, after all, is education – quality, innovative, interactive education that produces more than competency. The work of all of us, reflected in the tens of thousands of hours donated to the cause of quality and safety, should be aimed at excellence.

We can balance the demands of education and service with the responsibilities of a safe, dependable, nurturing standard of health care. In this way, we are not only stewards; we are also advocates.

Many challenges lie ahead for us. Here's to many "teachable" moments! ■

Duncan McDonald is one of three Public Directors of the ACGME and, is the first non-physician chair of the ACGME Monitoring Committee.

Residents Discuss What Constitutes the Best Institutional Graduate Medical Education

Ilan Rubinfeld, MD, MBA and Marsha Miller

The ACGME has long been fascinated with the concept of performance excellence and the existent models utilized to describe and reward such performance. In the world of graduate medical education, the most likely focus of such models would be Institutional GME. Ideally, such a standard could be utilized for awarding institutions who consistently exhibit excellence in their stewardship of the various residencies within their institution. Prospective residents and fellows could then look to these awards and standards as a way to choose training programs beyond the individual branding of the institutions health care products.

Dr. Leach conceived of this project resulting in an annual award for the institutions exhibiting excellence in stewardship of their residency programs. Potentially there could be three categories of this award offered to: small community hospitals, larger community hospitals, tertiary academic centers.

To begin describing such a model and make it relevant to our needs, we turned first to our residents as consumers of graduate medical education. We were recently given the privilege of interacting with the Resident RRC Council. This

"The residents described the criteria they would utilize to distinguish institutions of excellence. ..."

occurred during the meeting of the ACGME and, specifically, the Resident RRC Council session on Sunday, February 10, 2004. After a brief introduction on quality systems and methods the Council was facilitated through a nominal group process with a rank ordering exercise. The residents described the criteria they would utilize to distinguish institutions of excellence and then prioritized them. A summary of the residents' recommendations was presented to the RRC Council of Chairs on the following day.

The criteria developed by the members of the RRC Resident Council encompass the following:

Quality of physicians

An institution should have outstanding physicians as educators and achieve excellence in patient care as well as teaching. The residents expect the faculty to actively maintain the level of training and be empowered within their institutions to do so.

Adequacy of resources

The institution must maintain excellent physical facilities and support systems for care and education. Prioritization of educational mission must be carefully considered when distributing physical resources as well as accounting for faculty time. Institution must, at the same time demonstrate the ability to wisely link resources to care and educational outcomes.

Career resources

Excellent institutions will provide resources with which residents can make informed decisions about various career paths. This should include careful tracking of residency outcome such as job/fellowship placement and board passage. ■

Dr. Rubinfeld is a surgeon in academic practice in Detroit, MI, and Marsha Miller provides staff support to the Resident RRC Council, which comprises the resident representatives for the 26 RRCs, the Transitional Year Review Committee, and the Institutional Review Committee.

The authors would like to acknowledge the input provided by the residents, and thank the ACGME and Dr. Leach for allowing them to moderate the residents' discussion and summarize the findings.

Simplifying the Accreditation Process

Julie Jacob

Attendees at the ACGME's 2004 Annual Educational Process who attended the "Simplifying the Accreditation Process" session got an overview of various RRC projects designed to make the accreditation process simpler, yet still effective.

Several hundred program directors, program coordinators, designated institutional officials and others involved in graduate medical education attended the session, which was held twice on March 4. The session highlighted initiatives to make the accreditation process less cumbersome for program directors and coordinators, while still maintaining its thoroughness and rigorosity.

Dr. David Leach, ACGME Executive Director, introduced the panel of speakers. Dr. Leach noted that a common theme of the various simplification projects was the elimination of *muda* – a Japanese word meaning unnecessary work – from the accreditation process, while still maintaining, or even improving, its effectiveness.

Doris Stoll, PhD, executive director of the RRCs for general surgery, plastic surgery, thoracic surgery and urology, discussed the RRC for Plastic Surgery's project to streamline the program information form (PIF).

The shortened PIF form was "many years in the making," said Dr. Stoll. It arose out of a general consensus among RRC members and program directors that many questions on the PIF did not measure medical education quality, and that many of the citations given to programs were for things not relevant to the quality of the residents' education.

After thorough discussion and analysis, the RRC developed a shortened version of the plastic surgery PIF that eliminated curriculum vitae, most appendices, most charts and many questions, said Dr. Stoll. The information remaining in the PIF were demographic data, scholarly activities, block diagrams, operative data, action taken on previous reviews and improvements and program changes and improvements.

Eighteen programs participated in the pilot project with the shortened PIF. The outcome was positive, said Dr. Stoll. Out of the 18 programs that participated in the pilot project, most received continued full accreditation. A few programs were given warnings, a few were put on probation and a few placed on a shortened review cycle, demonstrating that the shortened PIF is effective in assessing whether a program is complying with ACGME program requirements.

The next step, said Dr. Stoll, is to create a "better way of evaluating the quality of the curriculum presented to residents."

Larry Sulton, PhD, executive director of the RRCs for emergency medicine, neurology, neurological surgery, preventive medicine and psychiatry, discussed projects in those RRCs to streamline the accreditation process and link it to a model of constant quality improvement.

“Accreditation is a very complex process, but our aim is to really evaluate it and see how we can simplify it,” said Dr. Sulton.

Arthur Sanders, MD, chair of the RRC for Emergency Medicine, then talked about the RRC’s pilot project to develop a continuous quality improvement model of accreditation. The RRC first established consensus standards for scholarly activities, minimum numbers of procedures, faculty staffing levels and similar benchmarks for evaluating programs.

The RRC developed a pilot program that will extend the review cycle for programs with full accreditation to eight years. Programs that participate in the pilot, will have to submit yearly web-based quality improvement reports. The goal of the pilot project is to determine whether the yearly quality improvement reports will make it easier for program directors to complete the PIF. The RRC will also determine whether the extended review cycle, combined with the yearly progress reports, provides adequate information to assure quality programs, said Dr. Sanders.

“It will determine if we can truly move to a constant quality improvement model in our review cycle,” said Dr. Sanders.

Thomas Nasca, MD, chair of the RRC for Internal Medicine, then spoke about the RRC’s Computer Assisted Accreditation Review (CAAR) Process. The CAAR process examines programs for adherence to specific standards, he explained.

“Programs that participate in the pilot, will have to submit yearly web-based quality improvement reports.”

Since CAAR was introduced in 1991, the RRC has seen a steep increase in the pass rate on the Internal Medicine Board certification exam, said Dr. Nasca. In addition, he noted, “CAAR has contributed to the transformation of internal medicine residencies from service-oriented to educationally-oriented programs.”

However, the drawback to CAAR, Dr. Nasca noted, is that “programs are so structured that the uniqueness of programs is lost.”

To offer program directors more flexibility, the RRC for Internal Medicine is developing a second set of program requirements. These will allow programs with established history of excellence to follow a minimum set of requirements and then innovate while providing yearly reports to the RRC.

At the conclusion of the session, Dr. Leach asked the program directors in attendance to write down one idea to simplify the accreditation process. A compilation of ideas will be published in a future issue of the *Bulletin*. ■

Julie Jacob is the ACGME’s Director of Communications

A Conversation with 160 Designated Institutional Officials

The March 2004 ACGME Annual Educational Conference included a special session for designated institutional officials (DIOs), entitled “Institutional Responses to ACGME Mandates.” The session was attended by approximately 160 DIOs. Attendees heard three speakers, also DIOs, present on their institutions’ work to address the new common duty hour limits and the general competencies. This was followed by a “town hall” meeting, during which attendees worked in small groups to identify important issues for DIOs, to enable them to provide enhanced support to programs in the implementation and monitoring of the Common Program Requirements. A brief needs assessment had also been fielded electronically to individuals registered for the session. The results highlighted the need for more communication between the ACGME and DIOs; they also underscored the DIOs’ desire for added support in their expanding role. The DIOs also expressed a wish for added transparency in the accreditation process. The ACGME’s staff and leadership will consider the results at the upcoming meeting of the Board of Directors in June.

Below, two of the three speakers at the DIO session summarized their remarks for the readers of the *ACGME Bulletin*.

The ACGME’s DIO Session – One Speaker’s Perspective

Ethan Fried, MD

On March 3, 2004, I attended and spoke at the Annual ACGME Educational meeting in Chicago. I have long been a member of the Association of Program Directors in Internal Medicine (APDIM) and have always viewed that organization as my safety zone supporting me against the “mean old RRC”. Yet suddenly, there I was, out of my zone, with a “speaker” nametag about to address a group of fellow DIOs about how we approached competencies and duty hours at my institution. The session was moderated by Ingrid Philibert, Director of Field Activities and Dr. Nathan Blank, the ACGME field representative who was the site visitor for my first institutional review. It would take some getting used to, this role of working with the ACGME as opposed to working for my program and hoping that I would not get “dinged” by the ACGME.

I described the structure of my graduate medical education committee (GMEC). Innovative ideas highlighted in my presentation were how we enticed program directors to attend the GMEC meetings by offering them CME credit for this activity, and how we invited representatives from hospital administration and the house staff union organizer. I told the group that I preferred to think of the GMEC as a resource for program directors rather than as another layer of oversight. I

described the content of the competency portfolio we distributed to the program directors and the “Action Item Grid,” a spreadsheet that captures site visit citations, internal review areas of concern, and performance on the competency measurements. Recently, we added areas of non-compliance identified via the resident survey to the list of “Action Items.” I also described the process used to ensure compliance with duty hour standards in New York State where duty hour restrictions are the law. I informed my audience that we painstakingly avoid using the terms “work hours” and “shifts.” The surest way to turn off an

“The surest way to turn off an audience of faculty trained before 1989 is to make it seem like residents should be trained in shifts.”

audience of faculty trained before 1989 is to make it seem like residents should be trained in shifts. In fact, what we say is that the duty hour laws say nothing about a diminished level of continuity. What they assume is that at some point everyone has to leave. They simply require us to design a transition that is robust enough so that the new team has as much understanding of the patient as the old team did. Then they say we should execute this transition at a time before residents are required to work at the same cognitive level as a person who is legally drunk.

The presentations – mine and those of three other DIOs that highlighted their initiatives to keep their programs on track with the duty hour limits and the general competencies – were followed by small group discussions during which DIOs shared frustrations and creative ideas and made suggestions to the ACGME about how their job could be made easier. Ms. Philibert and Dr. Blank circulated among the tables and all of us listened attentively as each table presented its report. The comments and ideas were recorded on flip charts.

Last week, Dr. Blank performed a site visit on one of the training programs at my institution. I sat in at the faculty meeting with his permission, and took lots of notes about how that department complied with the ACGME regulations. Dr. Blank even suggested a few ideas that were not only easy to implement but approached such things as “professionalism” from a completely new direction than the one we had imagined.

Perhaps there is room in my little zone of safety for the ACGME. I certainly know whom I can call for advice. ■

Ethan Fried, MD, is the internal medicine residency program director and the designated institutional official at St. Luke’s-Roosevelt Hospital Center, New York City.

Addressing Competencies and Duty Hours at Dartmouth-Hitchcock Medical Center

H. Worth Parker, MD

Recently there have been two notable new “unfunded mandates” from the ACGME that have caused angst and energy from those of us who wear the label of DIO (Designated Institutional Official). We have had to re-evaluate our present institutional systems and create new ones to provide a mechanism for delivery and measurement to ensure compliance for these new mandates.

The omnibus General Competencies project has been a challenge for me personally to get my arms around. How would I go about leading my Program Directors when I was struggling myself?

The effort needed clarity due to the laboratory-for-change approach taken by the ACGME. Their grass roots, best practice, tool box, non-prescriptive approach was leaving our programs and me awash in a sea of anxiety. The eleven-year time line for total implementation of these new competencies gives the DIO the impression that the ACGME leadership knows how much work this will be.

Positive things began to happen, largely independent of my efforts. Several program directors at Dartmouth-Hitchcock Medical Center who were facing RRC visits rewrote their curricula incorporating the language of the general competencies. We began to share these documents with other program leaders who claimed they were clueless. Dartmouth faculty involved in the VA Quality Scholars program developed an elective where

“The eleven-year time line for total implementation of these new competencies gives the DIO the impression that the ACGME leadership knows how much work this will be.”

a resident could learn the basics of the science of improvement and then design a simple improvement project to be carried out during one of their block or continuity rotations.

We learned that the first step was having program directors beginning to understand how these competencies might be delivered. The second step – getting the other members of the faculty to engage – continues to remain difficult. It was becoming clear that opportunities occurred throughout the institution that was being missed by faculty and residents.

The GME office redesigned a job description and created a “compliance officer” role. The compliance officer is in charge of collecting, posting and advertising on our intranet site all conferences, grand rounds and seminars across the entire campus. A weekly E-letter from our office details these. The compliance officer is brought into the planning of such offerings early on so that mutually acceptable times and enough lead-time can be used

to get maximum attendance. There is a General Competencies Committee that meets every six to eight weeks and includes not only GME and program directors, but also members from web development, teleconferencing lab and library services. I can report a glacial shift in awareness and participation and the first threads of the competencies are being woven into the fabric of everyday teaching.

The mandate for compliance with the common duty hour requirements began on July 1, 2003. Like many other teaching institutions, our preparatory work began well in advance of that date, and we were sidetracked by attempting to find the least costly approach to measuring the hours. The institution spent six months trying to work with the personnel software that we already owned and where all of the residents were

“Like many other teaching institutions, our preparatory work began well in advance of that date, and we were sidetracked by attempting to find the least costly approach to measuring the hours.”

listed as employees. Our existing system would have worked with some tinkering, but in April 2003 we found out that the residency evaluation system that we already were paying for and that was housed and serviced through dollars already spent would be coming on-line with a duty hour tracking tool before the start date. We chose this option and it has worked well.

Our pre-July surveys told us that there were five or six programs at risk. They have gradually fallen in line, but the 30-hour rule still is the hardest for our center to police and ensure compliance.

External and internal whistleblower events helped focus our faculty and administration on the task at hand. I described in some detail to the attendees at the March ACGME conference our internal whistleblower event to show how the institution responded. A tale of a small program in which residents take “call from home,” but this call can be active, frequently forcing the residents to stay in house. A resident resigned and there was less than adequate response from the program to off load the call from the other more junior residents. Their RRC visit is in June 2004 and our institution’s response to the event led the ACGME to allow for further investigation to occur at that time. ■

H. Worth Parker, MD, is the designated institutional official at Dartmouth-Hitchcock Medical Center and the new chair of the ACGME’s Institutional Review Committee.

An Interview with Carl Getto, MD

Dr. Getto is the senior vice president for medical affairs at the University of Wisconsin Hospital and Clinics and Associate Dean for Hospital Affairs at the University of Wisconsin Medical School. He serves as the Chair of the Federal Council on Graduate Medical Education (CoGME), authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs. Dr. Getto also is a member of the ACGME’s Institutional Review Committee. Ingrid Philibert interviewed him for the *ACGME Bulletin*.

As you participate in the meetings of the national Council on Graduate Medical Education (CoGME), what are the national “hot topics” related to residency education?

Over the years of CoGME’s existence, the size and composition of the US physician workforce has been a recurrent topic. In 2004, CoGME is once more engaged in discussions on this topic, this time in the context of a national re-thinking of the projections about physician supply and demand. The data now suggest that the nation may be facing a physician shortage in the coming years, though this conclusion is by no means unanimous. Another topic is the specialty distribution, and what will happen to primary care. The need for primary care

“The need for primary care is evident in the perspectives of public health and rural medicine. At the same time, looking at the demand patterns of baby boomers as they age into the phase of their life when they will need the most care, it is apparent that primary care lacks broad consumer support.”

is evident in the perspectives of public health and rural medicine. At the same time, looking at the demand patterns of baby boomers as they age into the phase of their life when they will need the most care, it is apparent that primary care lacks broad consumer support.

What are similarities and differences between the topics discussed at CoGME and those in your discussions at the ACGME?

One similarity is the discussion of physician competencies. CoGME has been discussing the effect of changes in the composition of the workforce and the work environment on physician competence, especially in procedural and technical areas. In addition to the effect of the duty hour limits, well known to the readers of the *Bulletin*, there is the observation that the current generation of residents desire balance between their professional and personal lives. Irrespective of how we may feel about it, we cannot continue to train residents in the old model, ultimately neither the residents nor the public will stand for it. In my role as senior VP for medical affairs at the University of Wisconsin Hospital and Clinics, we are looking for new attending physician models, including hospitalists. It is becoming more evident that the viable approach for residency education in the future is a model based on solid, high-quality clinical care, into which the residents' learning will be integrated.

How will this change resident education?

I would like to think that we can get residents out of situations in which they just provide service, or pay them a reasonable salary for that aspect of their role. There is also a need to add

“...we can reduce the purely redundant work such as multiple work-ups on the same patient.”

other purely educational elements such as teaching them complex decision-making skills. I think we can help reduce the purely redundant work, such as multiple work-ups on the same patient, if we establish a certain skills basis, and accept that the work-up is done once, either by the resident or faculty.

In the different venues in which you are part of discussion about graduate medical education, how are the ACGME and its accreditation system perceived?

In the best light, the ACGME is viewed as advancing beyond the bureaucratic model of accreditation through the adoption of the six general competencies. In the worst light, the ACGME is viewed as a better than regulation by the government, but not much better.

A related question is what future course of action this perception may suggest for the ACGME. I would like to continue to see the organization moving ahead. There is a need for new educational models and pilots that move the existing boundaries around residency education. It would be helpful to break down the walls that keep residents contained within the current model of acute, tertiary educational care. As I envision this, training in large group practices could play a major role in the education of physicians in the future. At some point, we will also have to start educating our health professionals in

multi-disciplinary groups, instead of keeping them apart for four to six years and then expecting them to work together. I would also like to see more collaboration between the ACGME and the JCAHO, similar to what happened to produce the current “matched” requirements for resident position descriptions and supervision.

What are the most significant barriers to high-quality graduate medical education for all residents?

The system of financing is tailored to the current system of residency education. The flow of funds favors training in hospital settings, and discouraged training in ambulatory

“...the perceived vulnerability of the graduate medical education financing stream keeps the community from making creative proposals; for fear that any change will ultimately result in an overall reduction of support for physician education.”

venues. This is one area that CoGME's 15th Report did not completely address – how to structure funding to foster transition to an adult education model, more flexibility and how to move resident education out of the inpatient hospital. In addition, the perceived vulnerability of the graduate medical education financing stream keeps the community from making creative proposals; for fear that any change will ultimately result in an overall reduction of support for physician education. A third barrier is the fact that the current system does not link physician education to clinical quality, although it is clear that the places that provide the best care in the nation are the settings where physician education should occur. The issues are worth considering, since the residency education system is set up for a 35- to 40-year return on investment. This suggests we should get it right. ■

Innovation in Residency Education – Winning Posters from the 2004 Marvin R. Dunn Poster Session

From March 3 to March 5, 2004, approximately 700 program directors, designated institutional officials and coordinators attended the 2004 ACGME Educational Conference. The conference featured the Marvin R. Dunn Poster Session, named in honor of Dr. Dunn, the late Director of RRC Activities. This issue of the ACGME Bulletin includes the abstracts for the winning posters, judges' awards and one honorable mention from the session. The abstracts highlight the variety of high quality posters on topics related to residency education shown at the session.

FIRST PRIZE

Systems-based Practice Training for House Staff – A Pilot Program

Christine B Turley MD, Kathryn J Jinkins RN BSN MEd, Marilyn Marx MD MBA, University of Texas Medical Branch (UTMB), Galveston, TX

Purpose: To implement an experiential training program in Systems-Based Practice providing practical knowledge of the complex business systems that occur around the patient care cycle, utilizing the clinical revenue cycle as a model.

Methodology: This training program, "Systems Survivor", is organized in a game format modeled after the popular "Survivor" series, but modified into an inverse Survivor game. Each resident starts "alone" in the healthcare environment, and ends as a member of a team (the system). The "Survivor" theme, props and rewards are used throughout to stimulate engagement. The pilot is in its first year and consists of a five-day rotation. Emphasis is placed on acquiring knowledge of the interrelationships of patient care and clinical revenue. The rotation follows the clinical revenue cycle focused around the patient care experience, through twenty-seven distinct areas. The site trainers are chosen from top performing staff members in each area. Residents participate in the actual work of each area (e.g., listen on phone headsets, evaluate documentation and coding with coders, complete precertification). The residents are expected to complete reading assignments, keep a journal of their rotation experiences and complete a multiple

choice pre- and post-test. Daily "Tribal Councils" (quizzes) are used to aid in consolidating key components. Evaluations, by both the trainers and the residents, are completed.

Summary of Results: Initial data show improvement in Systems-Based Practice knowledge scores. Site evaluations are favorable and overall course evaluations are high.

Conclusions: A Systems-Based Practice pilot program has been successfully launched at UTMB for residents to become more knowledgeable about our complex healthcare system and the appropriate role of the physician within it. This program provides innovative exposure to the financial system surrounding the clinical revenue cycle. These insights afford residents an improved ability to provide quality cost-effective patient care now and in the future.

SECOND PRIZE

A Patient Survey to Assess Resident Performance

P. Jeppsen, D. Simpson and J. Robinson, Medical College of Wisconsin, Milwaukee, WI

Purpose: In response to the ACGME Outcome Project, we systematically developed and piloted a patient rating form for ophthalmology residents, based on attributes patients associate with a "good doctor."

Methodology: An iterative, qualitative methodology using semi-structured interviews with patients in an ophthalmology outpatient clinic was used to identify, in the patient's own language, the attributes of a "good" ophthalmologist. Content analysis was used to identify the most common comments. Comments were then framed as survey-like questions with each question, where possible, associated with an ACGME competency. Questions were piloted with patients who were asked what scale they would use to grade a resident. Selecting the most common scale, a sample patient survey was created and piloted using patients seen by residents in clinics of two supervising faculty members. Patients were asked to complete the survey prior to leaving the clinic. Descriptive and inferential statistics were used to analyze survey responses.

Results: Ten themes emerged from content analysis from patient generated attributes of a "good" physician and were reframed as questions along with an overall quality of visit item. Items, by associated ACGME competency include: "Listening carefully to your full story" and "Answering your questions directly and completely" (Interpersonal and Communication Skills); "Treating you as a person" and "Being truthful, direct and upfront" (Professionalism); and "Doing a thorough exam" (Patient Care). There were no questions associated with practice-based learning and improvement or systems-based practice.

Preliminary analysis of completed questionnaires revealed that patients expectedly rated residents highly with the greatest variability in questions related to the competencies of Clinical and Surgical Skills. Further analysis of this data will be conducted.

THIRD PRIZE

Evaluation of Radiology Residents by Radiology Technologists as Part of the 360-Degree Assessment

Dedrie Plette, BSc, Mardjohan Hardjasudarma MD, Department of Radiology, Louisiana State University Health Sciences Center, Shreveport, LA

Purpose of Project: To devise a system for 360-degree evaluations for Radiology residents to comply with the Six Competencies, in particular Patient Care, Interpersonal and Communication Skills and Professionalism.

Methodology: Technologists are a vital component in the discipline of Diagnostic Imaging (Radiology) and work with and interact closely with residents. Thus far, they have not been asked to participate in resident evaluation.

With the full cooperation of the Technologist Supervisors of all the sections in the Department of Radiology, followed by individual discussions and feedback, a questionnaire was developed. Supervisors, or their designate(s) were asked to rate (in 5 strata) each resident for the preceding 6–12 months regarding a total of 16 questions, which were divided into 4 categories, namely Clinical, Patient Care, Interpretation of Studies and Professionalism. Three open-ended questions regarding the resident's strengths, weaknesses and unusual encounters were added at the end.

The responses (excluding opened-ended questions) were recorded to Scantron sheets for computer processing, the results of which also included the range and average for each question, category and the entire questionnaire. To safeguard respondent anonymity, a composite report from all respondents was generated for each resident, and discussed by the program director with him/her as part of the six-month evaluation.

Summary: Initial results are encouraging and informative. They will serve as the basis of other 360-degree evaluations, where we plan to include patients.

Conclusions: This is an efficient method, easily implemented, analyzed and monitored. It directly impacts on technologist–resident perceptions, and is used to improve, and if necessary correct relations between these two vital components of the Radiology residency program, ultimately contributing to the formation of the residents and improved patient care.

JUDGES' AWARD

Practice-based Learning through Review of Patients

Rajeshwar Peddi, MD, Forest Park Hospital, St. Louis, MO

Purpose: The objective of this exercise is to develop a methodology that provided the resident team on general medical floors, an opportunity for self-evaluation, learning and improving patient care practices based on the principle of practice-based learning and improvement which is one of the general competencies endorsed by ACGME for residents.

Method: The team maintained a log of all patients admitted for the month (June 2003). At month end, the team reviewed and discussed all admissions with the attending. Learning points from thirteen interesting and challenging cases were presented to a wider audience in 'PowerPoint'.

Results: Sixty-seven patients were admitted for the month. Results were tabulated which included demographic data, diagnosis, management and learning points from each case. Examples of learning points included atypical presentations of illnesses in elderly patients leading to difficulty in diagnosis, solving problems associated with diagnosis and differential diagnoses like differentiating delirium from dementia, pneumonia from congestive heart failure, management issues dealing with drug interactions and ethical issues like resuscitation status and end of life issues.

Conclusions: The conclusions were based on feedback from residents, interns and faculty. The exercise happened to be worthwhile, instructive and meaningful with a simple methodology. It pointed out the benefit of resident interaction with experienced faculty to reduce errors and highlight opportunities for improvement.

- The exercise added an essential component of self-evaluation and learning.
- It provided additional opportunities for study of the literature directed by the patient population.
- Residents gained experience in data collection and presentation.
- The benefit from this practice-based experience is enormous as in any given month; there are four medical floor teams, each with a resident, two interns and one or two medical students who participate in this exercise.

JUDGES' AWARD

Instructional Accountability: The Professional Growth Indicator

*Sally T Miller, Department of Surgery, University of Virginia,
Charlottesville, VA*

Purpose: Our program created an innovative process for faculty and residents to synthesize evaluation summaries, interpret their significances, and detail plans for improving educational effectiveness for the purpose of providing a tangible forum for constructive growth in the implementation of the ACGME's Six Competencies.

Methodology: In August 2003 we initiated the Professional Growth Indicator (PGI), an electronic questionnaire based on the Six Competencies. Faculty members reviewed their semi-annual evaluations by residents, monthly rotation evaluations, and annual program evaluations. Based on these evaluations they identified individual professional strengths and weaknesses and expressed their plans to improve instructional shortcomings on the PGI template. On a similar PGI template, residents considered their evaluation summaries and set forth new performance goals.

Summary of results: Fifteen out of 32 faculty members completed a PGI. Responses demonstrated great reflection and introspection concerning instructional accountability. Proposals for improvement included a heightened awareness of role modeling (Patient Care and Professionalism), closer advisor/advisee teamwork (Communication), and increased clinical and research participation (Medical Knowledge). Faculty results were shared confidentially with the department chairman. Fourteen out of 45 residents completed the PGI. These residents appeared to take a newfound responsibility for their education. Results were shared confidentially with program directors.

Conclusions: The PGI demands an entirely new focus on instructional accountability. As we observe growth of this year's participants, we anticipate an even higher rate of receptiveness next year.

JUDGES' AWARD

Developing an Assessment Center for Tracking Resident Competency: Establishing Inter-Rater Reliability of a Leaderless Group Discussion

*Ann T Rohrer MS, Robert M Heaney MD, Saint Louis University
School of Medicine, St. Louis, MO*

Purpose: Saint Louis University School of Medicine is in the process of adopting an assessment center to use during resident orientation. The assessment center is a process in which multiple raters evaluate residents' performance on several assessments

related to the general competencies. Techniques such as a leaderless group discussion (LGD), an in-basket exercise, a systems learning exercise, medical ethics vignettes, and personality inventories will be used. Evaluating residents relative to their skill in each dimension will generate a profile of the individual residents' strengths and areas for improvement, in addition to group training needs. The results also will be based on multiple ratings, which have had high inter-rater reliabilities in past studies. The current study focuses on establishing the inter-rater reliability associated with the LGD exercise entitled "Pursuing a Grant to Reduce Medical Error;" this reliability is important to establish in subjective testing.

Methodology: Five leaderless groups with six residents are asked to read the exercise scenario and work together to solve the assigned problem within 90 minutes. All participant roles are well defined and structured. Three trained assessors and one clinician observed each resident via videotape and evaluated the resident based on a set of criteria, using a five-point scale of effectiveness. The criteria were sensitivity, influence, oral communication, oral presentation skills, altruism, respect for others, ethics, initiative, problem analysis and decisiveness.

Summary of results: To establish inter-rater reliability, the ratings given by the assessors and clinician were computed using a Pearson correlation coefficient. Preliminary results indicate positive correlations among the assessors and positive correlations between the assessors and the clinician.

Conclusions: In conclusion, the initial findings of this study suggest that with training, assessors are able to identify and rate resident behavior similarly. Current studies are being conducted to establish the construct validity.

HONORABLE MENTION

The Night Float System: Ensuring Educational Benefit

*Hilary Sanfey, Shayna Lefrak, Sally Miller, Bruce Schirmer, Department
of Surgery, University of Virginia Health System, Charlottesville VA*

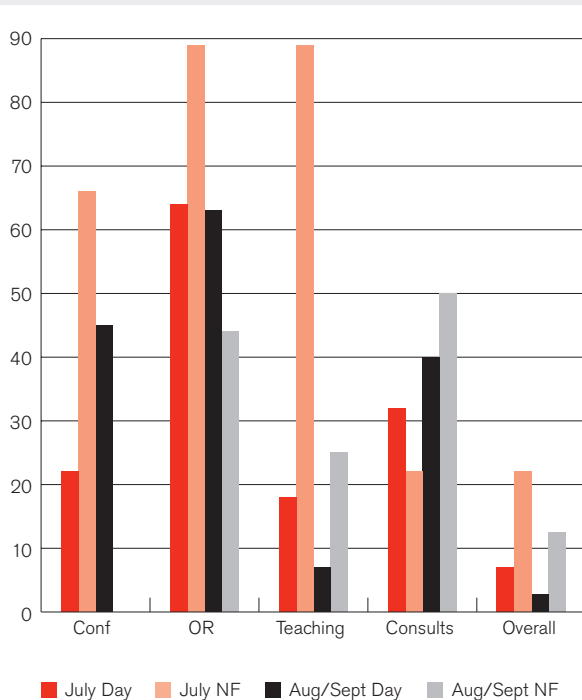
Introduction: The ACGME mandated a change in resident work hours effective July 2003. We studied a number of call schedule options and chose to use the night float (NF) model for PGY1 residents. Data do not exist to support the educational benefit of one system over another but we postulated that taking a block of night call would provide an opportunity for first year residents to develop diagnostic skills and improve clinical decision-making, without detracting from operative experience.

Methods: The educational benefit of the night float model was evaluated weekly beginning in July 2003 by anonymous questionnaire assessing resident conference attendance, operative experience, attending teaching interactions, consult and overall clinical experience for the previous seven days. IRB approval was obtained.

Results: When the preliminary results (Figure 1) were evaluated at the end of July it was apparent that a higher percentage of PGY1 night floats reported LESS satisfaction in terms of conference attendance, operative experience, and attending teaching interactions than their daytime colleagues. The data were of such concern that a number of interventions were made immediately to increase faculty awareness of the need to improve the educational experience. As a result, when the data for August and September were compared with the data for July the night float residents in August/September reported an improvement compared with the July night floats (Figure 1). Compliance with the 80-hour week was equal for both groups.

Conclusions: The night float model has the advantage of fulfilling ACGME requirements, reducing excessive cross-cover and providing continuity of patient care at night. However it has the potential to limit the resident's operative experience and didactic teaching. Continued monitoring and faculty intervention is critical if we are to succeed in our goal to provide our residents with the best possible educational experience. ■

Figure 1
Percentage of PGY1 Residents with Least Educational Experience



RRC/IRC Update

ACGME approves program requirements in Otolaryngology, Pathology and discontinues accreditation in Clinical Laboratory Immunology

The ACGME approved the Program Requirements for Requirements for Otolaryngology and the subspecialty requirements for Neurotology (formerly known as Otology/Neurology). Both will be effective July 1, 2004. The ACGME also approved revisions to the Program Requirements for Hematology (Pathology), without modification, effective July 1, 2004. The ACGME reviewed proposed new Program Requirements for Emergency Medicine and proposed Program Requirements for Neurology, and referred both to the respective Residency Review Committees for additional revisions.

The ACGME approved the request of the RRC for Allergy and Immunology to cease accrediting Clinical Laboratory Immunology, effective June 30, 2005, if residents have been appointed for the 2004–2005 academic year. This date will move up to June 30, 2004, if no residents will be appointed in the specialty for the coming academic year.

ACGME considers proposal from Surgical RRC Chairs

The ACGME reviewed a recommendation from the Chairs of the Surgical Residency Review Committees to extend duty hours for the chief resident years (the final accredited year in a core surgical specialty) to 88 hours. The aims of the proposal were to optimize surgical chief residents' operative skills; enhance continuity of patient care and continuity of residents' learning experiences; allow them to function as leaders and mentors for junior residents on the surgical care team; and promote their leadership skills and professional maturation. The proposal stipulated that during the extended hours chief residents would not be required to provide service activities that could be appropriately managed by physician extenders, junior residents or other support staff.

The discussion of the proposal by the Board of Directors highlighted the complex and divergent views on the effect of the duty hour limits on surgical education, the lack of data that show an actual negative effect, need to give programs more time to adapt their systems to comply with the standards, and concerns that changes in the duty hour standards would not be favorably received by the public. The discussion also emphasized that at present, programs that want to extend duty hours for their chief residents to 88 hours per week can avail themselves of the existing duty hour exception, with the endorsement of their sponsoring institution and the approval of their RRC. The Board of Directors referred the recommendation to the Duty Hour Subcommittee for evaluation and re-consideration, citing the need for additional time for programs to adjust to the new standards, and need for data on the effect of the standards.

Other News from the February ACGME Meeting

Second reading of bylaws changes

The ACGME unanimously approved the 2nd reading of the bylaws changes permitting appointment of a second voting resident director to the ACGME. This will give a vote to the Director of the RRC Residents Council, who currently sits on the Board of Directors with voice but no vote. Other bylaws changes will permit a public member to assume the role of treasurer; and, create flexibility in the scheduling and format of ACGME meetings at which votes of members and directors may be taken. The next step will be the approval of these changes by the ACGME member organizations.

Duty Hour Subcommittee reauthorized through September

The Duty Hour Subcommittee, appointed to advise the ACGME Board of Directors during the initial implementation period for the common duty hour standards, was granted reauthorization through September 2004. This will allow it to complete a series of tasks in keeping with its charter. Planned activities for the last four months of Subcommittee functions will include aggregating the input from the field on aspects of the standards that have been challenging to implement and may benefit from refinements, and advising on the formatting and presentation of data to assist the RRCs and ACGME in monitoring duty hour compliance. Another task will involve review of ACGME data from the first year under the new duty hour standards to begin to explore the effect of the standards on educational data collected by the ACGME. This will also review surgical operative volume during the first year under limited duty hours, to assess the benefits of extending duty hours for the chief resident year to 88 hours per week. The Subcommittee will also advise on a system to collect and disseminate innovative ideas for compliance with the duty hour standards that have emerged during the first year of implementation. An overarching goal of this effort is to move toward an approach that attends to compliance with the duty hour standards as one element of a set of attributes necessary for high-performing residency education programs and sponsoring institutions.

Appointments to ACGME Board of Directors

The ACGME elected as Director, Richard J. D. Pan, MD, MPH, representing the American Medical Association, to fill the vacancy left by the resignation of Edward Langston, MD. The ACGME also formally accepted the appointment of Rear Admiral Donald L. Weaver, MD, as the new Interim Federal Government Representative.

ACGME Moves 2005 Annual Educational Conference to Kissimmee, Florida

The 2005 ACGME Annual Educational Conference will be held March 3–5, 2005 at the Gaylord Palms Resort and Convention Center in Kissimmee, Florida. Additional information concerning sleeping room rates, conference registration fees, and contents of the program should be available on the ACGME web site (www.acgme.org) by early fall. ACGME will offer online registration for this conference.

Field Staff and ACGME News

Dr. Jeanne Heard joins ACGME

Jeanne Heard, MD, PhD, joined the ACGME on May 3, 2004 as Director of RRC Activities. Prior to assuming her current role, she was the Professor of Medicine, Associate Dean for Graduate Medical Education and Designated Institutional Official at the University of Arkansas for Medical Sciences.

New Field Representatives – John Zapp, MD and Nalini Juthani, MD

John Zapp, MD, a board-certified family physician with 31 years of experience as a family physician, residency educator and program director, joined the ACGME field staff in October 2003. Dr. Zapp completed his medical training from the University of Pennsylvania Medical School, Philadelphia. Between 1978 and 2003, Dr. Zapp held positions as family practice program director at Hunterdon Medical Center, Crozer-Chester Medical Center and, most recently, the Mercy Medical Center Family Practice Program in Redding, California.

Nalini Juthani, MD, a board certified Psychiatrist, joined the field staff in January 2004. She was born in Bombay, India and received her medical school training at the University of Bombay in 1971. In 1979 she assumed the position of director of the Bronx-Lebanon Hospital Center child psychiatry residency program and served in that capacity for 25 years. She received a number of awards for excellence in teaching of psychiatry and in 2001 was a finalist of the ACGME's Parker J Palmer "Courage to Teach Award." She has served as a Specialist Site Visitor for the Committee. She joined the ACGME field staff in January 2004. She resides in Scarsdale, New York, with her husband.

David Schramm, PhD, Field Representative retires

In December 2003, David Schramm, PhD, retired from the ACGME field staff after 15 years of service. ■

National and International News about Graduate Medical Education

AAMC submits comments to IRS on FICA exception for medical residents

In mid-May, the Association of American Medical Colleges (AAMC) submitted a comment letter to the Internal Revenue Service (IRS) to voice its objections to a proposed regulation that would make it impossible for a resident employed by a hospital to claim the student FICA (Federal Insurance Contributions Act) tax exception. Only residents employed by school, college, or university would continue to be able to claim FICA “student status.” The AAMC’s letter clarifies that the purpose of residency is to allow individuals training in all types of sponsoring institutions to have student status while they complete their clinical education in a chosen specialty.

European community projects the effect of its new work hours

An article in the British Medical Journal this Spring highlighted concerns with the implementation of the European Working Time Directive.¹ On August 1, 2004, the next phase of the Directive will go into effect, reducing working hours for residents, called junior doctors, to 58 hours per week. Physicians in training programs were not initially included in the 1993 Directive. In 2000, the European Union included residents in a phased implementation of the Directive that reduces their duty hours to an average of 58 hours per week in August 2004, declining further to 48 weekly hours by 2009.

The article summarized reports presented as part of a European Commission’s review of the Directive this Spring. This included projections from the United Kingdom predicting

“The AAMC letter clarifies that the purpose of residency is to allow individuals training in all types of sponsoring institutions to have student status while they complete their clinical education in a chosen specialty.”

that the reductions effective August 2004 will be comparable to a loss of 3,700 residents. The German government cautioned that the reduction to 58 weekly hours could necessitate a 25 percent increase in resident numbers, costing 1.75 billion Euros. In addition to the reduction in hours, two court decisions have had a major impact on resident hours. The first is a ruling by the European Court to include residents’ on-call time spent sleeping within the counted work hours; the other requires doctors to have their required rest period post-call, even if the

call time was spent sleeping. Comments from the Netherlands noted that if all on-call duties are included in the Directive, for this nation alone it could increase the demand for health care workers by 10,000 at an added cost of 400 million Euros per

“The article reported that France and Spain have applied to be exempted from the Directive, and Slovenia applied for an exemption even prior to joining the European Union in May of 2004.”

year. The article reported that France and Spain have applied to be exempted from the Directive, and Slovenia applied for an exemption even prior to joining the European Union in May of 2004.

The comments highlighted the larger number and larger role of “junior doctors” in the United Kingdom. The ratio of “junior doctors” to senior doctors is particularly high in the United Kingdom. Across the European Union it is 1.4; in the United Kingdom, it is 1.4 “junior” doctors to 1 “senior” physician. In contrast, the ratio of residents to practicing physicians in the United States is approximately 1 to 7.2.² The European commission responsible for implementing the Directive has requested advice on “possible future modification of the Directive.” ■

¹Sheldon, T. Pressure mounts over European Working Time Directive. British Medical Journal, April 2004; 328:911.

²Calculated from Physician Characteristics and Distribution in the US, 2004 Edition. American Medical Association, and data collected by the ACGME and the American Osteopathic Association.

A Self-assessment of the ACGME's Effectiveness

Ingrid Philibert

Some feel it would be disingenuous to demand that an organization must be “accountable,” without specifying accountability to whom and for what. Similarly, a discussion of organizational effectiveness presumes that the organization has a specific purpose, and “effectiveness” relates to how well it meets these particular goals. In September 2003, the ACGME embarked on a self-assessment of its effectiveness as an accrediting organization. At the heart of the process are five seemingly simple questions, shown below.

“...a discussion of organizational effectiveness presumes that the organization has a specific purpose, and ‘effectiveness’ relates to how well it meets these particular goals.”

Using these five questions, the self-assessment process has generated a lot of input from member and appointing organizations, and representatives for program directors, designated institutional officials, residents and other key constituencies. The ACGME plans to complete the process of soliciting input by July 1.

Questions for assessing the ACGME's effectiveness as an accrediting organization

1. What are the ACGME's goals relating to the accreditation process?
2. How is the ACGME performing related to these goals?
3. What are areas for improvement?
4. What are important opportunities for the ACGME to address (what does the ACGME not do that could enhance the accreditation process or improve service to key constituencies)?
5. What activities does the ACGME currently engage in that do not add value to the accreditation process and that could be discontinued?

At the heart of the self-assessment is the involvement of constituencies in a process to hone in on a small set of measures of effectiveness the ACGME will use for an ongoing assessment of its performance and to identify opportunities for improvement. Input is being received from member and appointing organizations, and from the Residency Review Committees, senior leadership and ACGME staff. Some of this is received by mail, some by e-mail and some is solicited in person via

“appreciate inquiry” exercises conducted by ACGME senior staff. All of it is focused on the five questions. ACGME has also asked input from dedicated groups of program directors, residents or designated institutional officials, sponsored by member and appointing organizations, and has also directly contacted randomly selected members of these constituencies. Views of the ACGME's effectiveness will be aggregated across by constituent groups (e.g., residents, RRCs, member organizations) and across all constituencies.

After the views of constituencies have been collected and aggregated, the next step involves selecting a small number of indicators that match the key areas of importance identified across all groups. They will form a “dashboard of strategic indicators,” which will be used to assess performance and guide strategic planning. Plans also call for reviewing and, if needed, revising the measures through ongoing dialogue with the constituent community. Thus, the collection of input from constituents becomes one element of a “plan – do – check – act” cycle that utilizes data as the basis for decision-making and continuous improvement.

The theme of this issue of the *ACGME Bulletin* is transparency and accountability, raising the question how does assessment relate to accountability. The focus of accountability is external – on the public at large and the nation's elected officials. The audience has an interest in the general quality, efficiency and fairness of the ACGME's work. The scope of assessment is broader and spans both internal and external audiences. Assessment focused on what works well and what is in need of improvement, with both relating closely to the ACGME's mission and goals for the accreditation process.

What would an ideal approach of assessing the ACGME's effectiveness look like? Taking our cues from research, the ultimate measure of effectiveness would be a large positive

“...collection of input from constituents becomes one element of a ‘plan – do – check – act’ cycle that utilizes data as the basis for decision-making and continuous improvement.”

effect distal to the inputs. For ACGME, this could take the form of a significant improvement in the quality of care provided by physicians in practice as a consequence of their exposure to the general competencies. The time horizons involved make this approach impractical. What takes its place is a comprehensive review of the perceptions and thoughts of stakeholders, as the information relevant to ACGME effectiveness and performance that is readily available. ACGME is not alone in choosing this approach, as the constituency model has been widely used in assessments and in research on organizational effectiveness.^{1,2,3}

How does assessment of the ACGME's effectiveness relate to transparency? There is power in transparency, such as disclosing metrics and their interpretations to residency programs, and sharing relevant performance data with constituents. It

“There is power in transparency, such as disclosing metrics and their interpretations to residency programs, and sharing relevant performance data with constituents.”

replaces the “black box” of accreditation with a window. Disclosing the larger metric of how ACGME assesses its own effectiveness to its various constituencies will enhance both transparency and ACGME effectiveness, by shedding light on the processes thought most important to the ACGME's functioning and by bringing constituent opinion to bear on these processes. We hope that this effort ultimately will encourage ACGME creativity, frank and forthright discourse about its effectiveness, and suggestions for how that effectiveness can be enhanced. ■

¹Connolly T, Conlon EJ, Deutsch, SJ. Organizational Effectiveness: A Multiple-Constituency Approach. *Academy of Management Review*. 1980; 5(2):211-218

²Tsui AS. A Multiple Constituency Model Of Effectiveness: An Empirical Examination Of The Human Resources Subunit Model. *Administrative Science Quarterly*. 1990; 35:458-483.

³Zammuto RF. A Comparison Of Multiple Constituency Models Of Organizational Effectiveness. *Academy of Management Review*, 1984; 9:606-616.

Is There a Need for the Preliminary or Transitional Year?

Patrick Duff, MD

I am writing this commentary from the perspective of a residency program director and associate dean for students at a relatively large medical school. I believe that, despite the beneficial impact of the Electronic Residency Application Service (ERAS), the residency application process for senior students remains unnecessarily confusing, frustrating, time-consuming, and expensive. The present process also creates considerable extra work for the faculty and administrative staffs of the nation's medical schools. I believe that now is an appropriate time to address the following problems.

First, the specialties that require a *preliminary or transitional year of training* should carefully re-examine this requirement. If the requirement is based solely on tradition and has no proven educational value, it should be eliminated. If this introductory year truly is of *substantive* educational value in specialties such as Ophthalmology, Otolaryngology, Neurological Surgery, Neurology, Anesthesiology, Radiology, Radiation Oncology, and Dermatology, then it should be formally incorporated in the residency curriculum and paid for by the specialty program, allowing students to match their specialty at the PGY1 level. In the present system, students must apply to multiple residency programs for their specialty training (PGY2) and then to several additional preliminary or transitional programs for PGY1. Students incur major additional expense (up to \$2,000 for students at our medical school) in interviewing for the latter programs. These additional interviews also require students to miss extra days from class, beyond those usually allotted for interviews, thus creating difficulty for faculty members responsible for maintaining a consistent educational experience in senior electives. ■

Dr. Duff is a professor and director of the residency program in obstetrics and gynecology at the University of Florida College of Medicine, Gainesville, Florida.

Editor's Introduction

Transparency

Executive Director's Column

Transparency and Disclosure in a Postmodern Age

David C. Leach, MD

When Any Change Program Will Do...

A Report from the Field

Paul Batalden, MD and Tina Foster, MD, MPH, MS

Stewardship and Accountability: The Role of the ACGME Monitoring Committee

Duncan McDonald

Residents Discuss what Constitutes the Best Institutional Graduate Medical Education

Ilan Rubinfeld, MD, MBA and Marsha Miller

Simplifying the Accreditation Process

Julie Jacob

A Conversation with 160 Designated Institutional Officials

Innovative Ideas for Institutional Oversight

Ethan Fried, MD and H. Worth Parker, MD

An Interview with Carl Getto, MD

Innovation in Residency Education – Winning Posters from the 2004 Marvin R. Dunn Poster Session

ACGME News

RRC/IRC Update

Other News from the February ACGME Meeting

ACGME Moves 2005 Annual Educational Conference to Kissimmee, Florida

Field Staff and ACGME News

In Brief

National and International News about Graduate Medical Education

Executive Director's Occasional Column

A Self-assessment of the ACGME's Effectiveness

Ingrid Philibert

Letter to the Editor

Is There a Need for the Preliminary or Transitional Year?



ACGME

**Accreditation Council for
Graduate Medical Education**

515 North State Street
Suite 2000
Chicago, Illinois 60610

NON-PROFIT ORG.
U.S. POSTAGE
PAID
ACGME
PERMIT NO. 9451
CHICAGO, IL

Change of Address:

Requests for a change of address should be sent to the editor at the address given above. Please include a copy of the mailing label from the most recent copy of the ACGME Bulletin along with your new address.